County of Marin

CULTURAL HUMILITY & RESPONSIVITY PLAN

Report for Fiscal Year 2024-2025 & Updates for Fiscal Year 2025-2026

FINAL 01/27/26

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Introduction

Statement from BHRS Director, Todd Schirmer, PhD, CCHP

Marin County Behavioral Health and Recovery Services (BHRS), a Division of the County's Health and Human Services (HHS) Department, is pleased to present the 2025 update to our Cultural Humility and Responsivity Plan (CHRP). This past year has brought substantial developments at the federal, state, and local levels, each of which will shape the direction of our equity work and the services we provide in the years ahead.

At the federal level, recent policy shifts concerning diversity, equity, and inclusion (DEI) have introduced new considerations for state and local behavioral health systems. Several federal funding streams, including block grants and certain SAMHSA-administered grants, now carry heightened scrutiny around DEI-related activities. Marin County joined a lawsuit against the federal administration regarding these conditions on federal grants and received a preliminary injunction preventing enforcement of the policy shifts. While any changes remain in flux, BHRS is taking a thoughtful and measured approach to ensure continued compliance while remaining grounded in our core values of service access, cultural humility, and equitable care. We will continue to safeguard critical funding while upholding our commitment to meeting the needs of communities who have historically experienced barriers to behavioral healthcare.

At the state level, BHRS has now completed our first Behavioral Health Services Act (BHSA) Community Program Planning Process under the new BHSA framework and has finalized Marin County's inaugural Three-Year Integrated Plan. This planning process represented a significant undertaking, including over 30 in-person and virtual meetings and a survey completed by hundreds of Marin County residents, to bring community members, partners, and staff together to articulate a shared vision for behavioral health services in Marin. The Integrated Plan informs the priorities in this CHRP update and establishes a more cohesive structure for aligning our equity strategies across all funding streams. We expect the state will eventually issue guidance formally integrating the two documents.

We also continue to move forward with California Advancing and Innovating Medi-Cal (CalAIM), which has fundamentally reshaped clinical eligibility, documentation practices, and reimbursement models. The expansion of Medi-Cal benefits for incarcerated people up to 90 days pre-release has required close coordination with the Probation Department and the Sheriff's Office. Our shared efforts aim to ensure continuity of care for incarcerated individuals and support their stability upon reentry. The Behavioral Health Links portion of the CalAIM Justice Involved Initiative formally launched in 2024 and we expect the full Correctional Facility to go live later in 2026.

In December 2024, Marin County launched the Community Assistance, Recovery, and Empowerment (CARE) Court, marking a major milestone in the continuum of civil behavioral health interventions. Implementation continued throughout 2025, with a strong emphasis on outreach and engagement to support eligible individuals who may not otherwise access voluntary services. CARE Court represents a significant operational and philosophical shift, and BHRS remains committed to delivering this program in a manner that honors client dignity and advances meaningful recovery outcomes.

At the local level, BHRS continues to align closely with the broader strategic direction of Marin County HHS. In early 2025, HHS adopted a new Strategic Plan and advanced its Race Equity Roadmap**,** both of which provide an essential framework for our work. These initiatives reaffirm the County's commitment to reducing racial and ethnic disparities, strengthening community partnerships, and ensuring that services are accessible, culturally responsive, and grounded in data-informed decision-making. The Race Equity Roadmap, in particular, offers concrete pathways for addressing systemic inequities and improving outcomes for communities that have long faced disproportionate behavioral health challenges. As BHRS implements the goals outlined in this CHRP update, these department-wide guiding documents remain central touchstones.

Internally, BHRS has strengthened its organizational infrastructure with the launch of the BHRS Diversity, Equity, Inclusion, and Belonging (DEIB) Council**.** The Council brings together staff from across the Division to guide equitable practices, foster accountability, and help ensure that our workforce, policies, and service delivery models reflect the communities we serve. This internal structure will play a central role in the CHRP's implementation in the year ahead, particularly in light of evolving state and federal landscapes.

Amid these many changes, our mission remains the same: to advance racial equity, cultural humility, and person-centered, community-informed behavioral healthcare. This year's CHRP continues to offer a transparent look at where we are succeeding, where we must improve, and how we will remain accountable to our community. Thank you for taking the time to engage with this material and for your continued partnership in supporting BHRS' equity goals.

FY 2025/26 CHRP Update Authors

jenn moore (they/them) is the Program Manager of Equity and Inclusion (PMEI) for Marin County's Health and Human Services – Behavioral Health and Recovery Services. The PMEI oversees BHRS' efforts related to cultural humility/equity, including community outreach and engagement and works collaboratively with the MHSA team on workforce development and training, community engagement and planning, and community-focused prevention efforts. jenn believes in being a values-driven leader and prioritizing efforts toward collective liberation.

Other contributions to this report from:
BHRS Division Directors and Program Managers
Equity and Community Partnerships Committee (ECPC)
BHRS Outreach and Engagement Senior Program Coordinator

NOTE: A glossary of acronyms and terms frequently used in this CHRP Annual Update is included in Appendix A.

Commitment to Cultural & Linguistic Competency

Relevant Committees and Workgroups

Equity and Community Partnerships Committee (ECPC)

- The committee responsible for holding BHRS accountable to the Cultural Humility and Responsivity Plan (CHRP) is the BHRS Equity and Community Partnerships Committee (ECPC). The ECPC is comprised of the BHRS Equity and Inclusion Manager, a community co-chair, community-based organization representatives, community volunteers, and other representatives from across BHRS, including Quality Management, the Adult System of Care, the Children's System of Care, and Outreach and Engagement.

- The following can be reviewed at Member Materials of our public Google drive:

    - Charter
    - Decision-Making Process
    - Co-Chair Responsibilities
    - Community Agreements

BHRS DEIB Council

In FY 24/25, BHRS recruited, interviewed, and selected eight (8) BHRS staff members onto its BHRS Diversity, Equity, Inclusion, and Belonging (DEIB) Council to function as a responsive, sustainable, and shared leadership group that can manage the always changing equity needs of BHRS, as well as to create a path where advocacy can feel more accessible and comfortable in the presence of diverse leadership. The DEIB Council is distinct from the ECPC in that it focuses primarily on equitable outcomes and improved morale of BHRS staff, rather than the behavioral health community of Marin. The Council was formed after conducting a third-party organizational assessment to understand DEI system/core issues in supervision and staff support.

The assessment helped BHRS to determine eight (8) thematic areas as a starting place to address DEI issues that came up within the assessment. These goal areas reflect on an amalgamation of the original organizational assessment, Senior Management Team interviews, and supplemental staff feedback sessions, with findings gathered over a span of two (2) years:

1. Formally instituted DEIB policy, roles, committees, and/or mission
2. DEI specific expansions to client resources and services
3. DEI programming for supervisors and leadership
4. Staff-centered, internal conflict resolution or reparative system
5. Program for consistent, variable, voluntary staff trainings in DEI topics
6. Prioritization of community (clients/contractors) and team (staff) building

7. Transparency in communication, bottom-up evaluations, and multi-feedback pathways
8. DEI informed improvements to staff compensation, titles, and resources

In FY 2025/26, BHRS will be training individuals to understand the main themes of diversity, equity, inclusion, and justice that are needed for BHRS staff to better serve members and maintain a healthy work life. This fiscal year, the DEIB Council will set priorities and plans to meet needs/achieve goals for the present council and to find support to assess capacity for completing the chosen goals.

Latine Steering Committee

The Latine Steering Committee (LSC) is responsible for creating materials focused on increasing access to behavioral health services for the Spanish-speaking, Latine community. The LSC is comprised of BHRS staff, as well as a few passionate community members who bring vital perspectives to this work.

The steering committee chose to focus on developing vibrant, culturally relevant outreach tools that reflect the strengths and values of our community and help reduce stigma around mental health. These outreach tools provide bilingual materials that are simple, visual, and truly useful for individuals and families who may be navigating our system for the first time.

- Examples include:
  - BHRS Mental Health *Lotería* sets (600 Spanish, 400 English)
  - Rack cards with an overview of BHRS services and essential contact numbers
  - A navigation and eligibility booklet with FAQs, a glossary, billing basics, and how to access services
  - Colorful 4x6 bilingual index cards with contact information
  - 3x5 pocket flyers designed for wallets, backpacks, and purses
  - Flower-shaped wellness stickers
  - Wellness magnets with the same messaging
- Photos of some of these items are included in Appendix B.

The focus of these materials was on how individuals and families enter the BHRS system through ACCESS, Mobile Crisis Response Team [MCRT], and 988, rather than promoting all of the various programs within BHRS when clients do not have the option of self-referring to specific programs. The goal was clarity, cultural resonance, and accessibility.

For many individuals and families, especially those who are new to the behavioral health system, it is hard to know where to start or who to call. These materials simplify that first step. They offer reassurance and visibility—two things that go a long way in reducing fear and stigma. The navigation booklet helps demystify a process that can feel overwhelming. The *Lotería* sets use culture as a bridge to talk about sensitive

topics in a familiar and welcoming way. Each tool serves as a doorway, making BHRS feel more approachable and community-oriented.

Marin County Language Access Workgroup

The purpose of this workgroup is to help Marin County understand and strengthen its language access efforts, and to lay the groundwork for a comprehensive, countywide language access policy and plan.

A demographic analysis was conducted, including interviews with internal staff, outlining the Limited English Proficiency (LEP) population, and a high-level review of comparable jurisdictions. This scan included analysis of Sonoma, Santa Clara, and Sacramento counties, including their total populations, LEP populations, language access plans, language access policies, priority languages, interpretation services, translation services, compliance mechanisms, staffing supports, trainings, and oversight/evaluation.

Table 1. LEP Population in Marin County

Source: U.S. Census, American Community Survey (ACS) 2023.

Language	% LEP	# LEP
Spanish	42.50%	15628
French, Haitian, or Cajun	16.50%	299
German or other West Germanic languages	26.60%	775
Russian, Polish, or other Slavic languages	22.90%	215
Chinese (incl. Mandarin, Cantonese)	18.90%	1964
Vietnamese	51.70%	417
Tagalog (incl. Filipino)	32.70%	956
Korean	56.50%	365
Arabic	25.30%	310
Other Asian languages	39.60%	758
Other Indo-European languages	0.00%	0

For Marin County, the patterns identified underscore the need to prioritize language services in programs serving adults and seniors, while also supporting school-age LEP residents and their families to ensure equitable access across all stages of life. Furthermore, understanding the intersection between education and language is critical for targeting language services in workforce development, adult learning programs, and economic support initiatives.

In Marin, Spanish-speaking LEP households are disproportionately affected by poverty, which compounds barriers to accessing public services, benefits, and emergency resources. Foreign-born communities account for the vast majority of LEP residents, and Spanish-speaking households represent the largest share of those facing language access challenges.

These patterns reinforce the need for targeted outreach, bilingual services, and culturally appropriate communication to effectively serve immigrant populations in Marin County. The workgroup will be finalizing the recommendations and report, which will be distributed in quarter one of 2026. Capturing language needs at this level will support BHRS to provide appropriate language assistance services.

Health and Human Services (HHS) Equity Core Team

HHS launched a cross-divisional team to drive the HHS *Strategic Plan: Advancing Racial Equity* work forward. This core team will support HHS in implementation and learning, in addition to ensuring alignment across the HHS divisions, creating essential feedback loops to increase accountability.

Key BHRS Initiatives

BHRS Bilingual Outreach and Engagement

BHRS has a Bilingual Outreach and Engagement Senior Program Coordinator whose main priority is to support underserved communities in connecting with behavioral health services. BHRS' most significant racial disparity in access and engagement to behavioral health services is with Marin's Spanish-speaking, immigrant, undocumented, Latine and/or Hispanic communities. Spanish is also Marin's threshold language. For these reasons, that community has been identified as a priority for bilingual outreach and engagement services.

This past year, BHRS' Bilingual Outreach and Engagement Senior Program Coordinator worked on expanding access and building trust with the Spanish-speaking community in Marin. Some of their story is shared below:

> *I grew up in San Rafael, and this community played a huge role in shaping me. Being able to do this work now—serving the same families, elders, and youth who reflect where I come from—is an honor I carry with a lot of heart. My approach is rooted in authenticity, warmth, and a genuine desire to meet people where they are. I've learned that when we take the time to slow down, listen, and connect on a human level, people open up. That's especially true in Spanish-speaking immigrant communities, where trust is built through relationships, stories, and shared lived experience. Families respond to transparency—it makes the services feel real and reachable.*

This year was about connection—real, human, community-rooted connection. My goal has never been just to distribute materials; it's to build relationships, reduce stigma, and help families feel supported when taking the first steps toward care. It is a privilege to serve the community that raised me. I'm grateful for every conversation, smile, and story shared, and I look forward to continuing this work with even more intention in the year ahead.

Mental Health Lotería *Game*

BHRS Mental Health created a Latine mental health version of *Lotería*. *Lotería* is a traditional Mexican game of chance, similar to bingo, with different cards and images. Players place tokens on the cards and shout "*Lotería*" when they have four (4) tokens in a row. Mental Health *Lotería* has been one of the highlights of the year. *Lotería* is meaningful across Latino households, and transforming it into a conversation tool about wellness, coping skills, and mental health has resonated deeply. Photos of the game are included in Appendix B.

The game includes mental health concepts as well as everyday coping strategies like reading, walking, cooking, pets, and community. By approaching these topics through play, we are able to reduce stigma and invite individuals and families into healing discussions in a gentle, culturally grounded way.

In FY 2025/26, BHRS will partner with libraries, schools, and nonprofits to host *Lotería* game nights, workshops, and family mental health events. This is a key strategy for increasing engagement with Spanish-speaking families and helping them feel comfortable reaching out for support.

Community Events and Tabling

This year, BHRS participated in a variety of events across Marin County, including:

- Four (4) West Marin health fairs
- San Pedro Elementary Latino Heritage Month event
- Davidson Middle School Hispanic Heritage celebration
- Four (4) Back-to-School Nights
- Spanish-language mental health event at the Multicultural Center of Marin
- Marin County Library Spring Celebration
- National Alliance on Mental Illness (NAMI) Walk
- A Spanish-speaking parent group through the Probation Department

Many of these opportunities came through long-standing relationships the Bilingual Outreach and Engagement Senior Program Coordinator has with the community. This strategy underscores the importance of personal connections and how they can allow us to reach more people and create meaningful conversations. A sample of a tabling event may be found in Appendix B.

FY 2025/26 and Beyond

Next year, BHRS aims to:

- Launch ongoing *Lotería* workshops with libraries and schools
- Partner with community organizations for family mental health nights
- Expand outreach in West Marin and the Canal neighborhood to expand access to services
- Strengthen follow-up systems for individuals and families for outreach after events
- Develop additional bilingual materials and possibly short videos for *Lotería*

Training of Staff and Providers

BHRS Cultural Humility Training

Each year, BHRS supports staff in completing cultural humility trainings via live virtual trainings and on-demand online trainings.

In FY 24/25, BHRS offered 14 different cultural humility trainings to staff and contractors which included:

- Culturally Responsive Clinical Supervision: Ethical and Trauma-Informed Multicultural Supervision Strategies – 16 registrants for online training
- Cultural Competency and Trauma-Informed Care for Working with Trans and Trans BIPOC Clients: Create a Welcoming and Gender-Affirming Safe and Trusting Environment – 26 registrants for online training
- Sexual Assault and LGBTQ+ Identity – 34 attendees
- Healing Hearts, Sustaining Souls: Navigating Trauma Responsiveness and Burnout Prevention – 49 attendees
- Neurodivergence, EBPs, and LGBTQ+ Identity – 56 attendees
- Working with Latine Communities: Navigating Migration, Trauma, and Resilience – 38 attendees
- Breaking the Mold: Redefining Men and Masculinities – 22 attendees
- Behavioral Health Interpreter Provider Training – 101 attendees
- Behavioral Health Interpreter Non-Provider Training – 58 attendees
- Decolonizing Mental Health and Embracing Traditional Healing – 50 attendees
- Sex Trafficking, CSEC, and LGBTQ+ Identity - 60 attendees
- Honoring the Black Diaspora within Latine Communities – 55 attendees
- Personality Disorders and LGBTQ+ Identity – 63 attendees
- Mitigating Biases in Crisis Response – 36 attendees

Each year, BHRS also offers several in-person trainings on cultural diversity, equity, and inclusion. These trainings are available to all BH staff and partner agencies. These trainings help strengthen staff skills and create a safe environment for discussing culture. They also help staff understand the importance of recognizing and valuing how each person uniquely contributes to strengthening the system of care.

BHRS Culturally-Responsive Supervision

BHRS leadership offered a 10-session training on culturally responsive supervision. The purpose of this training was to create a supportive and proactive space for managers, supervisors, and directors to address inclusivity, equity, justice, and diversity issues within the workplace and in the provision of clinical services. This series aims to minimize microaggressions, enhance the ability to respond to ruptures, and promote a culturally responsive environment in co-worker dynamics, organizational practices, and clinical work. The consultation seamlessly blended discussions related to personnel and clinical spaces, recognizing the interconnectedness of individual experiences with organizational and clinical dynamics.

Incorporating a supervisor's supervision model, the sessions provided an additional layer of support for those in managerial roles, ensuring a holistic approach to addressing challenges. The sessions served as a designated space for open dialogue, constructive discussions, and collaborative problem-solving. Feedback and insights provided by training participants are included in Appendix C.

BHRS Latine Learning Academy (LLA)

The mission of the Latine Learning Academy was to equip Marin County Behavioral Health Providers (internal county staff and external CBO providers) with the tools, best practices, and culturally congruent strategies necessary for effectively working with diverse Latine populations. This Academy aimed to enhance client care by fostering the use of culturally relevant and community-centered values and practices, which promoted more healing and meaningful care for individuals who identify as Latina/e/o/x or who speak Spanish.

The Academy held 10 sessions, a mix of in-person and virtual sessions over the course of January – May 2025. Each session immersed participants in experiential exercises (e.g., mindfulness, drumming) and a mix of small and large group discussions. Topics covered included *Personalismo, Respeto, Dignidad, Simpatía,* and *Familismo*, assimilation and acculturation, working through a collective lens, USA cultural expectations and laws, understanding the impact of migration, integrating spirituality and ceremony, collaborating with elders and healers, use of storytelling and self-disclosure, and creating culturally welcoming spaces.

Examples of cultural and linguistic discussions included:

- Differences between collectivistic societies vs. individualistic societies
- Utilization of the tension between the personal and professional self, how work context shapes self-disclosure, self-disclosure as it relates to indigenous concept of *In la Ketch mi otro yo* (my other me/self)
- How speaking to someone in their native language activates a different part of the brain than a second or third language
- How people understand one another through others, family, age, generation, geographical/cultural context, dialects and indigenous languages

- Impacts of colonization
- Stages of engagement with clients: initial-*personalismo*, middle-kinship, *corazón to corazón* (heart to heart), cultural significance and traditions, end-when interactions and work ends with clients and the grieving process
- Time spent engaging with the client is the medicine
- Psychological stress of acclimating to a foreign culture in a new country is akin to feelings of being *desubicado* (lost)
- How we accompany the client in our work/spaces can bring about great relief to the client
- Eurocentrism is the worldview that prioritizes European/white being the norm, which becomes central to everything - education, psychology, institutions, etc.
    - Attitudes of traditional healing practices by Mental Health Professionals
        - *Drapetomania*: the term that plantation owners proposed as a mental illness for Africans to describe the reason they wanted to escape slavery. They believed slavery was the best thing for them.
        - *A Legacy of Negligence: The Historical Mistreatment of Indigenous Peoples in the United States Colonizers* imposed their world view on indigenous people including that they should be "grateful" for reservations (and oppression). History of boarding schools demonstrated the view that indigenous people were "resistant to civilization".
- Recognize the process of cultural humility starts with your own self-reflection.
    - Cultural humility allows us to ask questions and have curiosity about cultural traditions, experiences and utilize *Personalismo*.
- Community-Defined Evidence vs. Practice-Based Evidence vs. Evidence-Based Practice
    - Community-defined Evidence (CDE): CDEs are a set of practices that communities have shown to yield positive results as determined by community consensus over time, and which may or may not have been measured empirically but have reached a level of acceptance by the community. Interventions come from the community themselves.
        - Example: *hilo contado*/embroidery/knitting group. People gather and work on their textile while engaging in casual conversation with each other. The craft itself is the kinesthetic way to keep people engaged and a facilitator helps to maintain conversation flowing between them. If the group decides, they can transmit their worry into their craft and in this way they will lead with what they know. This type of group could be called a process group, support group, *comadre* group.
        - Drumming circles and when you establish a repetitive pattern, the two brain hemispheres become synchronized. It is hypothesized that brainwave entrainment might induce a desired state.
    - Practice-Based Evidence: A range of treatment approaches and supports that are derived from, and supportive of, the positive culture of the local society and traditions. Additionally, they are practices that work with the intended populations practiced from a provider to the community.

- Evidence-based Practice (EBP): “Evidence-based Practice” means the range of treatment and services shown to be effective in academic-based or other formal research studies. An evidence-based practice has been, or is being evaluated, and meets the following criteria: (1) has some quantitative and qualitative data showing positive outcomes, but does not yet have enough research or replication to support generalized positive outcomes; and (2) has been subject to expert/peer review that has determined that a particular approach or strategy has a significant level of evidence of effectiveness in research literature.

A total of 20 providers from across BHRS and contracted agencies participated in the Latine Learning Academy, which was facilitated by two bilingual and bicultural subject matter experts, each with clinical expertise in serving the Spanish speaking, indigenous, and Latine populations of the greater Bay Area. Two sessions featured guest speakers who self-identify as community members, elders, leaders, and activists. These sessions were impactful as speakers shared how they use the concepts being explored in the Academy in real world and practical situations with clients, in work and community settings.

A key ask of Academy graduates included a commitment to giving back to the communities the Academy aimed to serve post-graduation. In 2026, BHRS will be following up with Academy graduates to learn about the various ways the learnings from the Academy has informed their work.

Photos and feedback provided by LLA participants are included in Appendix D.

Cultural Humility Survey of Staff and Organizational Providers

In an effort to assess the cultural composition and awareness of its workforce, BHRS staff and organizational providers completed the Cultural Humility Survey in December 2025. The complete results are shown in Appendix E.

Summary of Survey Results

The survey asked several questions about cultural proficiency and responsiveness (e.g., I examine my own cultural background and biases [race, culture, sexual orientation] and how they may influence my behavior toward others.)

To each survey question, the response options included Frequently; Occasionally; Rarely or Never; and Did Not Occur to Me. Noteworthy responses are briefly outlined below; the complete results may be found in Appendix E.

Across all respondents:

A **high** percentage of staff responded "**Frequently**" to the following questions:

- I recognize and accept that clients are the primary decision makers about their treatment, even though they may be different from my own beliefs. (96% responded Frequently)
- I recognize that family may be defined differently by different cultures. (91% responded Frequently)
- I recognize that gender roles in families may vary across different cultures. (87% responded Frequently)

The survey also contained questions about staff participation in professional development activities over the past six (6) months.

The **majority** of survey respondents reported that they had participated in the following activities:

- Talked to a colleague about a racial and/or cultural issue (71%).
- Reflected on my race/ethnicity and how it affects my work with clients and/or working relationships (62%).
- Read/ watched/ listened to media about multicultural issues (69%).
- Learned something about a racial and/or cultural group other than my own (74%).

A **low** percentage of survey respondents reported that they had participated in the following activities:

- Sought guidance about a racial, gender or other cultural issue that arose during therapy/service delivery or within my team (26%).
- Sought consultation or supervision regarding multicultural issues regarding a client and/or family (27%).
- Talked to a friend/associate about how our racial differences affect our relationship (29%).
- Challenged a racist remark (23%).
- Challenged a sexist remark (19%).

Program Update and Highlights

Mental Health Adult System of Care (ASOC) Division Updates

- The division has implemented providing initial clinical assessments for new clients entering the system of care within our division.. These assessments were previously completed by the Access Team whose structure has changed to become a call center. The division has implemented an intake committee and procedures to ensure best client match to program. Assessments are being completed by all teams. Goals include: reducing wait times for clients entering the system of care and expedient assignments into teams that best match their needs.
- Behavioral Health Bridge Housing (BHBH) Grant Updates: Clients from the division have utilized BHBH for temporary housing at Arrowood in Sonoma County (20 designated beds) and utilized the following resources: funds for motels, rental stipends, Sober Living Environment (14 beds), participation funds including landlord incentive and mitigation funds. Upcoming: Homeless and Coordinated Care Division recruitment of 3 positions (supervisor, two housing navigators) to serve BHBH program and Arrowood; recruitment in collaboration with BHRS and will coordinate with BHRS ongoing. Continued coordination with BHRS Substance Use Administration division and Crisis and Justice Involved Services division, and Department of HealthCare Services, Felton Institute (onsite Arrowood provider) and Sonoma County Behavioral Health.
- Senior Peer Counseling Program has begun two new counseling groups (Redwoods and Rotary Manor). This is an expansion of the 1:1 peer counseling services program.
- BRIDGE Kerner welcomed a new Behavioral Health Practitioner who is bilingual in Spanish and Korean languages expanding services for non-English speakers served by the team.
- BHRS Language capacity: Spanish (all teams have bilingual providers in various roles), Vietnamese (HOPE), and Korean (BRIDGE Kerner) and Farsi (BRIDGE Bon Air).
- BRIDGE Bon Air Terrific Tuesdays social group which is open to all clients has expanded to provide individual socialization slots (service provided in English and Spanish).
- BRIDGE Bon Air has collaborated with West Marin Health and Human Services to serve undocumented Spanish speaking clients. Continued collaboration to increase services to rural geographic region of the county.
- Casa Canal opened in 2025 which converted a vacant office building into homes for people exiting homelessness and includes 41 units of permanent housing in the Canal district of San Rafael and provides residents with supportive and mental health services.
- The STAR team is actively working and collaborating with the Crisis and Justice Involved (CJI) Services to support CARE Court clients, with STAR absorbing and operationalizing portions of the CARE Court client workload. Multiple cross-team working meetings were held to jointly design and refine a coordinated workflow

that clarifies roles, referral pathways, and service handoffs between STAR and CJI.

Mental Health Children System of Care (CSOC) Division Updates

- In the last year, CSOC was able to maintain a high proportion of the Latine Medi-Cal Population with 63% of the CSOC clients served identified as Latine. Of the Latine served, many clients' primary or preferred language was Spanish.
- The number of younger children (0-5 years old) served increased by 29% FY2024-25. Most of these children and families are involved in the Child Welfare system.
- There is a high proportion of bilingual Spanish speaking staff to serve the Latine Population. 68%, or 13 of the 19 clinicians, in CSOC are Bilingual in Spanish.
- Newcomer student-focused services are currently offered in five (5) different Marin schools.
- A Child and Family Team (CFT) facilitator was hired to hold more regular CFT meetings to emphasize family voice and choice in the services they receive. The facilitator is Bilingual Spanish, and it is invaluable to hold meetings in the family's primary language.
- Direct referrals from outside providers, such as Child Welfare, Probation, and Marin Community Clinics has significantly reduced the wait time for referred clients and families to get access to treatment.
- A number of staff attended the Latine Learning Academy to increase and reinforce their understanding of the needs and challenges of serving the local Latine community.

Substance Use Services (SUS) Program Updates

New and Expanded Substance Use Services

- New contracts to implement Opioid Settlement Funded services to support community members with opioid use disorders (OUD):
    - Provide Trauma Treatment to Marin Residents with OUD – Grants awarded to Marin Treatment Center and Marin City Health and Wellness
    - Provide Care Coordination/Service Navigation for Marin Residents with OUD – Grant awarded to Ritter Center and co-applicant Marin Community Clinics
- Expanded access to adolescent substance use services through a contract with Muir Wood for adolescent residential substance use treatment services as well as a contract with Family Spring for in-person adolescent outpatient substance use treatment services.
- Expanded the contract with Buckelew Programs to add additional respite services, enhance police drop off services, add more care coordination, and increase the ability for clients who are not on probation to have the type of care a "probation hold" gives.

- Expanded the Recovery Coach Program by adding a new contracted Recovery Coach.
- Road to Recovery moved to 3270 Kerner Blvd. to co-locate with adult mental health services. The Program received its first ever AOD certification from DHCS. Additionally, Road to Recovery received State approval and implemented the Recovery Incentives Program, which utilizes Contingency Management to treat stimulant use disorders (StimUD). Participation also provides the opportunity to further address disparities and the disproportionate impact of StimUD within our system of care. For example, when stratified by race and ethnicity, clients who reported stimulants as their primary substance were more likely to identify as Hispanic/Latine or Black/African American, as compared to White beneficiaries.
- The Narcan Vending Machine initiative was expanded to support geographically equitable access to Narcan by launching a new machine at the Fire Station in Marin City.
- Expanded the hours of the Seeds of Hope quarterly luncheon and service fair, which attracts more than 200 attendees and approximately 30 tables with information/services at each event. The September 2024 event had more than 350 attendees.

Grants to Implement and Expand SUD Services

- Continued implementation of a $1.9 million five-year SAMHSA Grant to enhance the Adult Drug Court Program. Grant funds are used to expand capacity to provide substance use disorder and recovery support services for participants engaged in Marin County's Adult Drug Court (ADC) Program by adding bilingual Spanish-English speaking treatment providers; enhancing trauma informed and grief/loss treatment; providing low-income clients with assistance to support their recovery; and increasing treatment and recovery residence options for clients with specialized needs. The impact of these efforts has already been seen including an increase in participants preferring and receiving services in Spanish compared to prior years.
- Continued implementation of a $7.8 million grant to remodel 30 Joseph Court into a Residential substance use treatment program for adults with co-occurring substance use and mental health conditions. Construction of the new 15-bed residential substance use treatment program commenced in April 2025.
- Awarded a $2 million grant from the Behavioral Health Oversight and Accountability Commission to pilot strategies that incentivize best practices to increase access to and use of Medication Assisted Treatment (MAT) for opioid, alcohol, and tobacco use disorders, including a focus on engaging underserved communities.

Other Substance Use Initiatives

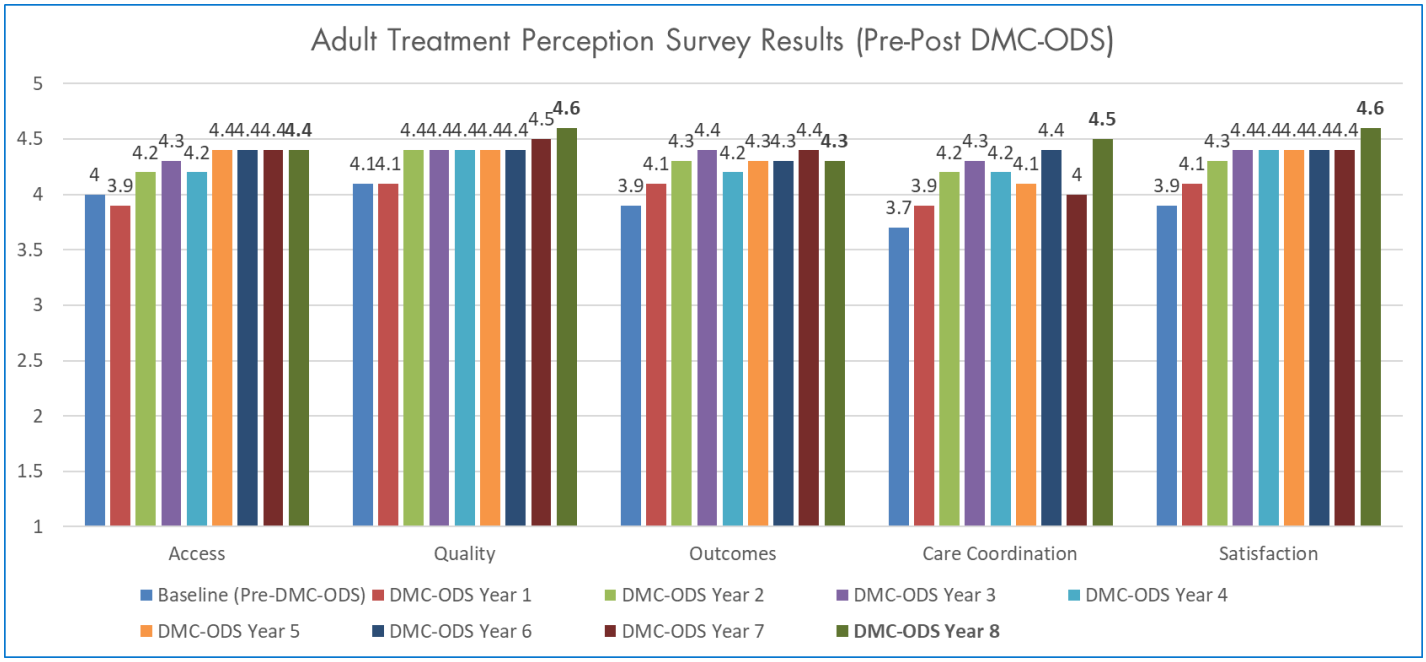
- **Enhancing Care Coordination**: Based on feedback from clients in the Treatment Perceptions Survey and from the external Strategic Plan evaluation findings identified by Resource Development Associates, a desire to increase care coordination was identified, and then created and contracted an incentive structure for providers to potentially earn financial incentives for increasing care coordination in the upcoming year's contracts.
- **Media to Promote SUD Services and Address Stigma**: Marin BHRS continues to implement media campaigns and messaging (English & Spanish) to promote available resources and reduce stigma. Campaigns have included print and social media, bus shelter ads, and promotion of the BHRS website and Access line.
- **School and Community-Based Prevention**: Contracted with four (4) Community Prevention Coalitions to implement substance use prevention education and policy initiatives across the geographic areas of Marin. Contracted with Youth Leadership to implement Friday Night Live chapters at three (3) schools across the County.
- **Assessing Infrastructure to Enhance Outcomes and Quality**: In partnership with BHRS Quality Management, opted into and completed the County self-assessment using the National Committee for Quality Assurance's (NCQA) Managed Behavioral Healthcare Organization (MBHO) Quality Management and Improvement and Care Coordination standards.

SUD Workforce Engagement and Development

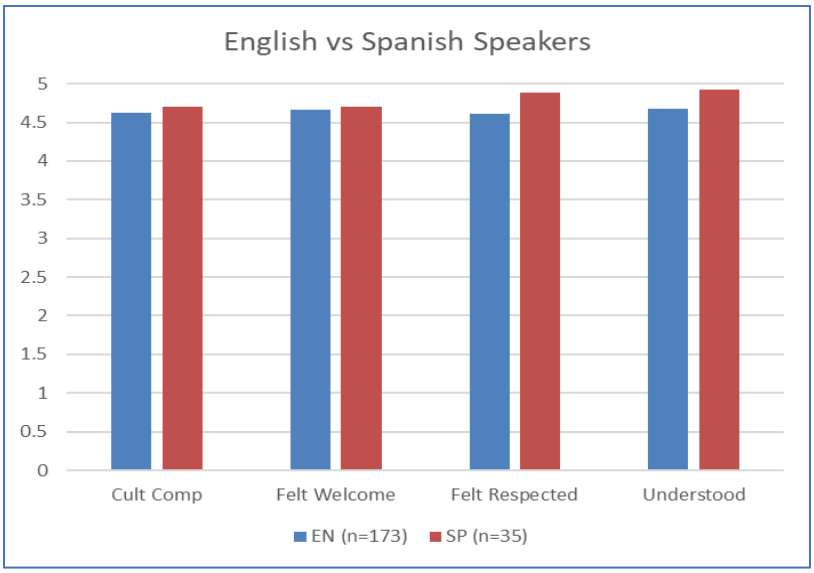
- Completed a co-occurring capacity workforce development pilot with the Odyssey team.
- Provided extensive support and technical assistance to BHRS staff, HHS teams and contracted providers on SmartCare implementation, including billing, reporting and clinical data entry.
- As part of the Behavioral Health Oversight and Accountability Commission (OAC) Grant, participating agencies are eligible for incentives to hire and engage in increased MAT prescribing.
- Utilized Opioid Settlement Funding for Provider recruitment outside of DMC-ODS with a focus on providing enhanced treatment and care coordination for Marin residents with an Opioid Use Disorder; funds were also utilized to pay for clinicians to become EMDR certified.
- Creation of the SUD Care Coordination Behavioral Health Practitioner (BHP) role, the clinician works with Recovery Coaches, with one project focusing on developing and implementing a standardized referral form and process to support equitable access to Recovery Coach services and align with a member's needs and preferences.

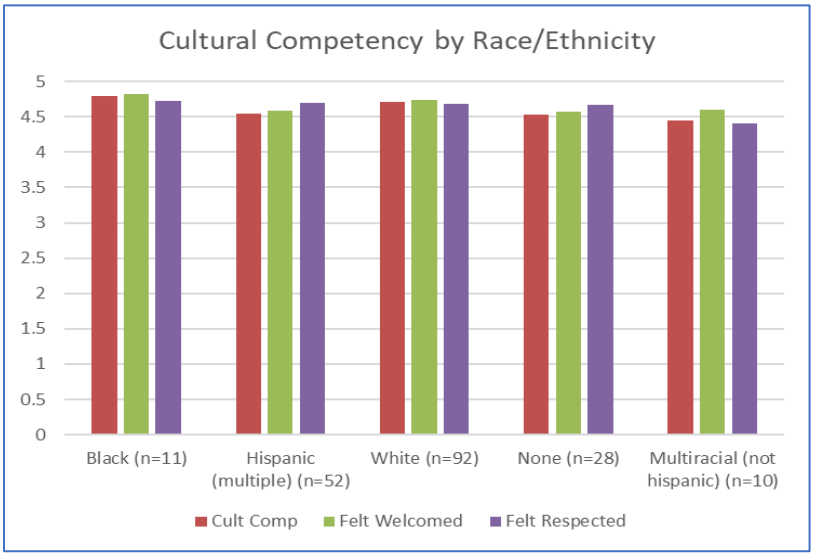
SUD Treatment Perceptions Survey (TPS) Results

In the 2024 Treatment Perceptions Survey (TPS) Administration, surveys were completed by 208 members and assessed outcomes, quality, access and satisfaction. As detailed below, with the exception of the outcomes domain, results were the same or higher in all domains as compared to the previous seven years. A detailed countywide analysis and provider-specific reports were shared with DMC-ODS Providers. All DMC-ODS providers are required to implement at least one performance improvement project to address client feedback raised in the TPS survey and/or as part of the care coordination incentive initiative.



Regarding questions on cultural responsiveness, and feeling welcomed, respected and understood, scores were high across all race/ethnicities and there were no significant differences reported between Spanish and English speakers.





SUD FY 2025/26 Goals

The BHRS Substance Use Services Strategic Plan 2020–2027 outlines strategies, performance indicators, metrics, and action steps to:

1. Strengthen accessibility and cultural responsiveness of services;
2. Engage communities in deep collaboration to effect meaningful change, including engaging diverse community stakeholders; and

3. Catalyze partnerships to improve conditions that affect health and wellness, including procurement processes and contracts that reflect equity-related goals.

Substance Use Services Strategies

Beginning in 2019, BHRS-SUS staff embarked on a strategic planning process facilitated by Resource Development Associates (RDA) to chart the course of the division's work over the course of the SUS planning cycle. The process included an analysis of secondary data and listening sessions with SUD providers and other stakeholders. In addition, Marin BHRS-SUS collaborated with other county departments to assess cross-system planning needs, address service improvements, and identify focus populations to streamline community engagement data collection events such as community listening sessions and community planning surveys. Community listening sessions collected input across systems that included housing, mental health, and substance use. For example, this five-year planning cycle aligned for the first time with the Mental Health Services Act (MHSA) three-year planning process. BHRS took full advantage of the opportunity to develop plans that address the high rates of co-occurring substance use and mental health and align our prevention efforts.

The resulting Substance Use Services Strategic Plan 2020-2027 focuses on the synergy created by strategies that enhance existing commitments, partnerships, infrastructure, and resources with the potential to uplift Black, Latine, and other communities of color in Marin County. Using the four focus areas to frame our subsequent strategies, we will achieve the following outcomes:

- **Client**: People will receive the right services when and where they need them
    - Strategy 1: Strengthen accessibility and cultural responsiveness of services
    - Strategy 2: Integrate service delivery to support clients more efficiently and effectively
- **Community**: Substance Use Services will be shaped by the perspectives and needs of the community
    - Strategy 3: Engage community in deep collaboration to effect meaningful change
- **Conditions**: Policies, systems and environments will be more equitable
    - Strategy 4: Catalyze partnerships to improve conditions that affect health and wellness
- **Quality**: Programs and services will be more effective
    - Strategy 5: Implement evidence based and data driven practices
    - Strategy 6: Promote growth and development of staff and partners

Other SUD Goals:

- Expand the continuum of culturally and linguistically responsive substance use services, including:
    - Stabilizing and enhancing the continuum of services available in Spanish.

    - Increasing the number of clinicians that can prescribe Medication Assisted Treatment (MAT) for Opioid Use Disorders, Alcohol Use Disorders and Tobacco Use Disorders.
    - Expanding in-person substance use services for adolescents.
    - Increasing the number of Recovery Coaches.
    - Exploring service delivery in West Marin.
- Expand the reach of Contingency Management to treat stimulant use disorders.
- Implement and refine the Behavioral Health Services Act (BHSA), including implementing field-based SUD Outreach and Treatment Initiation and supporting efforts to increase co-occurring capacity within the BHRS Mental Health Adult System of Care.
- Implement new initiatives, including SB 43, Proposition 36 and the CalAIM Re-Entry initiative.
- Implement initiatives to raise awareness of substance use resources and decrease stigma.
- With implementation of SmartCare, develop new dashboards and reports that analyze services and access data, including stratifying by race/ethnicity, language, and other demographic data, to assess and address equitable access to, and outcomes related to, treatment.
- Contract for additional substance use treatment services funded by Opioid Settlement Funds, as prioritized by the community engagement process convened in the Fall and Winter of 2024, which included services for Spanish speakers, youth services and services in West Marin.
- Create one or more new initiatives to support our communities impacted by losses of life due to the overdose epidemic. We will focus on professionals and people who lost a loved one, based on feedback gathered at community listening sessions, funded by Opioid Settlement Funds.
- Hire a person with lived experience of homelessness to assist with the Seeds of Hope.

Crisis and Justice-Involved Division Updates

Bias in Crisis Response Training

- Implemented a mandatory Bias in Crisis Response training for all direct service staff to strengthen staff awareness of how bias influences crisis assessment, engagement, and decision-making.
- The training, now also provided to all new hires in our division, reinforces centering self-reflection, understanding of lived experiences, and recognition of power dynamics in crisis encounters.
- It equips staff with concrete practices to adapt crisis interventions to the cultural, linguistic, and community contexts of the individuals they serve.

CARE Court Implementation (December 2024 Launch)

- Launched the County's CARE Court program, including new clinical and operational workflows that support assessments, care planning, and cross-system collaboration for individuals who have had challenges in getting connected to stable treatment.
- The CARE Court model focuses on meeting clients where they are, working to understand an individual's background, support preferences, and barriers to engagement, ensuring that care plans are not one-size-fits-all but culturally informed and tailored.
- The CARE team and partners emphasize respectful, person-centered engagement with individuals who may have experienced trauma or distrust of institutions.

Behavioral Health Links Launch (October 2024 Launch)

- Launched Behavioral Health Links, a centralized referral, access, and navigation pathway to establish connection to BHRS services for those exiting jail/prison.
- The model creates equitable, consistent entry points to care that account for different cultural needs, languages, and levels of system familiarity.
- It emphasizes relationship-building and adapting navigation support to the lived experiences of diverse populations.

Mental Health Services Act (MHSA) Team Updates

Financial Incentives Programs

- Continued participation in CalMHSA Medi-Cal Peer Support Specialist Certification program
- Awarded $107,707 in loan repayment funds
- Provided stipends to Masters Level Interns training in Behavioral Health and Recovery Services, including increased stipends for Bilingual interns

Psychology Internship Training Program

- In FY24/25, the American Psychological Association (APA) Psychology Internship Program supported six (6) predoctoral interns, two (2) of which were bilingual. The APA internship program offers a Latino Family Health track for interns who are bilingual/bicultural in the Spanish-speaking language. This program offers supervision in Spanish as a feature to increase bilingual/bicultural skillset while in the field with clients.

Peer Workforce

- There are currently a total of six (6) Certified Peer Specialists in Marin County, four (4) of whom are bilingual.
- The Enterprise Resource Center (ERC) promoted racial equity in FY24/25:
    - Provided Cultural Humility and Diversity Equity and Inclusion trainings to students in the Peer Education Program.
    - Staff completed a 1-hour Diversity, Equity and Inclusion (DEI) training course with Pryor Leaning.
    - Offered Peer Education in Spanish for the first time in almost 40 years in Marin County.
    - Onboarded a Cultural Liaison who plays a crucial role in fostering understanding and communication between individuals and groups from diverse cultural backgrounds, promoting cultural awareness and sensitivity within the organization, serving as a bridge between individuals with different cultural backgrounds and our agency. They provide community outreach in which they engage with diverse communities to build relationships and promote inclusivity.
    - Offered a Mental Health Support Group to people of color once a week.
    - Hosted Mental Health Advocates San Francisco (MHASF) in the facilitation of a weekly Spanish support group in the evenings.
    - Hosted a Narcotics Anonymous (NA) group in Spanish in the evenings.
- Addressed diversity in hiring practices. In FY24/25, staff demographics were as follows:
    - 40% Caucasian
    - 30% Hispanic or Latino
    - 20% Black or African American
    - 10% Asian

Operations Division Update

Quality Management

Following the transition to a new Electronic Health Record (EHR) system in July 2023, BHRS identified a decline in demographic data collection, which is required for state reporting and essential for identifying disparities in client care and outcomes. This decline was due to incomplete data conversion from the previous systems, differences in demographic data templates and dictionaries within the new EHR (causing confusion and incomplete data entry), and inconsistent data collection practices across the Adult System of Care (ASOC) and Crisis Services.

To address these challenges, the BHRS Quality Management (QM) department has partnered with the BHRS Equity team, the HHS Equity team, and the HHS Measurement, Learning, and Evaluation (MLE) team to improve demographic data collection, entry, and reporting.

BHRS recognizes that accurate and consistent capturing and reporting of demographic data in behavioral health care is essential for advancing equity. When providers reliably collect information on factors such as race, ethnicity, age, gender identity, language, and socioeconomic status, it becomes possible to identify disparities in access, quality, and outcomes of care. This data helps our system to understand who is being underserved, tailor services to community needs, allocate resources more fairly, and evaluate whether interventions are working for all groups. Without high-quality demographic data, inequities can remain hidden; with it, BHRS will be better equipped to design, monitor, and sustain behavioral health care that is truly inclusive and equitable.

Using QI tools and a Results Based Accountability (RBA) framework, the aforementioned teams will convene to identify solutions for data collection and reporting. This group has an additional goal of fostering a cultural shift across our systems of care, moving demographic data collection from a compliance-driven task to a care-centered practice. The workgroup's initiative centers on aligning demographic data collection with our core values of equity, quality, and client-centered care. Rather than viewing data collection solely as a state reporting obligation, we are working to help providers see it as a meaningful tool that enhances understanding of clients' lived experiences and informs more responsive care. This cultural shift is intended to build intrinsic motivation for accurate data collection rooted in its impact on real client outcomes.

Grievances

For the FY 2025/26, Quality Management updated the BHRS standard grievance reporting procedures to include the newly mandated information on Transgender, Gender Diverse, and Intersex (TGI) Grievance reporting requirements. In the first quarter of FY 2025/26, there were no reported grievances for mental health or DMC-ODS.

Administration

- Implementation of two (2) Office Assistant II Extra Hire Spanish Bilingual staff members to backfill when regular hire Office Assistant III Bilingual promote or leave their positions during the past 18-24 months (FY24-26) has reduced the burden for remaining staff during staffing vacancies or planned/unplanned out-of-office staffing gaps.
- BHRS Contractor Scope of Services includes at least one (1) outcome that focuses on advancing equity. Contractors reporting system is also required to monitor equity outcomes.

Access to Services

- The roll out of the new model of having treatment teams complete assessments within the Adult System of Care (ASOC) went live in June 2025. The Senior Management Team Access Workgroup considered lessons learned from the same shift that was completed within the Children's System of Care (CSOC) from the fiscal year prior, along with feedback and suggestions from ASOC management and line staff in the development of new protocols and training staff on the new processes. Additionally, Access staff and the Behavioral Health Practitioners on the treatment teams were trained on the assessment process (including informing clients of the availability of culturally-competent services), the shifting of responsibilities, and the timeliness document to be completed during various times of a client's care.
- Two Behavioral Health Practitioner (BHP) positions were moved from the Access Team to the two Bridge Teams (as these teams were identified to likely complete the bulk of assessments). The language capacity needs of each team were considered in determining which team would assume the Bilingual BHP position – ultimately being placed with the Bridge Kerner team. A BHP position on the Access Team was converted to a Bilingual Support Services Worker (SSW) position to better support responsivity to the community's needs.
- Additional training was provided to the Access Team staff in gathering demographic information as well as eligibility information upfront as workflows for eligibility continue to be revised.
- A West Marin clinician was hired to provide culturally competent services in both English and Spanish to rural West Marin clients. The position; however, is now vacant and will not be renewed by social services despite BHRS efforts to fill that position.
- A new tool called the Level of Care Utilization System (LOCUS) has been chosen by ASOC and Quality Management (QM) as an outcomes measure that will assist with team placement. The use of the LOCUS is intended to help with determining level of care for placement within BHRS programs with improved accuracy. The anticipated result is a reduction in disputes about placements and thereby more timely and accurate connection to services for clients. The LOCUS will also be available for treatment teams to determine need and/or readiness for clients to step up or down in levels of care. This tool's template has been integrated, tested, and approved for SmartCare use.

Medical Provider Updates/Goals

- An equity goal for FY 2024/25 was to execute the contract, design an operational workflow, and pilot Transcranial Magnetic Stimulation (TMS) Therapy and Esketamine treatments for BHRS clients. Both services are high intensity treatment options for individuals with conditions that have not responded to other primary treatments. TMS and Esketamine services are currently only available through out-of-network providers in the private healthcare sector. Both services

have a high out-of-pocket expense that makes these services inaccessible for the vast majority of BHRS clients.

- The contract with the community provider was successfully executed according to plan in October 2024. Operational workflows were designed and the first client was referred to TMS services in November 2024. In January of 2025, the first client was referred to Esketamine services. Between November 2024 and May 2025, seven (7) clients received the TMS treatment course and three (3) clients have received the Esketamine treatment course. This was slightly higher than the anticipated volume for this pilot period. Both cohorts showed positive response to the treatments based on the measurement scales. A protocol was established to provide transportation to and from the treatments for clients in need.
- Establishing psychiatric services as part of the 30 Joseph Court short-term residential substance use program. We currently lack a residential program that can fully offer services for individuals with co-occurring disorders. With the anticipated opening of 30 Joseph Court in 2026, we have set a goal to incorporate a psychiatric provider to provide direct services on-site. This provider would allow the program to admit clients with a higher level of psychiatric acuity. Working in conjunction with the MAT prescriber, the program will provide comprehensive co-occurring treatment, filling a significant gap for our community.

Other Plans and Equity Efforts

Marin County Digital Accessibility

Marin County is committed to making accessible the services, programs, and activities offered by BHRS to the public through the web and mobile applications (“apps”). All electronic content and web-based systems that are developed, maintained, or procured under a county contract must meet Web Content Accessibility Guidelines. For more information, refer to Appendix F.

Pertinent Data Updates

The following data provides an overview of demographic information of Marin County, Medi-Cal beneficiaries, and BHRS clients and staff.

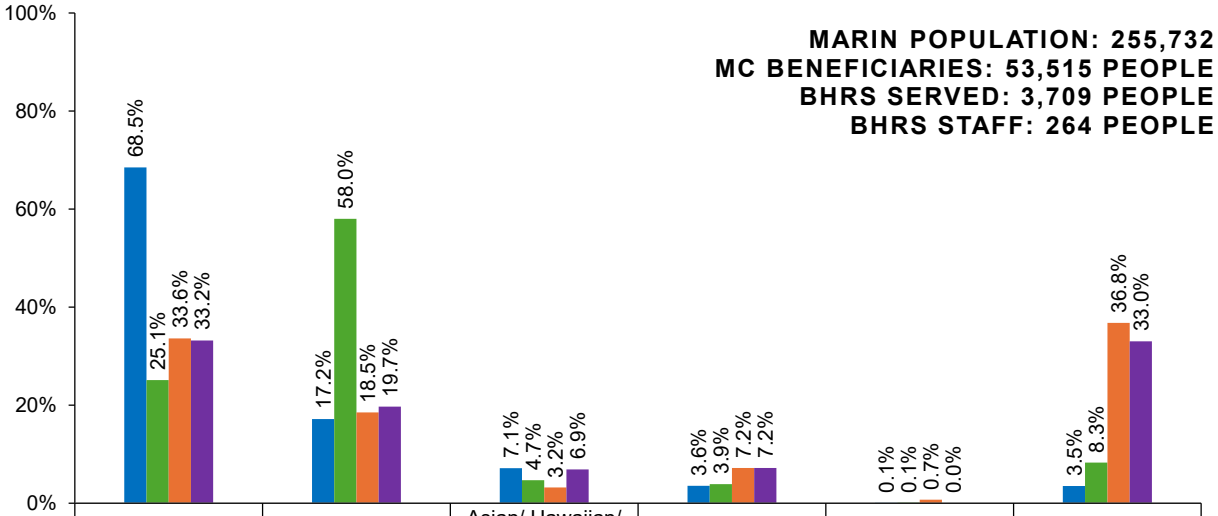
Figure 2 shows the Marin County total population, the Medi-Cal beneficiary population, the BHRS clients served, and the BHRS staff in FY 2024/25. The graphs show the percentage of each of these populations by race/ethnicity. For example, of the 255,732 people in Marin County, 68.5% were White; 17.2% were Hispanic; 7.1% Asian/ Hawaiian/ Other Pacific Islander; 3.6% Black; 0.1% Alaskan Native or American Indian; and 3.5% other/unknown.

Across all four populations, the Marin population has a higher percentage of people who are White (68.5%) compared to Medi-Cal Beneficiaries (25.1%); BHRS clients served (33.6%); and BHRS staff (33.2%). For the data regarding persons who are Hispanic, the percentages vary for Medi-Cal beneficiaries compared to the other three populations. For Medi-Cal beneficiaries, 58% were Hispanic, while the Marin population, BHRS clients served and staff were similar (17.2%, 18.5%, and 19.7%). The other race/ethnicity groups show very small percentages across all four populations. The other/unknown data shows a high percentage of data not reported for BHRS clients and staff. This data highlights the opportunity for BHRS to review how this information is collected and provide training to help improve how this important data is reported.

Figure 2

FY 24-25 Race/Ethnicity Distribution Comparison

Marin County Population, Medi-Cal Beneficiaries, BHRS Clients, and BHRS Staff



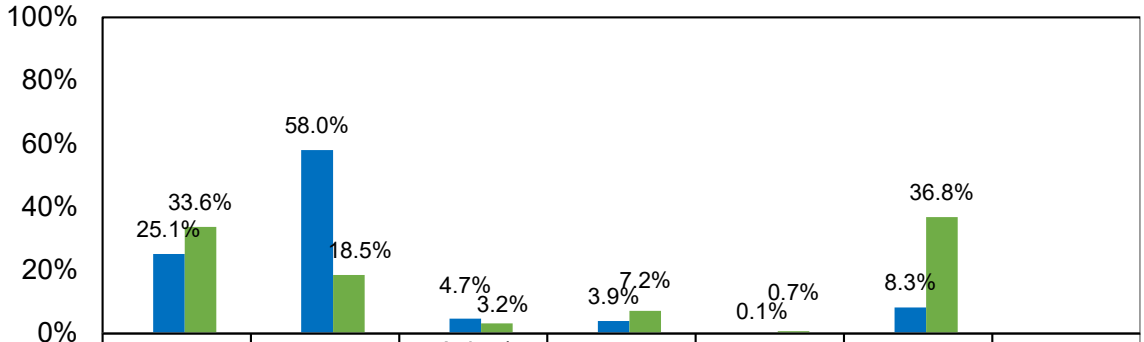
	White	Hispanic	Asian/ Hawaiian/ Other Pacific Islander	Black or African American	Alaskan Native or American Indian	Other/ Unknown
Marin Population	68.5%	17.2%	7.1%	3.6%	0.1%	3.5%
Medi-Cal Beneficiaries	25.1%	58.0%	4.7%	3.9%	0.1%	8.3%
BHRS Served	33.6%	18.5%	3.2%	7.2%	0.7%	36.8%
BHRS Staff	33.2%	19.7%	6.9%	7.2%	0.0%	33.0%

Figure 3 shows the race/ethnicity distribution for Medi-Cal beneficiaries and BHRS clients served. There were a total of 53,515 Medi-Cal beneficiaries and 3,709 BHRS clients served in FY 2024/25. The proportion of people who were White in the Medi-Cal beneficiary population was 25.1% and 33.6% for BHRS clients. For people who were Hispanic, 58% were Medi-Cal beneficiaries and 18.5% were BHRS clients. There were 4.7% of the Medi-Cal beneficiaries and 3.2% of the BHRS clients who were Asian/Hawaiian/Other Pacific Islander. There were also a small percentage who were Black (3.9% and 7.2%) and Alaskan Native or American Indian (0.1% and 0.7%). There was a high percentage of BHRS clients with other/unknown race/ethnicity (36.8%).

Figure 3

FY 24-25 Race/Ethnicity Distribution Comparison

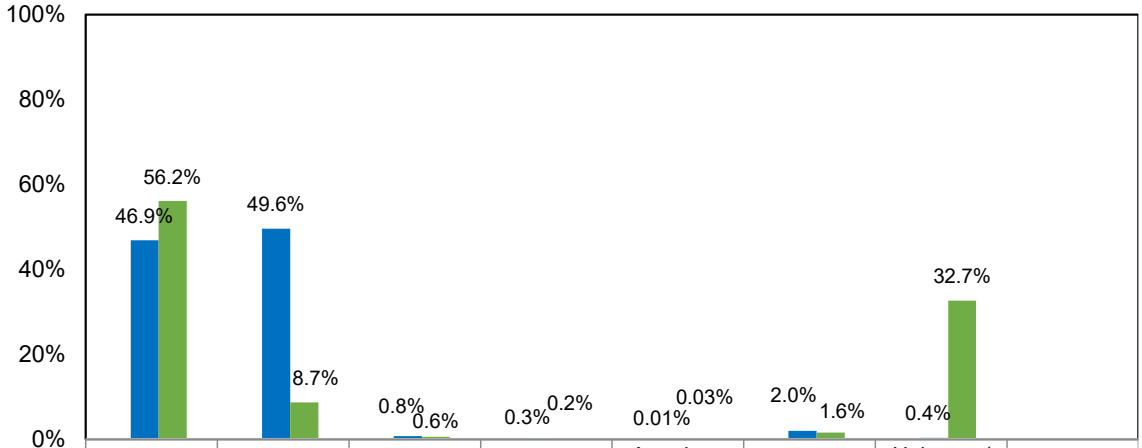
Medi-Cal Beneficiaries and BHRS Clients



	White	Hispanic	Asian/ Hawaiian/ Other Pacific Islander	Black or African American	Alaskan Native or American Indian	Other/ Unknown	Total
# Medi-Cal Beneficiaries	13,449	31,024	2,489	2,078	57	4,418	53,515
% Medi-Cal Beneficiaries	25.1%	58.0%	4.7%	3.9%	0.1%	8.3%	100.0%
# BHRS Served	1,248	685	119	266	25	1,366	3,709
% BHRS Served	33.6%	18.5%	3.2%	7.2%	0.7%	36.8%	100.0%

Figure 4 shows the language distribution for Medi-Cal beneficiaries and BHRS clients served in FY 2024/25. For Medi-Cal beneficiaries, 46.9% have a primary language of English, compared to 56.2% for BHRS clients. There were 49.6% of the Medi-Cal beneficiaries had a primary language of Spanish, compared to 8.7% for BHRS clients. There were small numbers of persons who speak Vietnamese, Farsi, American Sign Language, and other non-English languages. For the BHRS clients, 32.7% had unknown/not reported primary language. This data illustrates the need to provide additional training to BHRS staff to help accurately collect this information from all BHRS clients.

Figure 4
FY 24-25 Language Distribution Comparison
Medi-Cal Beneficiaries and BHRS Clients



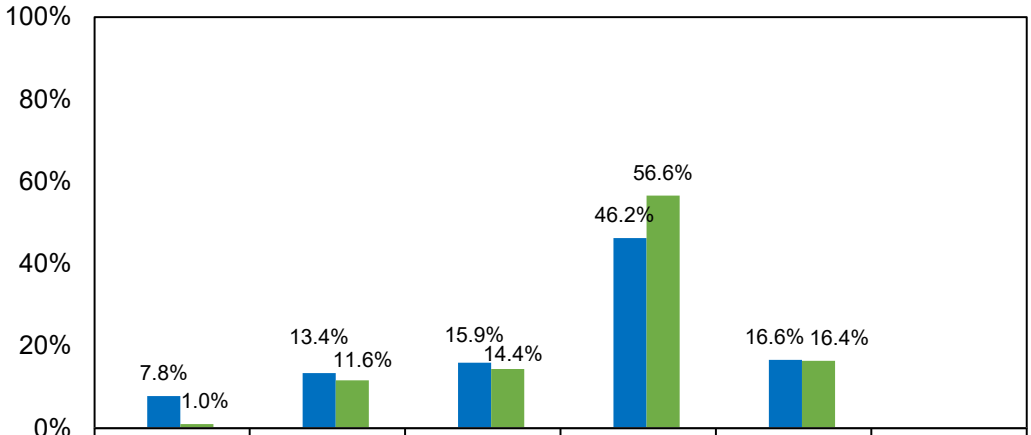
	English	Spanish	Vietnamese	Farsi	American Sign Language	Other Non English	Unknown/ Not Reported	Total
# Medi-Cal Beneficiaries	25,080	26,568	427	146	5	1,071	218	53,515
% Medi-Cal Beneficiaries	46.9%	49.6%	0.8%	0.3%	0.01%	2.0%	0.4%	100.0%
# BHRS Served	2,083	323	24	6	1	59	1,213	3,709
% BHRS Served	56.2%	8.7%	0.6%	0.2%	0.03%	1.6%	32.7%	100.0%

Figure 5 shows the age distribution of Medi-Cal beneficiaries and BHRS clients served. There were 7.8% of the Medi-Cal beneficiaries and 1% of the clients who are 0-5 years of age. There were 13.4% of the Medi-Cal beneficiaries and 11.6% of the clients who were aged 6-15. The 16-25 age range was similar, with 15.9% of the Medi-Cal beneficiaries and 14.4% of clients served. The 26-59 age group shows the highest percentage with 46.2% of Medi-Cal beneficiaries and 56.6% of clients. For the 60 and older population, there were identical proportions with 16.6% of Medi-Cal beneficiaries and 16.4% of the clients.

Figure 5

FY 24-25 Age Distribution Comparison

Medi-Cal Beneficiaries and BHRS Clients



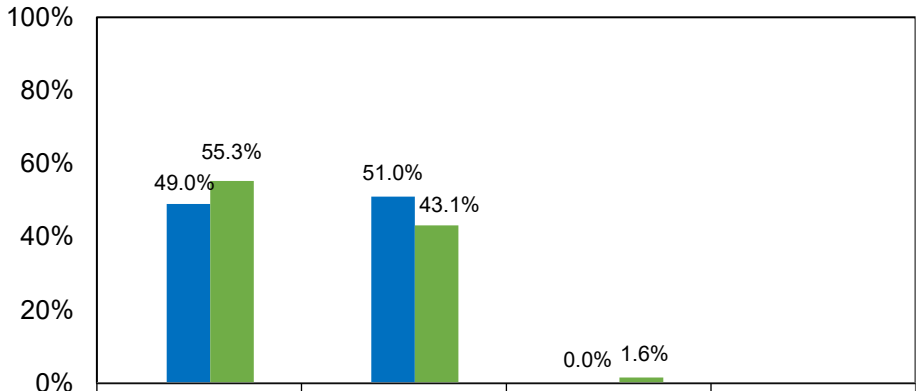
	0-5	6-15	16-25	26-59	60 and older	Total
# Medi-Cal Beneficiaries	4,200	7,163	8,512	24,750	8,890	53,515
% Medi-Cal Beneficiaries	7.8%	13.4%	15.9%	46.2%	16.6%	100.0%
# BHRS Served	37	432	533	2,098	609	3,709
% BHRS Served	1.0%	11.6%	14.4%	56.6%	16.4%	100.0%

Figure 6 shows the gender distribution of Medi-Cal beneficiaries and BHRS clients served. This data is similar across the two reported genders. For Medi-Cal beneficiaries, 49% were male and 51% were female. For BHRS clients served, 55.3% were male and 43.1% were female. There were 1.6% of clients who did not report their gender.

Figure 6

FY 24-25 Gender Distribution Comparison

Medi-Cal Beneficiaries and BHRS Clients



	Male	Female	Not Reported	Total
# Medi-Cal Beneficiaries	26,232	27,283	-	53,515
% Medi-Cal Beneficiaries	49.0%	51.0%	0.0%	100.0%
# BHRS Served	2,051	1,600	58	3,709
% BHRS Served	55.3%	43.1%	1.6%	100.0%

Figure 7 shows the main cities of residence in Marin County for BHRS clients served, with the largest city on the left. San Rafael had 46.3% of the Medi-Cal beneficiaries and 44% of the BHRS clients. Novato had 27.1% Medi-Cal beneficiaries and 21.1% BHRS clients. The next 11 counties had small percentages of Medi-Cal beneficiaries and BHRS clients. The final column shows those who had a residence that was not Marin County. The data labeled "Non-Marin" may represent the 12% of BHRS clients who do not have a city of residence reported.

Figure 7

FY 24-25 City of Residence Distribution Comparison

Medi-Cal Beneficiaries and BHRS Clients

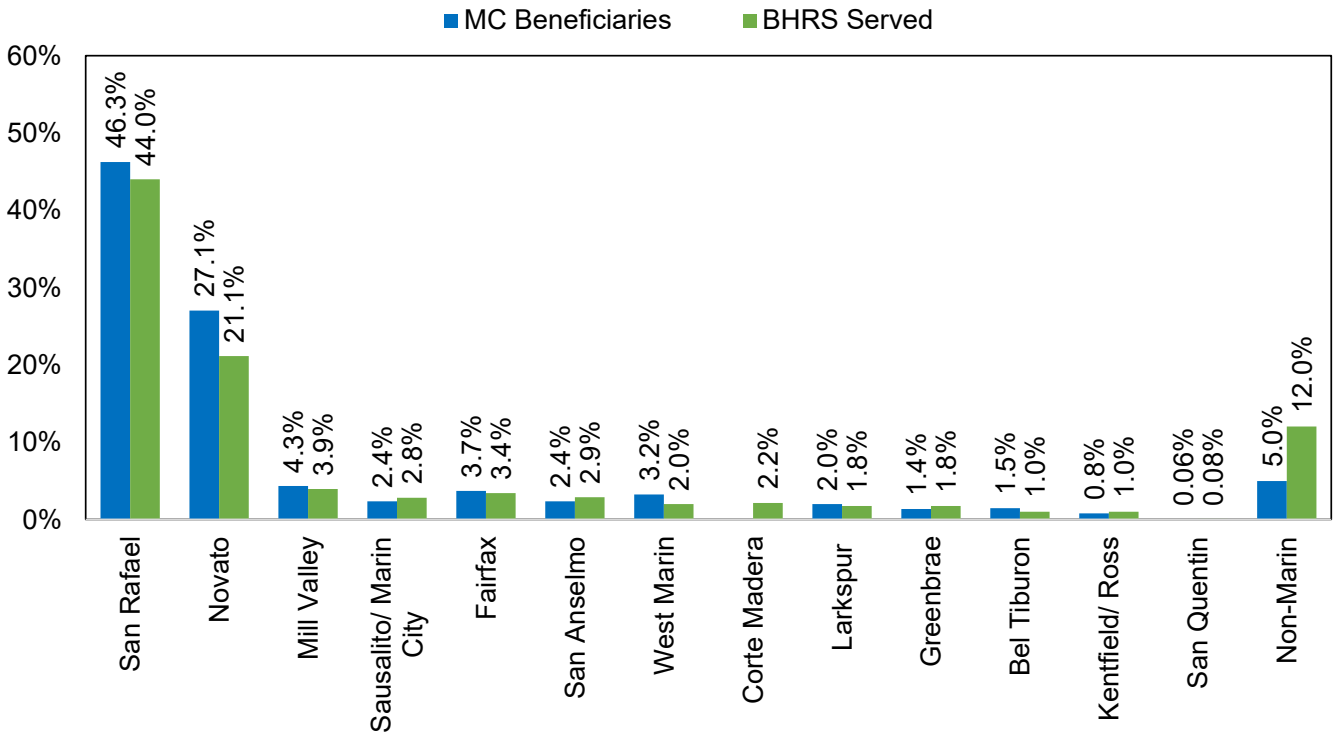
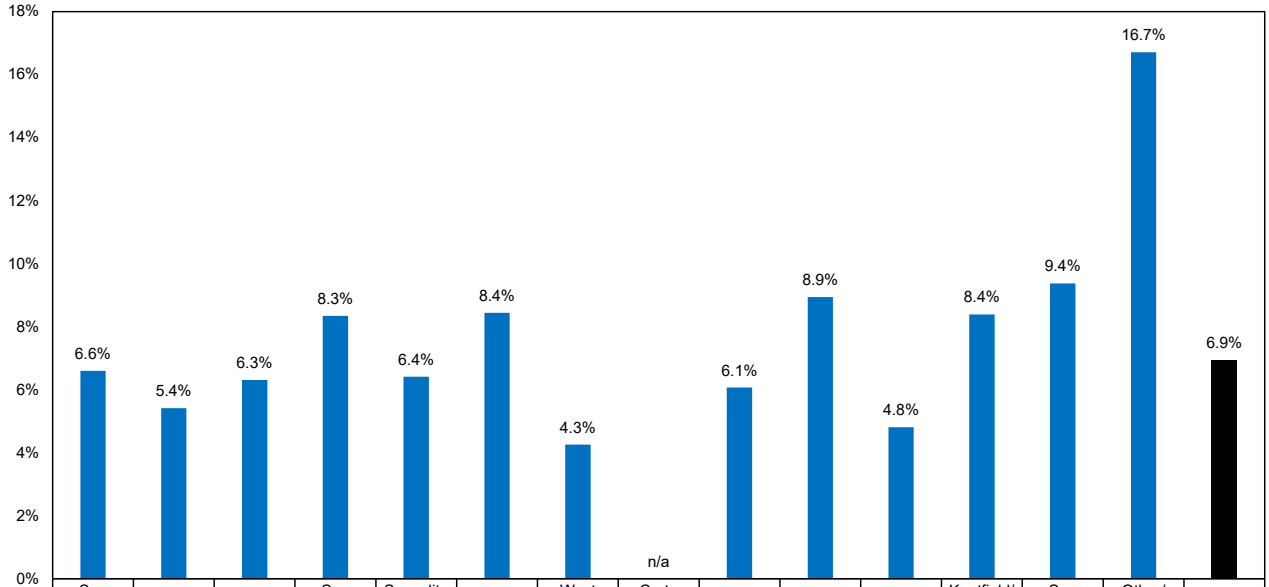


Figure 8 shows the penetration rate by city of residence. This data shows the proportion of BHRS clients out of the total number of Medi-Cal beneficiaries. There is more variability with the smaller cities/towns. The data for San Rafael shows a penetration rate of 6.6%, indicating that 6.6% of the Medi-Cal beneficiaries living in San Rafael received BHRS services. Novato shows a penetration rate of 5.4%. The other cities have a small number of clients served, so the penetration rate varies across cities.

Figure 8

FY 24-25 Medi-Cal Penetration Rate by City of Residence

BHRS Clients out of Medi-Cal Beneficiaries

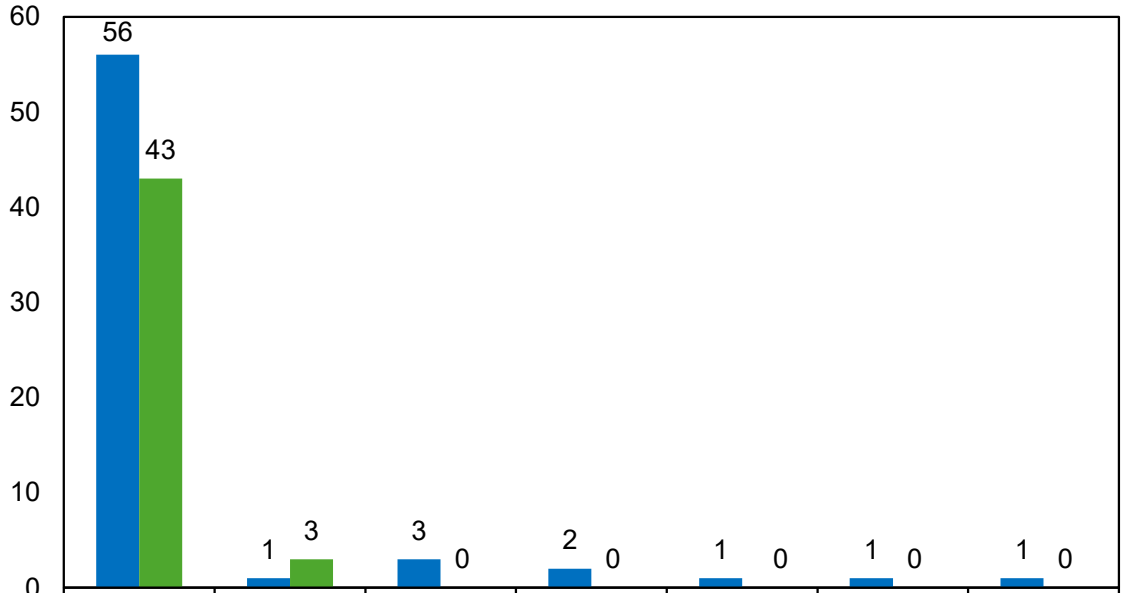


	San Rafael	Novato	Mill Valley	San Anselmo	Sausalito Marin city	Fairfax	West Marin	Corte Madera	Greenbrae	Larkspur	Tiburon	Kentfield/ Ross	San Quentin	Other/ Outside	Total
# BHRS Served	1,633	784	146	105	127	107	74	80	65	65	38	36	3	446	3,709
# Medi-Cal Beneficiaries	24,759	14,477	2,315	1,259	1,981	1,268	1,737	-	1,071	727	790	429	32	2,670	53,515
PR	6.6%	5.4%	6.3%	8.3%	6.4%	8.4%	4.3%	0.0%	6.1%	8.9%	4.8%	8.4%	9.4%	16.7%	6.9%

Figure 9 shows the number of reported BHRS clinicians rendering services in languages other than English to Medi-Cal beneficiaries. Please note that "Fluent" is not an indication if a clinician is in a Bilingual Classification or receiving a Bilingual Differential. Clinicians who speak multiple additional languages would be represented multiple times in this graph, as well. For clinicians who speak Spanish, 56 reported to be fluent in Spanish with 42 being certified to provide services in Spanish.

Figure 9

Number of Clinicians, by Spoken Language



	Spanish	Vietnamese	Farsi	Cambodian	Hmong	Mandarin	Tagalog
Fluent	56	1	3	2	1	1	1
Certified	43	3	0	0	0	0	0

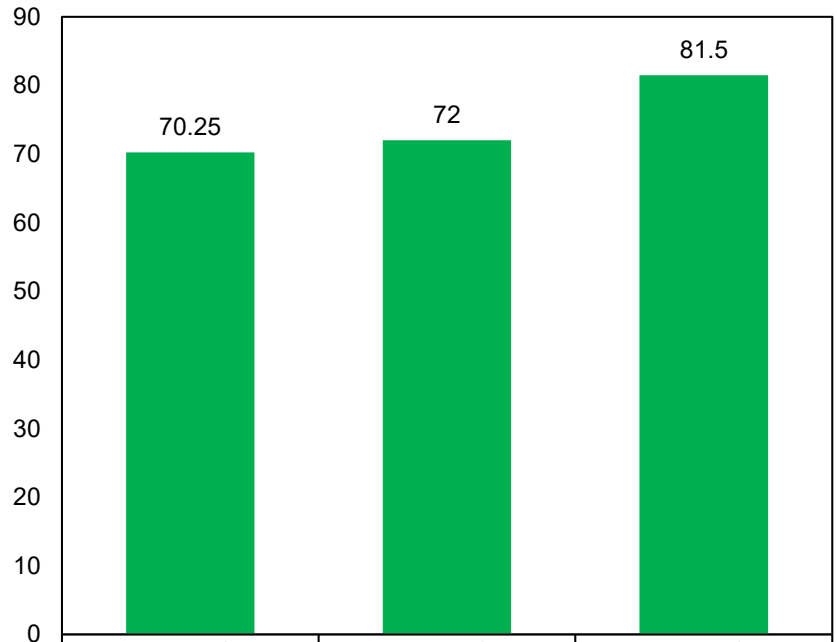
Over the past several years, BHRS has been successful at hiring bilingual, bicultural staff who are Latine and/or Hispanic and who are certified to speak Spanish. BHRS also has other staff who are certified in Vietnamese. As the Medi-Cal population continues to expand, there is an ongoing need to continue to increase the number of bilingual and/or bicultural staff throughout the BHRS program. It is a goal of BHRS to have all Limited English Proficiency (LEP) clients receive services in their primary language, whenever possible.

The Marin County population is 17.2% Hispanic and 18.5% of the BHRS clients identify as Hispanic. With 19.7% of the BHRS staff identifying as Hispanic, BHRS is reaching the goal of staff diversity similar to the client population. This data demonstrates how BHRS has been successful in identifying opportunities to recruit and retain bilingual and bicultural staff.

Figure 10 shows the number of BHRS staff by bilingual classification, as reported as Full Time Equivalents (FTE). A staff person who works 40 hours per week would be reported as 1.0 FTE. A staff person who works 20 hours per week would be reported as 0.5 FTE. This data shows the total number of BHRS bilingual staff by FTE across three (3) fiscal years. It also shows the number of FTE with a Bilingual Classification and those who have a Bilingual Pay Differential. In FY 2022/23, there were 50.5 FTE with a Bilingual Classification and an additional 19.75 FTE with a Bilingual Pay Differential, for a total of 70.25 FTE bilingual staff. There was an increase in the total FTE for bilingual staff, with 72 FTE in FY 2023/24 and 81.5 FTE in 2024/25. This increase in bilingual FTE shows an increase in the number of staff who are able to deliver services in the client's primary language.

Figure 10

Number of BHRS Bilingual Staff FTEs, by Year

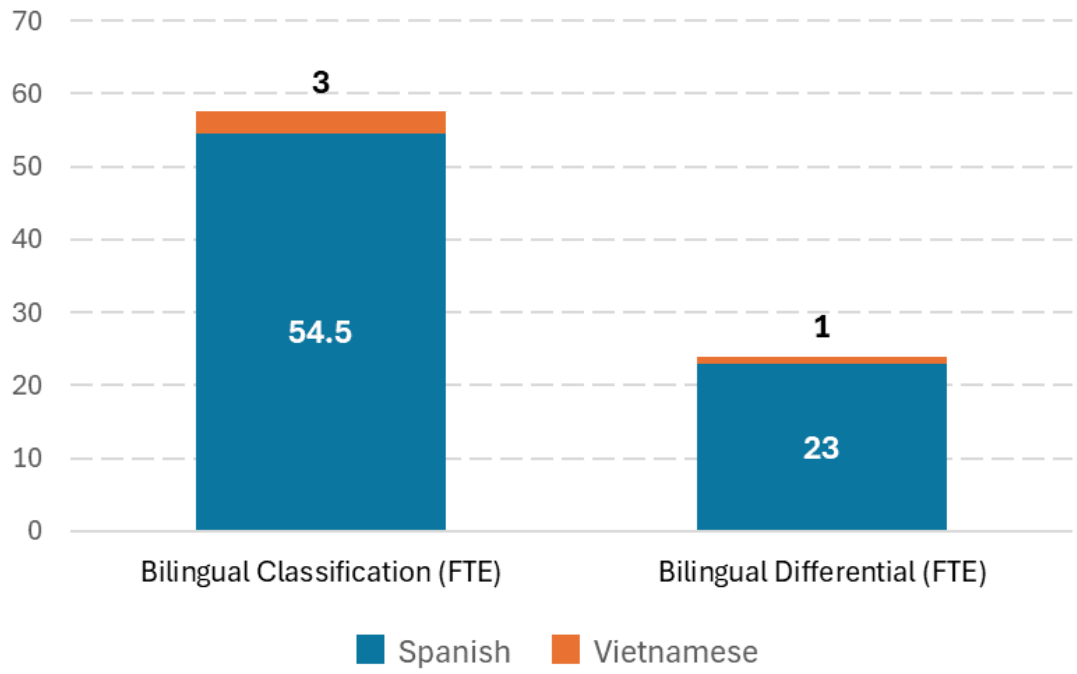


	FY 2022/23	FY 2023/24	FY 2024/25
Bilingual Classification FTE	50.5	49.5	57.5
Bilingual Differential FTE	19.75	22.5	24
Total Bilingual FTE	70.25	72	81.5

Figure 11 shows the number of BHRS staff FTE by language spoken for each designated bilingual assignment in FY 2024/25. Of the 81.5 bilingual staff FTE, there were 54.5 FTE staff whose position was classified as bilingual and they spoke Spanish. An additional 3.0 staff FTE who spoke Vietnamese. For the staff who received a Bilingual Differential, there were 23 FTE who spoke Spanish and one (1) who spoke Vietnamese.

Figure 11

BHRS Staff Languages Spoken, by Designated Bilingual Assignment



CHRP FY 2025-2026 Goals & Objectives; Status & Progress

Goal 1: To provide equitable and timely access to linguistically-appropriate integrated, behavioral health services		
Action Item	Objective	Status / Progress
1a	Update and translate documents utilizing a bilingual subject matter expert.	Bilingual subject matter experts have been identified who translate documents in a timely manner.
1b	Promote collaboration between the BHRS Program Manager of Equity and Inclusion (PMEI) and the Director of Countywide Communications to provide ongoing feedback on experiences with language translation/interpretation contracts.	Ongoing
1c	Participate in the County-Wide Language Access Workgroup and develop and implement any procedures that are unique to BHRS.	Awaiting report out in first quarter of 2026
1d	Analyze data on number of bilingual staff and languages spoken with number of clients who need bilingual services, where they are referred, and timeliness of service connection.	Data on the number of bilingual staff and languages spoken has been analyzed. Additional data will be analyzed to determine timeliness of service connections.

Goal 2: To address disparities using innovative, evidence-based, community-informed, and trauma-informed behavioral health services in collaboration with other community organizations		
Action Item	Objective	Status / Progress
2a	Distribute and promote the educational materials developed by the Latine Steering Committee.	Materials featured in Appendix B have been printed and are available for distribution. Currently, the *Lotería* game is being assembled and distribution in the near future. Each action item below is a strategy for distributing and promoting the educational materials developed.
2b	Utilize educational materials to address disparities within the Latine and Spanish speaking communities in Marin.	TBD
2c	Distribute the system navigation booklet, which includes information on an individual's financial responsibility, insurance eligibility, and the BHRS assessment process.	TBD
2d	Implement the *Lotería* game into communities.	Bilingual Outreach and Engagement Senior Program Coordinator is hosting community events and visiting key community locations (i.e., libraries) to disseminate information.
2e	Train staff on utilization of these *Lotería* tools.	Bilingual Outreach and Engagement Senior Program Coordinator is planning to host training sessions.
2f	Analyze the effectiveness of these *Lotería* tools.	Bilingual Outreach and Engagement Senior Program Coordinator is developing a survey.
2g	Unite the graduates of the Latine Learning Academy to identify support strategies for Newcomers, immigrants, and Spanish speakers to address disparities.	Graduates will be coming together in Quarter 1 of 2026.

Goal 2: To address disparities using innovative, evidence-based, community-informed, and trauma-informed behavioral health services in collaboration with other community organizations		
Action Item	Objective	Status / Progress
2h	Analyze timeliness metrics of ACCESS team.	Quality Management is tracking this as a part of the recent shift from Access completing assessments to treatment teams completing assessments.
2i	Support the Equity and Community Partnerships Committee (ECPC) to connect community with existing resources and supports.	Ongoing

Goal 3: To create a work environment where cultural humility, dignity and respect are modeled, so all BHRS staff experience equitable opportunities for professional and personal growth		
Action Item	Objective	Status / Progress
3a	Support BHRS' DEIB Council to identify and improve diversity, equity, and inclusion outcomes for BHRS staff.	DEIB Council is scheduled to resume Quarter 1 2026
3b	Analyze results of the Marin Staff Cultural Humility Survey to identify needed training.	TBD
3c	Streamline current cultural humility training opportunities, tracking system, and respective policy.	TBD
3d	Analyze the number of bilingual staff who receive bilingual pay.	TBD

Goal 4: To develop creative outreach and engagement activities to inform underserved communities about behavioral health services		
Action Item	Objective	Status / Progress
4a	Develop strategies for outreach approaches after BHSA Population-Based recommendations are complete.	TBD
4b	Analyze data from Performance Outcomes and Quality Improvement (POQI) and Treatment Perception Survey (TPS) surveys.	TBD
4c	Partner with BHRS Equity and Community Partnerships Committee (ECPC) to address barriers to engagement or access.	Ongoing
4d	Identify community organizations with existing social media platforms to create outreach campaigns.	TBD
4e	Return to outreach strategies that enable true connection and engagement (i.e., tabling events, visiting groups in-person, interactive programming).	Bilingual Outreach and Engagement Senior Program Coordinator position has shifted from predominantly in office to spending more time in the community, allowing greater flexibility and opportunities for outreach.

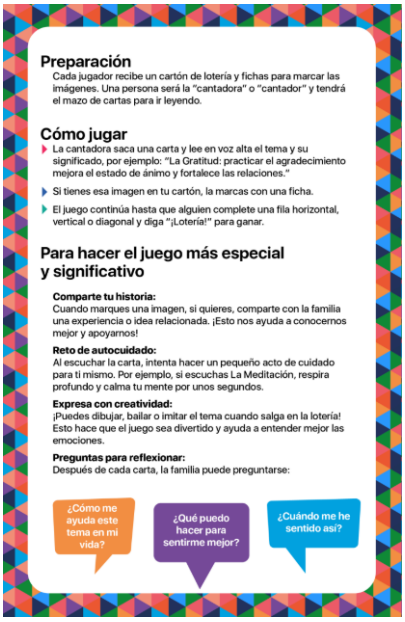
Goal 5: To utilize quality data to evaluate the impact of services on health equity, cost-effectiveness, and outcomes		
Action Item	Objective	Status / Progress
5a	Collect and produce accurate and reliable demographic, service-level, and outcome data.	Ongoing
5b	Analyze mental health and substance use disorder data by number of clients, demographics, services and outcomes annually.	Ongoing
5c	Develop and implement strategies to improve demographic data entry into the EHR "SmartCare."	Ongoing

Appendix A: Frequently Used Acronyms

- **ASOC** – Adult System of Care
- **BHRS** – Behavioral Health and Recovery Services
- **BHSA** – Behavioral Health Services Act
- **BIPOC** – Black, Indigenous, and other People of Color
- **CalAIM** – California Advancing Innovations in Medi-Cal
- **CalMHSA** – California Mental Health Services Authority
- **CARE Act** – Community, Assistance, Recovery, and Empowerment
- **CCPR** – Cultural Competency Plan Requirements
- **CHRP** – Cultural Humility and Responsivity Plan
- **CSOC** – Children's System of Care
- **DEI** – Diversity, Equity, and Inclusion
- **DEIB** – Diversity, Equity, Inclusion, and Belonging
- **DHCS** – Department of Health Care Services
- **DMC-ODS** – Drug Medi-Cal Organized Delivery System
- **ECPC** – Equity and Community Partnerships Committee
- **EHR** – Electronic Health Record
- **EQR** – External Quality Review
- **EQRO** – External Quality Review Organization
- **FY** – Fiscal Year
- **HHS** – Health and Human Services
- **HR** – Human Resources
- **LGBTQ** – Lesbian, Gay, Bisexual, Transgender, Queer
- **LSC** – Latine Steering Committee
- ***Lotería*** – A traditional Mexican game of chance revised to help discuss wellness, coping skills, and mental health with families
- **MHSA** – Mental Health Services Act
- **MLE** – Measurement, Learning, and Evaluation
- **MOU** – Memorandum of Understanding
- **PMEI** – Program Manager of Equity and Inclusion
- **POQI** – Performance Outcomes and Quality Improvement
- **QIP** – Quality Improvement Project
- **RBA** – Results Based Accountability
- **REAL** – Race, Ethnicity, and Language
- **REAP** – Race Equity Action Plan
- **SAMHSA** – Substance Abuse and Mental Health Services Administration
- **SMHS** – Specialty Mental Health Services
- **SMT** – Senior Management Team
- **SOGI** – Sexual Orientation and Gender Identity
- **SUD** – Substance Use Disorder
- **SUS** – Substance Use Services
- **TPS** – Treatment Perception Survey
- **WET** – Workforce Education and Training

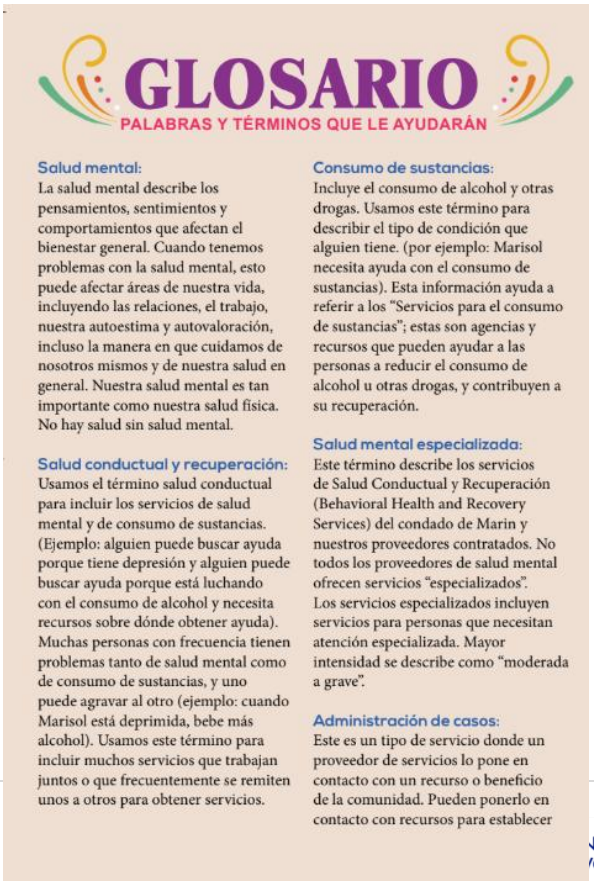
Appendix B: Photos of Materials & Activities

Lotería Game



Rack Cards in Spanish

Navigation Booklet in Spanish



GLOSARIO

PALABRAS Y TÉRMINOS QUE LE AYUDARÁN

Salud mental:
La salud mental describe los pensamientos, sentimientos y comportamientos que afectan el bienestar general. Cuando tenemos problemas con la salud mental, esto puede afectar áreas de nuestra vida, incluyendo las relaciones, el trabajo, nuestra autoestima y autovaloración, incluso la manera en que cuidamos de nosotros mismos y de nuestra salud en general. Nuestra salud mental es tan importante como nuestra salud física. No hay salud sin salud mental.

Salud conductual y recuperación:
Usamos el término salud conductual para incluir los servicios de salud mental y de consumo de sustancias. (Ejemplo: alguien puede buscar ayuda porque tiene depresión y alguien puede buscar ayuda porque está luchando con el consumo de alcohol y necesita recursos sobre dónde obtener ayuda). Muchas personas con frecuencia tienen problemas tanto de salud mental como de consumo de sustancias, y uno puede agravar al otro (ejemplo: cuando Marisol está deprimida, bebe más alcohol). Usamos este término para incluir muchos servicios que trabajan juntos o que frecuentemente se remiten unos a otros para obtener servicios.

Consumo de sustancias:
Incluye el consumo de alcohol y otras drogas. Usamos este término para describir el tipo de condición que alguien tiene. (por ejemplo: Marisol necesita ayuda con el consumo de sustancias). Esta información ayuda a referir a los "Servicios para el consumo de sustancias"; estas son agencias y recursos que pueden ayudar a las personas a reducir el consumo de alcohol u otras drogas, y contribuyen a su recuperación.

Salud mental especializada:
Este término describe los servicios de Salud Conductual y Recuperación (Behavioral Health and Recovery Services) del condado de Marin y nuestros proveedores contratados. No todos los proveedores de salud mental ofrecen servicios "especializados". Los servicios especializados incluyen servicios para personas que necesitan atención especializada. Mayor intensidad se describe como "moderada a grave".

Administración de casos:
Este es un tipo de servicio donde un proveedor de servicios lo pone en contacto con un recurso o beneficio de la comunidad. Pueden ponerlo en contacto con recursos para establecer

Wellness Circle Sticker and Contact Card in Spanish

Tabling Event Example

Appendix C: Participant Feedback – BHRS Supervision Training

- “[This training] helped me to support my teams communication during our team meetings and my individual supervision meetings.”

- “[This training] increased listening on my part. Not needing to fix things in the moment and being comfortable with not having the answers, but instead being present and open to my supervisees experiences.”

- “[This helped me to] be comfortable within the uncomfortable dialogs. Allowing free sharing and also being able to own my bias's and or "ouch moments". Being able to admit to others my missteps or bias's that negative impact the team and or our proved services to our clients. Being open to feedback and making changes to improve my ability to support the team and individuals.”

- “[I learned how to] build connection and relationship with each other before doing the hard work. [The facilitator] modeled activities and a way of being that I have brought with me into supervision and other working relationships.”

- “I am more aware of personalism and collectivism a value I use in my supervision.”

- “[This helped me to] warm and supportive space, feel confident to make mistakes, closer connection with colleagues, deeper understanding of restorative justice.”

- “[This helped me to] Making space for challenging conversations, discussion of personal experiences and how they impact the workplace, focus on restorative conversations.”

- “The session was educational. It provided insight into the emotional impact of support on individuals. Additionally, it is crucial to understand the significance of advocating for someone experiencing adversity. It is also important to carefully consider when and how to offer support to others.”

- “Great content and space to discuss critical issues related to identity interfacing and how to navigate these to create greater understanding and honor each person's experience.”

- “This DEI group has been the first one I have been in where I felt really connected to the other members, learned a lot about others, and feel hopeful about my DEI journey.”

Appendix D: Participant Feedback and Photos – Latine Learning Academy (LLA)

- "Through my participation in the academy, my personal growth around self-awareness, values, cultural identity, and motivation have deepened."

- "It has given me permission to re-incorporate cultural values (*familismo, personalismo, platica, dignidad, respeto*) with a heightened sense of intention and practice. To humanize clients, cultures, trainings, and interns making that the center of the work to build strong connections and rapport. Considering integrating *altares*, visual representations of culture, community based practices on a regular and intentional basis."

- "My participation and gained knowledge allowed me to enhance the way I work with my clients by reflecting significantly on what this work means to me, exploring its significance to my clients and how today's society impacts the work we provide. I was compelled to advocate for my clients in culturally sensitive ways during staff and supervision meetings."
-
- "I integrated more *personalismo* into my work which immediately increased the rapport with my clients. Our work felt more meaningful as a result of my conscious decision to allow my clients to learn more about their provider."

- "With an adult client, together we explored cultural rituals and traditions, collectivism vs individualism, and culturally relevant resources. This offered my clients and I the opportunity to connect more deeply but also extend the work we were doing in sessions out to her daily life."

- "LLA encouraged me to look more deeply at my learned biases and to identify them when they are present in my interactions and work relationships. Additionally, I was able to remain curious with my clients about their cultural identities and consider creative ways that they can continue to fulfill and strengthen those parts of themselves with therapeutic interventions."

- "I saw firsthand the healing that can happen when people are given space to be seen and heard. That moment taught me the importance of honoring each person's journey, especially when working with those who are navigating the spaces between cultures."

- "The training also deepened my understanding of complex cultural processes like assimilation, acculturation, cultural accommodation, and cultural negotiation. I used to think of these as academic terms, but now I understand them as real, often emotional experiences. I learned that acculturation could bring stress—especially when someone feels pressure to let go of their culture to fit into a

dominant one. I saw how cultural accommodation can mean something as specific as offering services in someone's native language, recognizing the role of family in decision-making, or honoring spiritual beliefs. And I came to appreciate that cultural negotiation is a constant, personal balancing act for many people who live between two or more cultures—choosing when to adapt, when to hold on, and how to stay whole. These insights changed the way I think and the way I show up for others."

- "The Academy didn't just give me tools—it helped me grow as a person, and reminded me that connection, respect, and heart-centered listening are at the core of meaningful service."

- "The Latine Learning Academy changed how I approach my work by helping me understand the deeper role that culture plays in people's lives. I learned that providing meaningful services isn't just about meeting needs, it's about honoring values, traditions, and lived experiences."

- "I also gained tools to better support the Latine community—like involving family in care decisions, recognizing the role of spirituality, and creating a welcoming, respectful environment. It helped me understand how cultural stress and identity struggles can impact someone's well-being, and how important it is to meet people where they are."

- "I use what I learned in the Latine Learning Academy every day to create a warm, welcoming space for my clients. If someone looks tired or upset, I offer tea, coffee, or warm soup to help them feel more at ease before we begin. These small acts of care help build trust and comfort. When I work in out-station offices, I bring herbs and a colorful Guatemalan tablecloth to decorate the space. These touches reflect our culture and help clients feel more at home. Clients often notice and appreciate the effort—some have even brought herbs like rosemary to add to the space, which creates a shared sense of connection."

- "Many clients tell me they feel better after our sessions, and some others refer to me. This reminds me that even small, culturally rooted gestures can have a powerful impact—and it motivates me to keep growing in my work."

- "This experience taught me to lead with my heart and to form genuine, culturally rooted connections with the clients I serve. I am now more aware of how my culture, language, and traditional rituals or ceremonies can play a significant role in the healing process for Latino clients. It has truly transformed the way I approach my work and deepened my commitment to culturally responsive care."

- "I began to recognize the importance of space—not just for the clients, but also for the clinician working with them."

- “Being part of the Latine Learning Academy helped me embrace my authentic self. I learned to integrate my cultural strengths with my clinical knowledge to build trust and support my clients in a more relational and less rigid way. That moment reminded me that healing often begins with genuine human connection—and that being fully present as a Latina clinician is a strength, not a limitation.”

- “The Latine Learning Academy not only raised my cultural awareness but also taught me to honor and embrace my own identity in order to engage with clients in a more meaningful way. I came to understand that being a fluent Spanish speaker is not enough. What truly matters is approaching others with empathy, curiosity, and a genuine interest in the diverse ways our communities live, heal, and believe. This shift allowed me to use my cultural identity as a powerful tool to build trust and connection in my work.”

- “It made me think critically about my space and who it is welcoming to, as well as my ability to provide services to/for specific populations.”

- “The training has empowered me to bring up disparities and racial differences without fear of not being appropriate or taboo. I am able to bring up conversations in team environments as well as with clients in a grounded and appropriate way.”

- “I feel less fragmented in my cultural identity by sharing and being witnessed during this experience.”

- “I have always carried a strong empathic awareness but somehow opening up to my roots and lineage makes my strength as a practitioner even stronger. I now feel that I have permission to make space for what I need even when the social structures do not value the time to reflect or take care of the self. In addition, all of the experiences that helped heal me as a young adult and into middle age were validated through the Latine Learning Academy, including music, dance and herbs/plant medicine.”

- “I have been highlighting some of grounding techniques we have learned and practicing with my clients. I even suggested drumming on their legs as a way to bring bilateral motion into their body.”

- “The LLA allowed me to process a sense of disconnection I feel to my fellow Latinos. Being able to work through that over the 9 weeks has given me the realization of what I find that I am missing, I am in a wonderful position to heal myself by working with others like me.”

- “I bring the game *Lotería* into client sessions, their faces light up at seeing a game they recognize from their early childhood/back in their country of origin - I brought rosemary and thyme into a session with an adult, and they asked if they

could take it home with them - I've shared information from the LLA in various groups I'm a part of, including staff meetings, individual supervision, group supervision."

- "I made the effort to incorporate and emphasize the topics we learned into my program's lesson plans especially when discussing culture, traditions, and the immigrant experience."

1/10
15 WAYS THERAPISTS CAN CAUSE HARM THROUGH A DECOLONIAL LENS PART 1
7,552
@decolonizingtherapy
2/10
PATHOLOGIZING RESISTANCE
LABELING SURVIVAL STRATEGIES AS DISORDERS RATHER THAN RECOGNIZING THEM AS VALID RESPONSES TO OPPRESSION.
7,552
@decolonizingtherapy
3/10
UPHOLDING CARCERAL LOGICS
USING COERCION, INVOLUNTARY HOLDS, OR POLICE COLLABORATION INSTEAD OF TRAUMA-INFORMED, COMMUNITY-CENTERED CRISIS CARE.
7,552
@decolonizingtherapy
4/10
IGNORING STRUCTURAL VIOLENCE
TREATING DISTRESS AS AN INDIVIDUAL PROBLEM WHILE IGNORING SYSTEMIC HARM LIKE RACISM, CAPITALISM, AND COLONIALISM.
7,552
@decolonizingtherapy
5/10
CULTURAL ERASURE
DISMISSING NON-WESTERN HEALING TRADITIONS IN FAVOR OF EUROCENTRIC MODELS OF MENTAL HEALTH.
7,552
@decolonizingtherapy
6/10
WEAPONIZING DIAGNOSES
USING PSYCHIATRIC LABELS IN WAYS THAT STIGMATIZE, PUNISH, OR JUSTIFY INSTITUTIONAL CONTROL OVER MARGINALIZED PEOPLE.
7,552
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GATEKEEPING ACCESS
MAKING HEALING CONDITIONAL ON COMPLIANCE WITH RIGID, BUREAUCRATIC, AND INACCESSIBLE SYSTEMS.
7,552
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8/10
CENTERING WHITENESS
PRIORITIZING WHITE COMFORT, FRAGILITY, AND NORMS WHILE SIDELINING THE LIVED REALITIES OF BIPOC COMMUNITIES.
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FINANCIAL EXPLOITATION
CHARGING HIGH FEES WHILE IGNORING THE ECONOMIC REALITIES CREATED BY RACIAL CAPITALISM.
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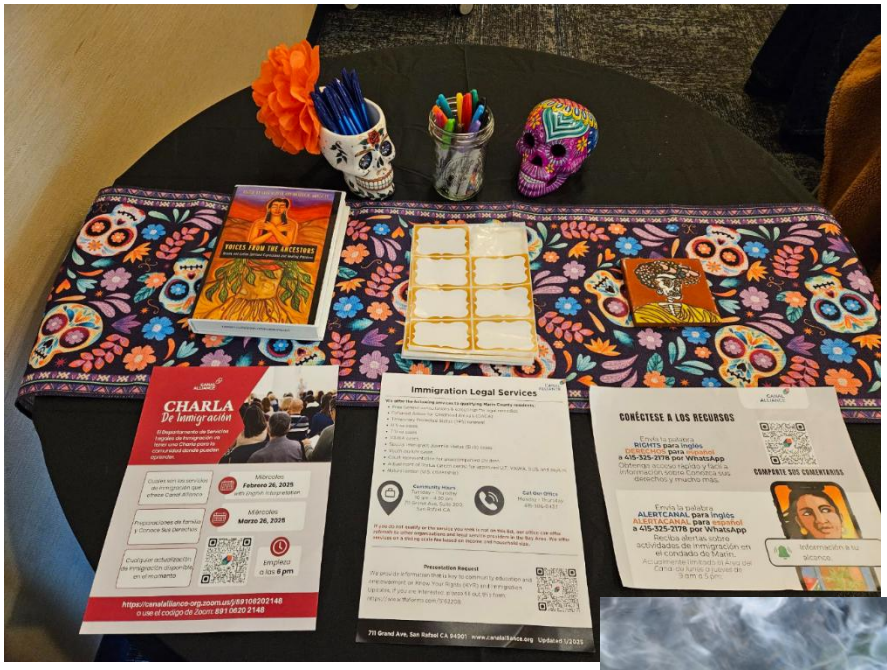

VOICES FROM THE ACCESSIBLE
CHARLA
De Inmigración
Immigration Legal Services
CONÉCTESE A LOS RECURSOS

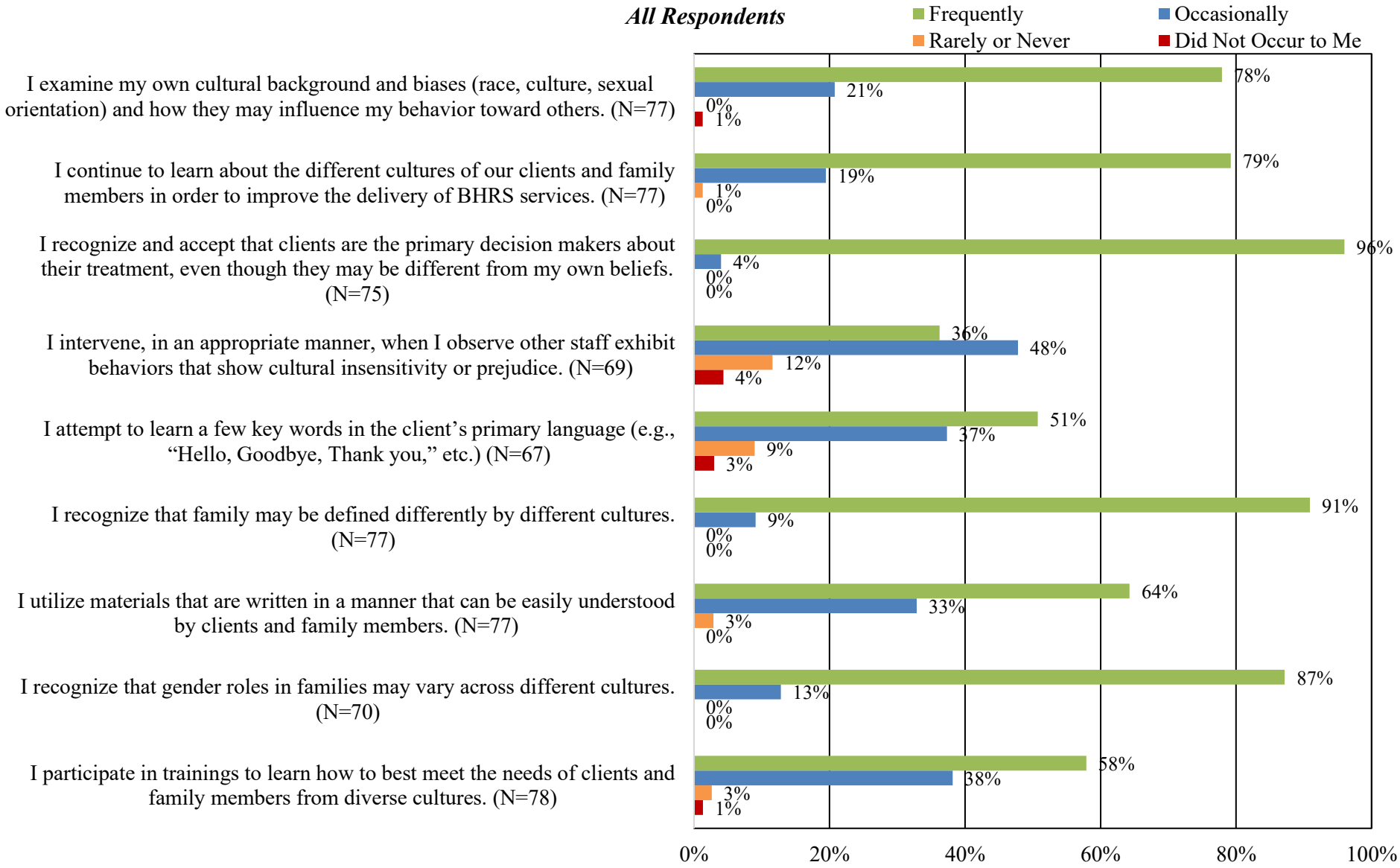
Appendix E: Cultural Humility Survey Results

Marin County Behavioral Health and Recovery Services

Staff and Org. Provider Cultural Humility Survey

2025

All Respondents



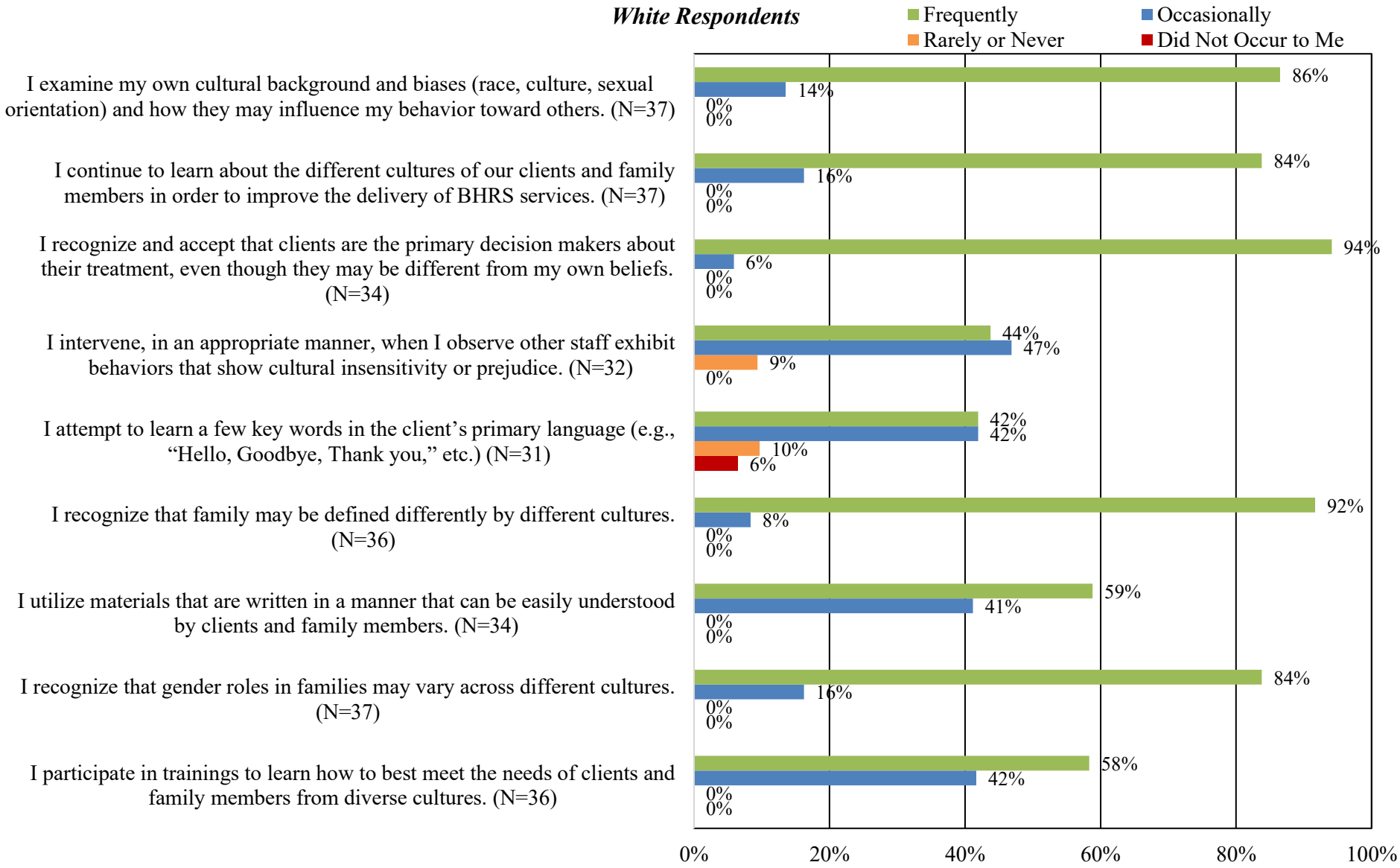
Produced by I.D.E.A. Consulting
ncallahan.idea@gmail.com (530) 304-5600

Marin County Behavioral Health and Recovery Services

Staff and Org. Provider Cultural Humility Survey

2025

White Respondents



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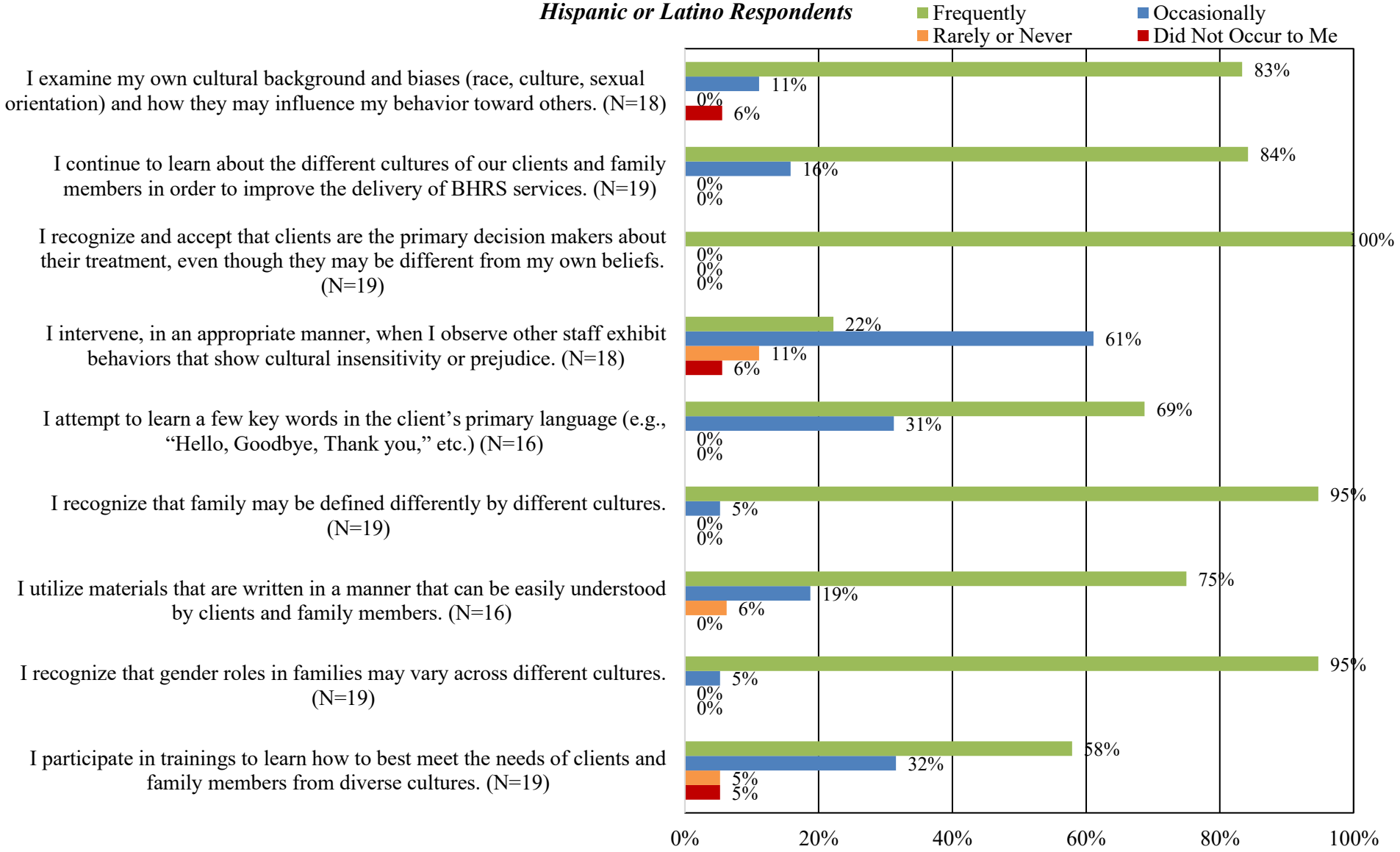
ncallahan.idea@gmail.com (530) 304-5600

Marin County Behavioral Health and Recovery Services

Staff and Org. Provider Cultural Humility Survey

2025

Hispanic or Latino Respondents



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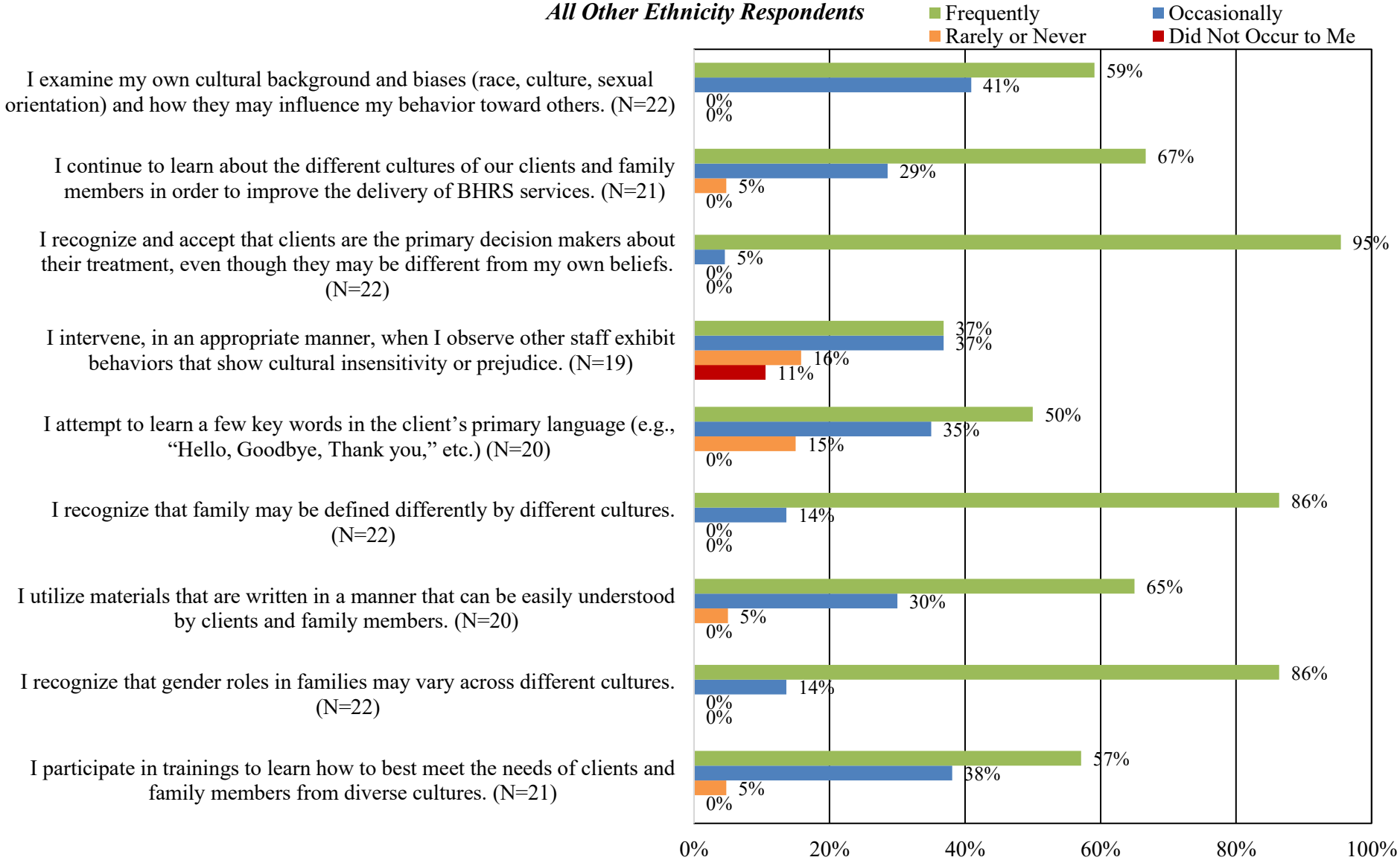
Marin County Behavioral Health and Recovery Services

Staff and Org. Provider Cultural Humility Survey

2025

All Other Ethnicity Respondents



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Marin County Behavioral Health and Recovery Services

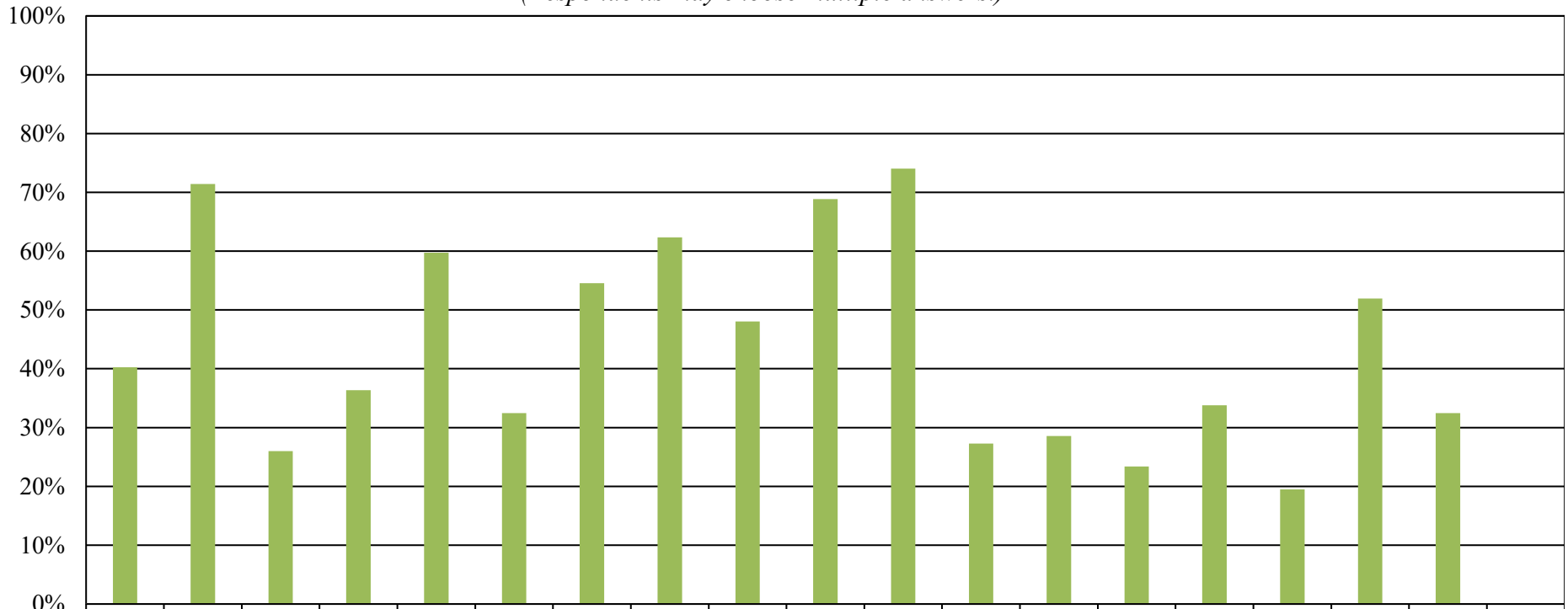
Staff and Org. Provider Cultural Humility Survey

2025

Participation in Professional Development Activities (Past Six Months)

All Respondents (N=77)

(Respondents may choose multiple answers.)



	Recognized a prejudice I have about certain people	Talked to a colleague about a racial and/or cultural issue	Sought guidance about a racial, gender or other cultural issue that arose during therapy/ service delivery or within my team	Sought guidance about barriers for people living with disabilities that arose during therapy/ service delivery	Attended a cultural humility training seminar	Attended a cultural humility event	Attended an event in which most of the other people were not my race/ ethnicity	Reflected on my race/ ethnicity and how it affects my work with clients and/or my working relationships	Reflected on my sexual orientation and gender identity and how it affects my work with clients and/or my working relationships	Read/ watched/ listened to media about multi-cultural issues	Learned something about a racial and/or cultural group other than my own	Sought consultation or supervision regarding multi-cultural issues regarding a client and/or family	Talked to a friend/ associate about how our racial differences affect our relationship	Challenged a racist remark	Challenged an anti-LGBTQ or transphobic remark	Challenged a sexist remark	I attended a sexual harassment training	Attended an implicit bias training	Total
# Respondents	31	55	20	28	46	25	42	48	37	53	57	21	22	18	26	15	40	25	77
% Respondents	40%	71%	26%	36%	60%	32%	55%	62%	48%	69%	74%	27%	29%	23%	34%	19%	52%	32%	100%

Marin County Behavioral Health and Recovery Services

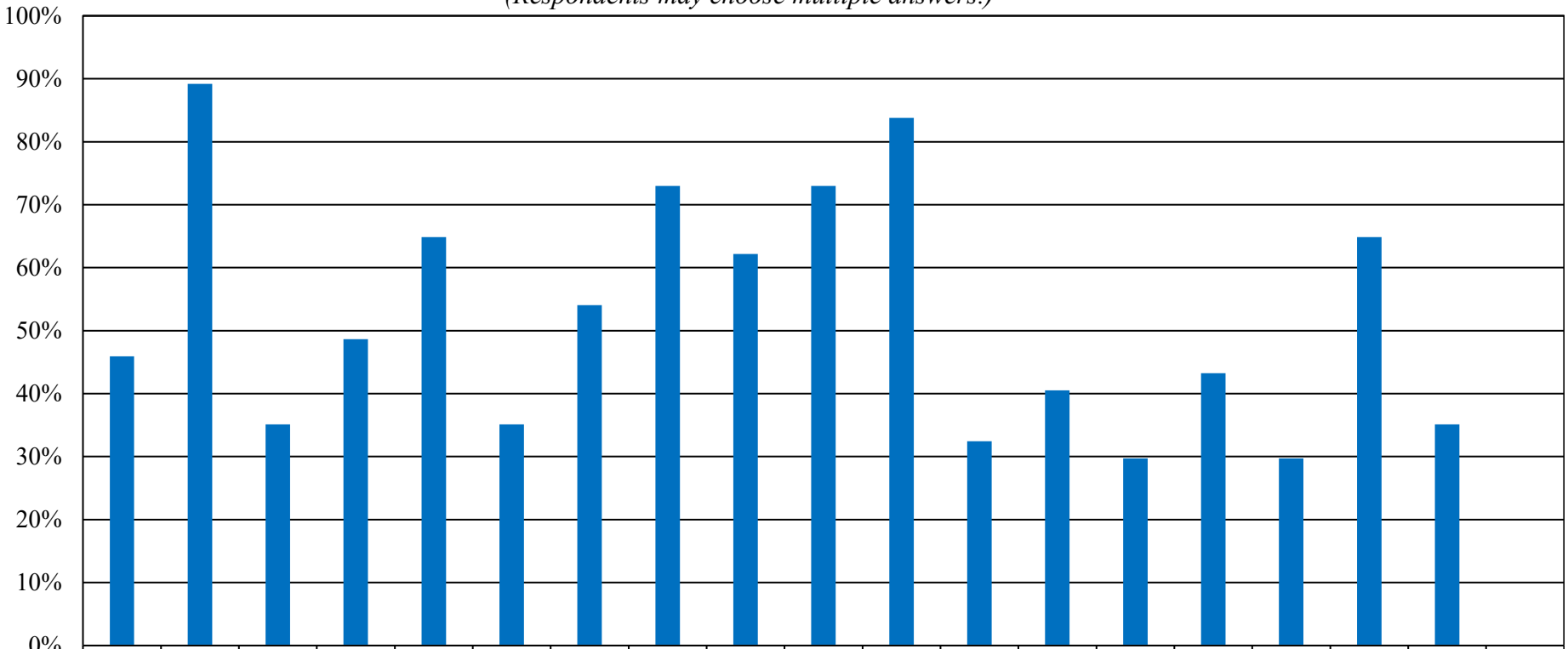
Staff and Org. Provider Cultural Humility Survey

2025

Participation in Professional Development Activities (Past Six Months)

White Respondents (N=37)

(Respondents may choose multiple answers.)



	Recognized a prejudice I have about certain people	Talked to a colleague about a racial and/or cultural issue	Sought guidance about a racial, gender or other cultural issue that arose during therapy/service delivery or within my team	Sought guidance about barriers for people living with disabilities that arose during therapy/service delivery	Attended a cultural humility training seminar	Attended a cultural humility event	Attended an event in which most of the other people were not my race/ethnicity	Reflected on my race/ethnicity and how it affects my work with clients and/or my working relationships	Reflected on my sexual orientation and/or gender identity and how it affects my work with clients and/or my working relationships	Read/watched/listened to media about multi-cultural issues	Learned something about a racial and/or cultural group other than my own	Sought consultation or supervision regarding multi-cultural issues regarding a client and/or family	Talked to a friend/associate about how our racial differences affect our relationship	Challenged a racist remark	Challenged an anti-LGBTQ or transphobic remark	Challenged a sexist remark	I attended a sexual harassment training	Attended an implicit bias training	Total
# Respondents	17	33	13	18	24	13	20	27	23	27	31	12	15	11	16	11	24	13	37
% Respondents	46%	89%	35%	49%	65%	35%	54%	73%	62%	73%	84%	32%	41%	30%	43%	30%	65%	35%	100%

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Marin County Behavioral Health and Recovery Services

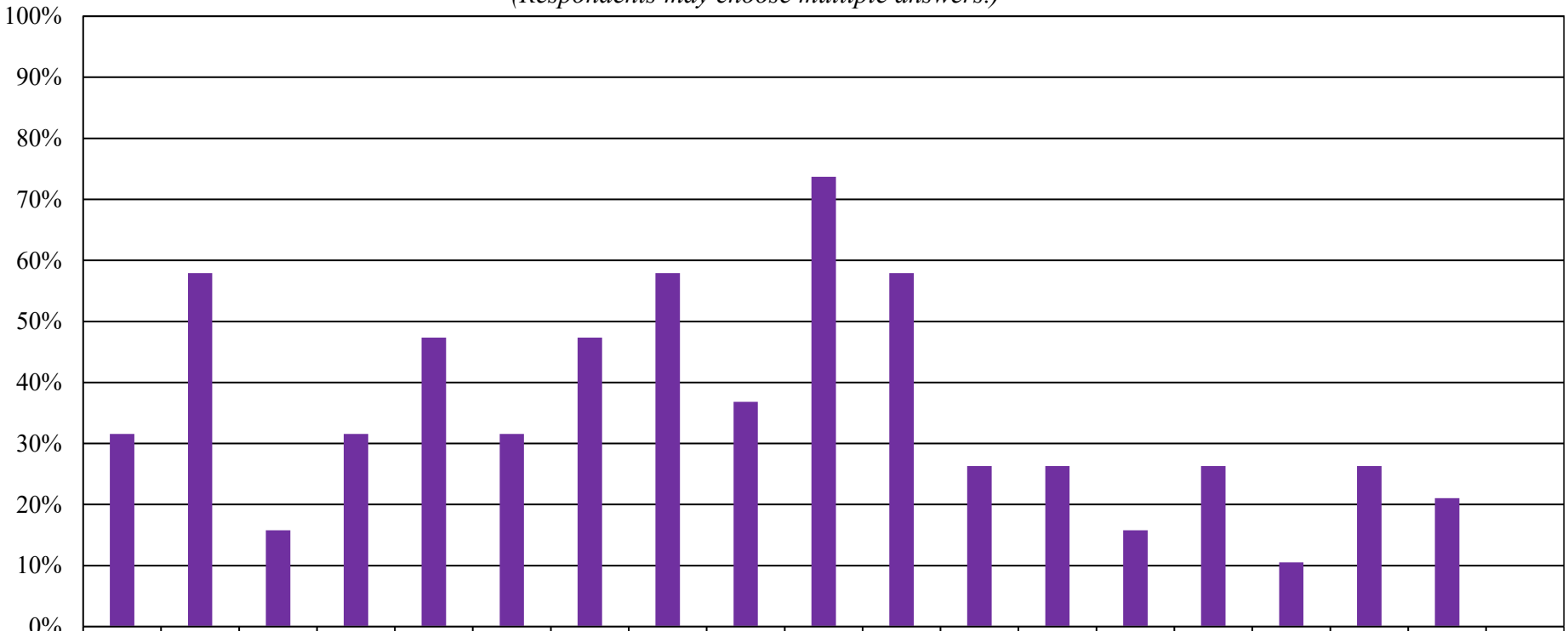
Staff and Org. Provider Cultural Humility Survey

2025

Participation in Professional Development Activities (Past Six Months)

Hispanic or Latino Respondents (N=19)

(Respondents may choose multiple answers.)



	Recognized a prejudice I have about certain people	Talked to a colleague about a racial and/or cultural issue	Sought guidance about a racial, gender or other cultural issue that arose during therapy/service delivery or within my team	Sought guidance about barriers for people living with disabilities that arose during therapy/service delivery	Attended a cultural humility training seminar	Attended a cultural humility event	Attended an event in which most of the other people were not my race/ethnicity	Reflected on my race/ethnicity and how it affects my work with clients and/or my working relationships	Reflected on my sexual orientation and/or gender identity and how it affects my work with clients and/or my working relationships	Read/watched/listened to media about multi-cultural issues	Learned something about a racial and/or cultural group other than my own	Sought consultation or supervision regarding multi-cultural issues regarding a client and/or family	Talked to a friend/associate about how our racial differences affect our relationship	Challenged a racist remark	Challenged an anti-LGBTQ or transphobic remark	Challenged a sexist remark	I attended a sexual harassment training	Attended an implicit bias training	Total
# Respondents	6	11	3	6	9	6	9	11	7	14	11	5	5	3	5	2	5	4	19
% Respondents	32%	58%	16%	32%	47%	32%	47%	58%	37%	74%	58%	26%	26%	16%	26%	11%	26%	21%	100%

Marin County Behavioral Health and Recovery Services

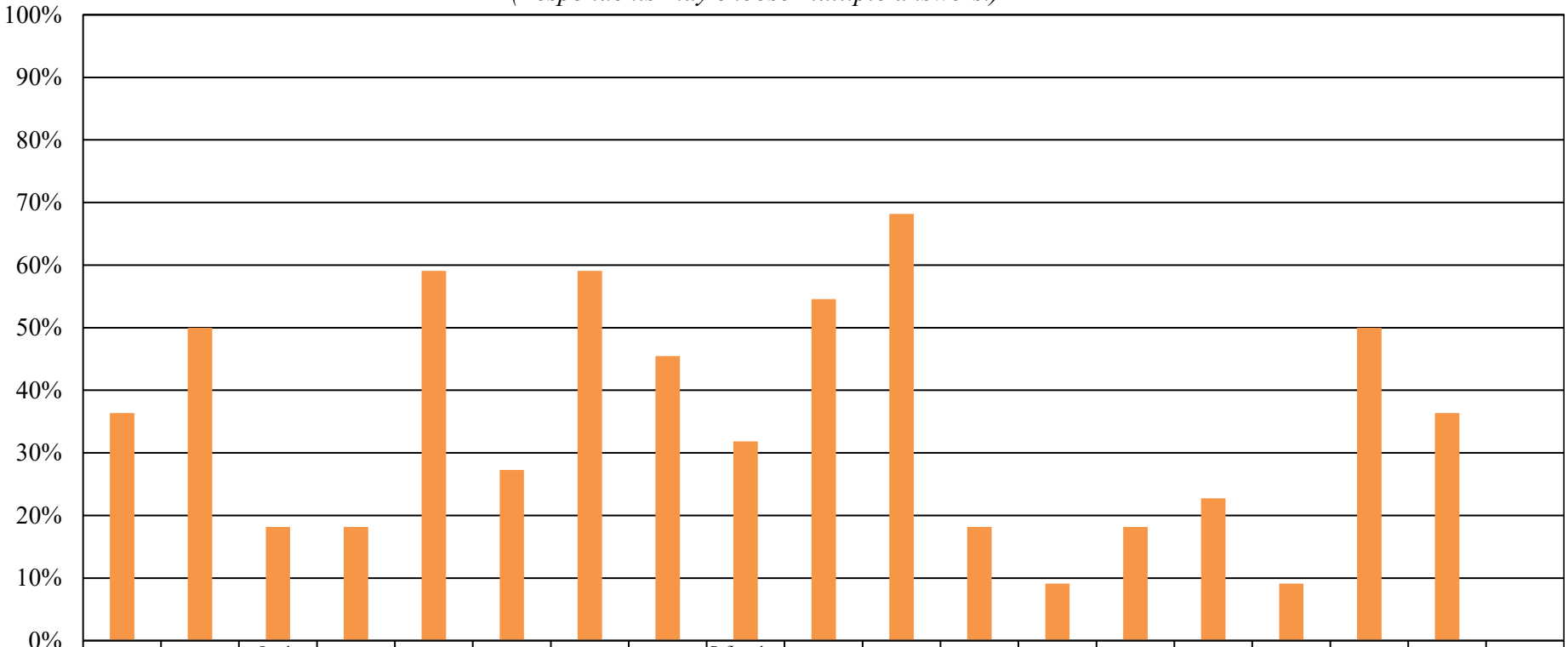
Staff and Org. Provider Cultural Humility Survey

2025

Participation in Professional Development Activities (Past Six Months)

All Other Ethnicity Respondents (N=22)

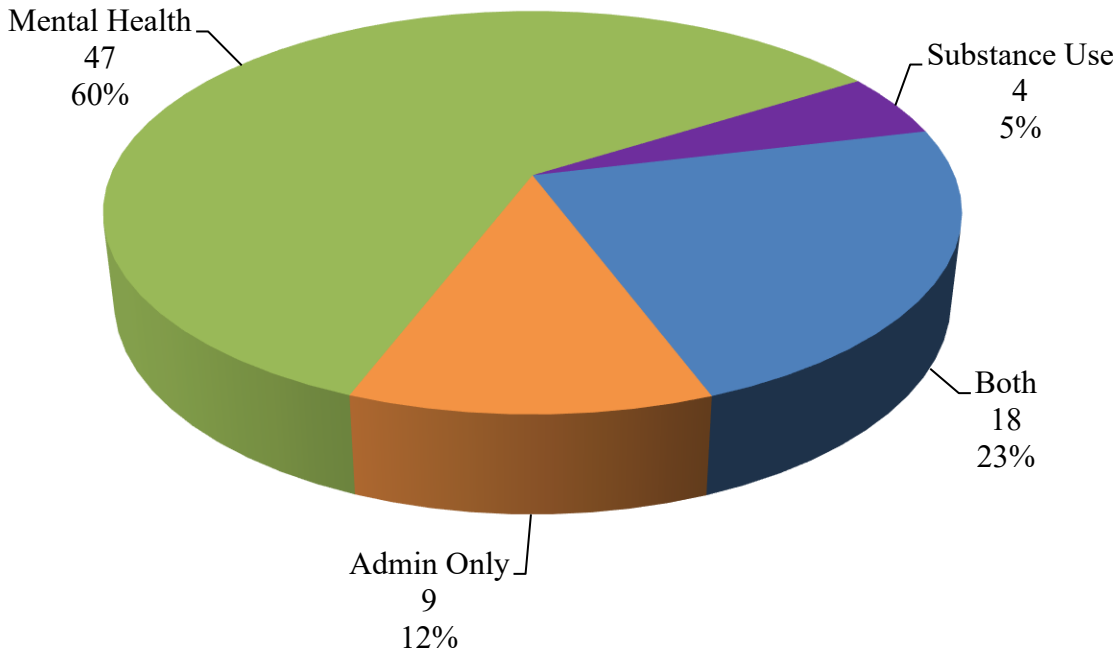
(Respondents may choose multiple answers.)



	Recognized a prejudice I have about certain people	Talked to a colleague about a racial and/or cultural issue	Sought guidance about a racial, gender or other cultural issue that arose during therapy/service delivery or within my team	Sought guidance about barriers for people living with disabilities that arose during therapy/service delivery	Attended a cultural humility training seminar	Attended a cultural humility event	Attended an event in which most of the other people were not my race/ethnicity	Reflected on my race/ethnicity and how it affects my work with clients and/or my working relationships	Reflected on my sexual orientation and/or gender identity and how it affects my work with clients and/or my working relationships	Read/watched/listened to media about multi-cultural issues	Learned something about a racial and/or cultural group other than my own	Sought consultation or supervision regarding multi-cultural issues regarding a client and/or family	Talked to a friend/associate about how our racial differences affect our relationship	Challenged a racist remark	Challenged an anti-LGBTQ or transphobic remark	Challenged a sexist remark	I attended a sexual harassment training	Attended an implicit bias training	Total
# Respondents	8	11	4	4	13	6	13	10	7	12	15	4	2	4	5	2	11	8	22
% Respondents	36%	50%	18%	18%	59%	27%	59%	45%	32%	55%	68%	18%	9%	18%	23%	9%	50%	36%	100%

Marin County Behavioral Health and Recovery Services
Staff and Org. Provider Cultural Humility Survey
2025

Program (N=78)



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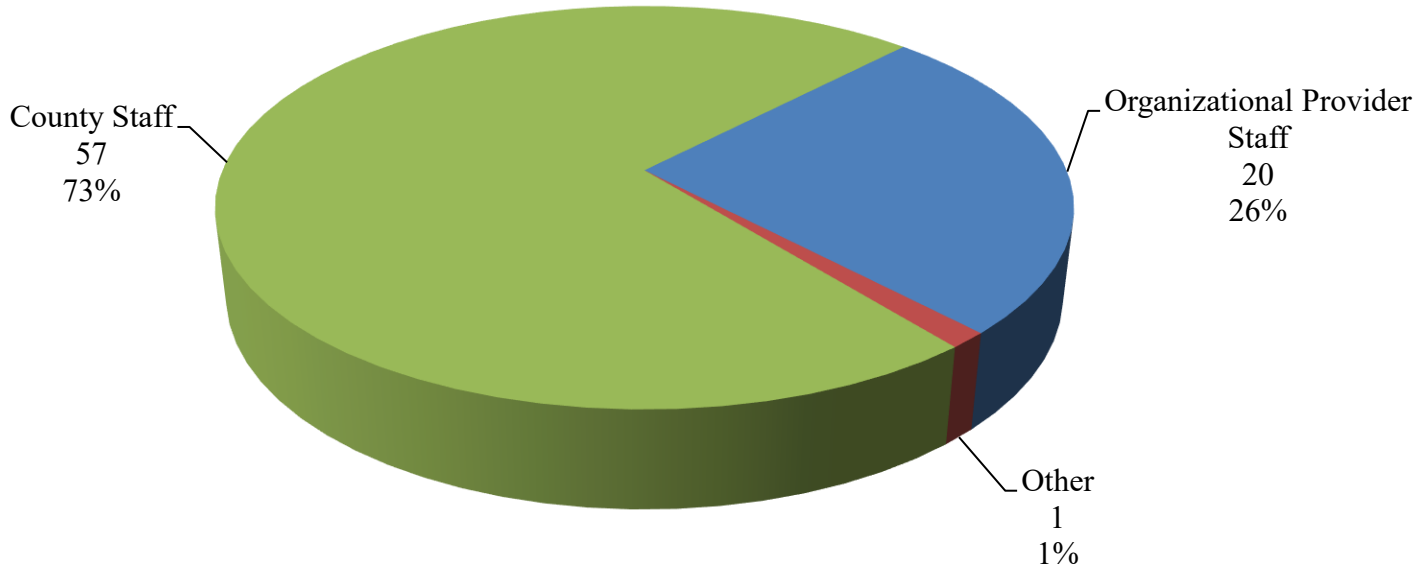
Staff and Org. Provider Cultural Humility Survey
2025

Employment Status (N=78)



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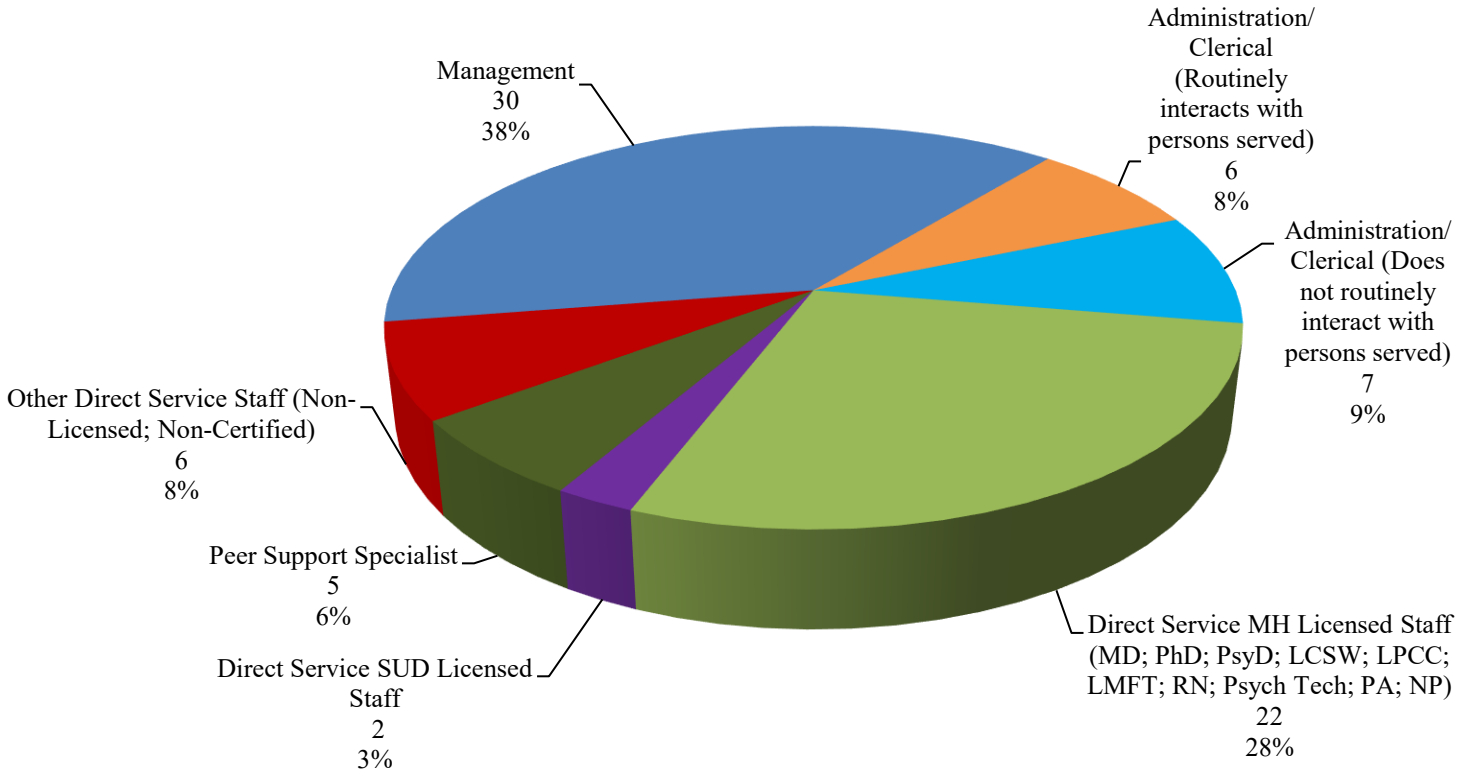
Marin County Behavioral Health and Recovery Services

Staff and Org. Provider Cultural Humility Survey

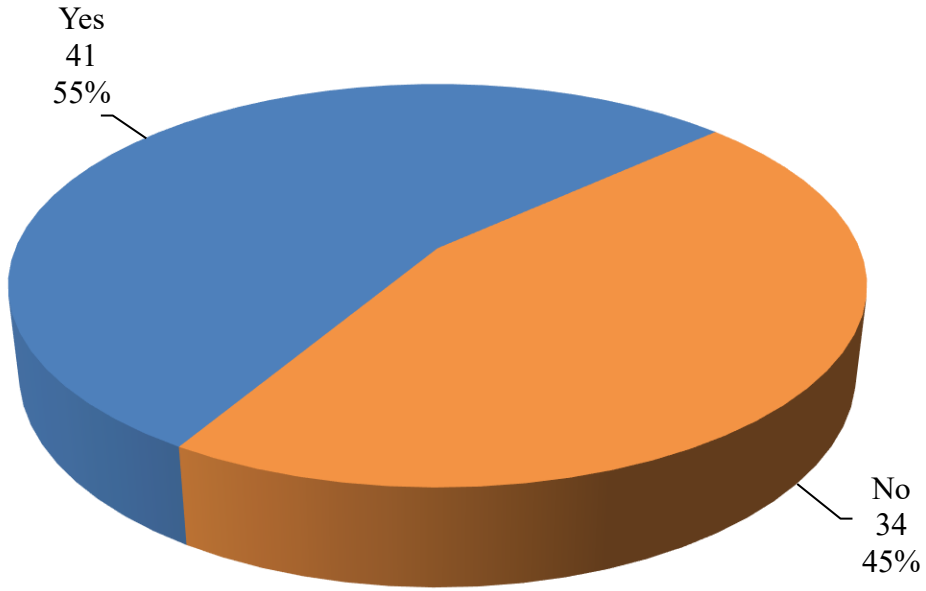
2025

Primary Job Function (N=78)



Marin County Behavioral Health and Recovery Services
Staff and Org. Provider Cultural Humility Survey
2025

Are you currently in a Supervisory position? (N=75)



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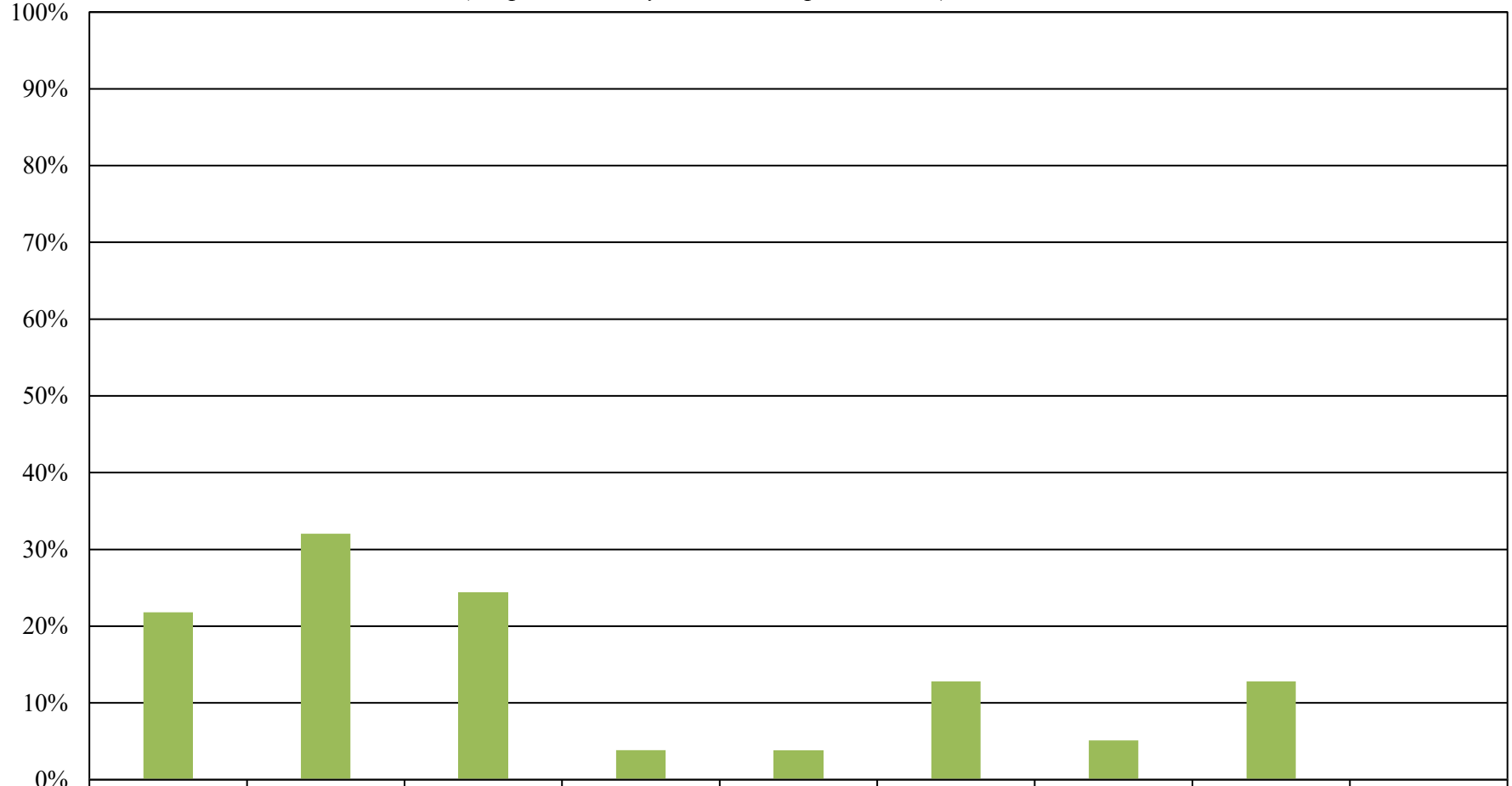
Staff and Org. Provider Cultural Humility Survey

2025

Job Division (N=78)

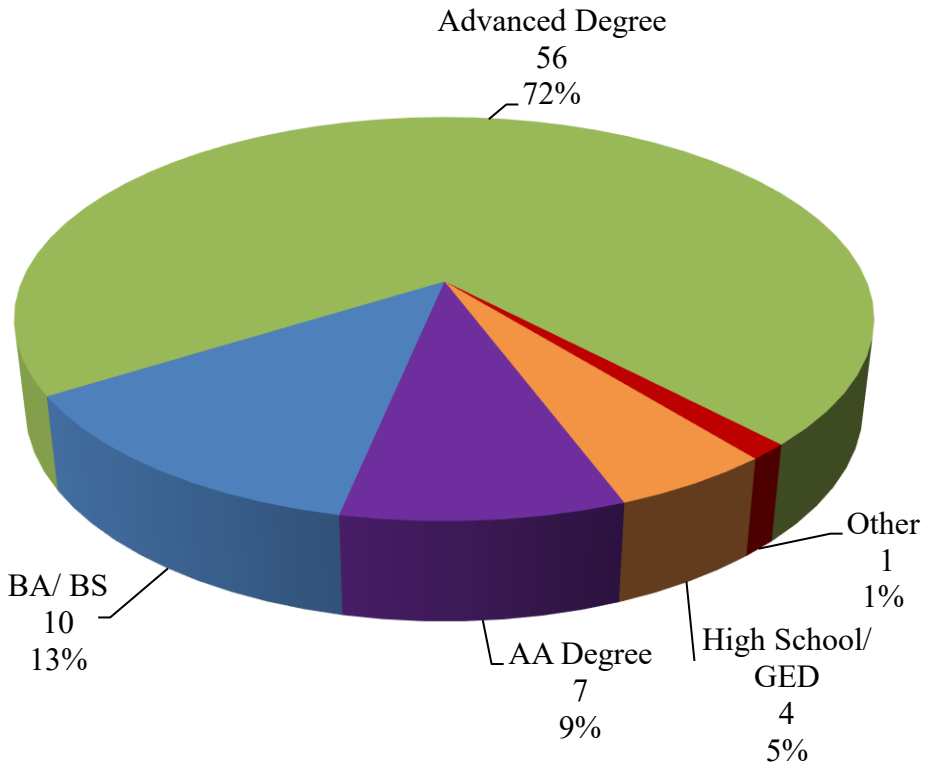
(Respondents may choose multiple answers.)



	Administration	Adult System of Care	Youth System of Care	Contracts Department (MH/SUD)	QI / Compliance	Contracted Providers in MH Plan	Contracted SUD Providers	Other	Total Respondents
# Respondents	17	25	19	3	3	10	4	10	78
% Respondents	22%	32%	24%	4%	4%	13%	5%	13%	100%

Marin County Behavioral Health and Recovery Services
Staff and Org. Provider Cultural Humility Survey
2025

What is the highest level of education you have completed? (N=78)



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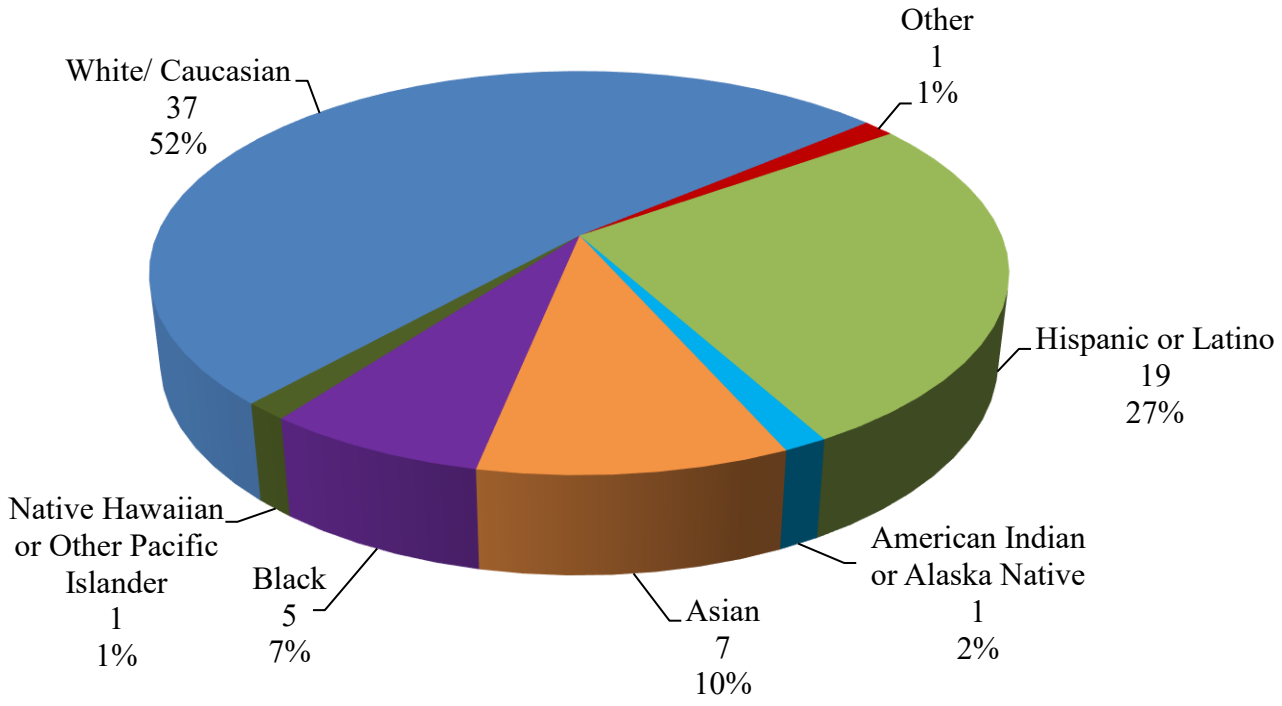
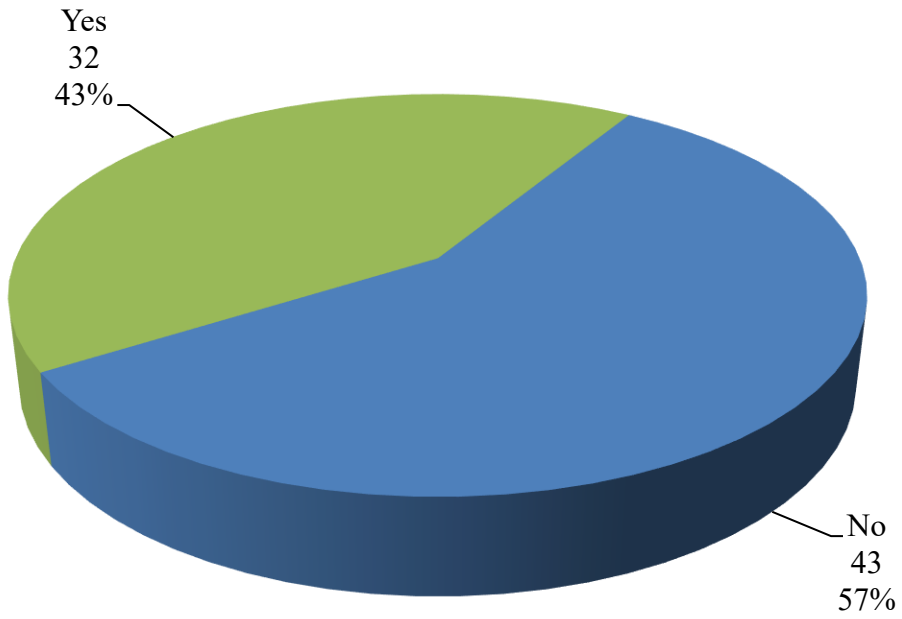
Staff and Org. Provider Cultural Humility Survey
2025

Race/Ethnicity (N=71)



Marin County Behavioral Health and Recovery Services
Staff and Org. Provider Cultural Humility Survey
2025

Do you consider yourself Bilingual? (N=75)



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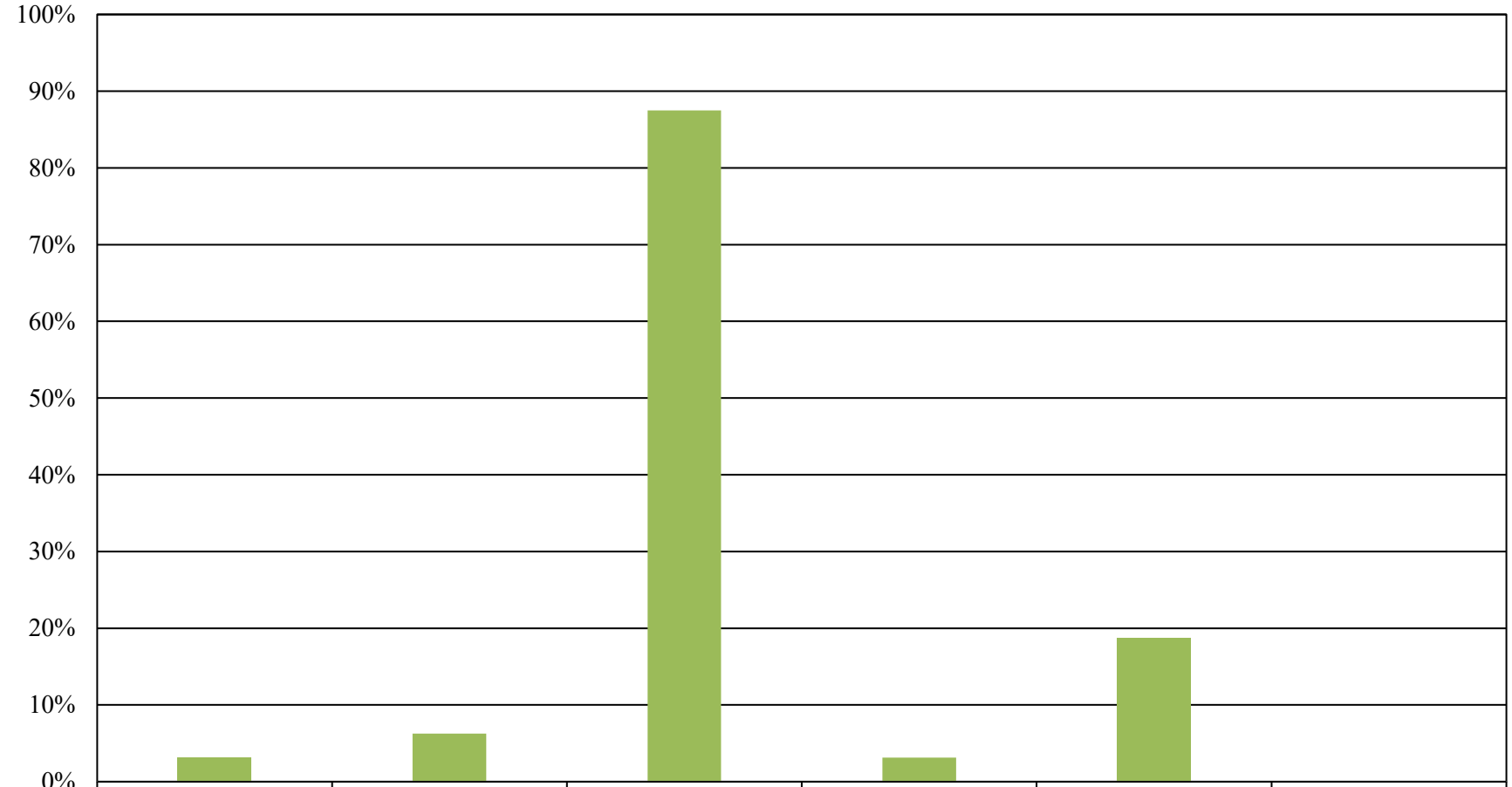
Staff and Org. Provider Cultural Humility Survey

2025

If Bilingual, which language(s) do you speak? (N=32)

(Respondents may choose multiple answers.)



	Mandarin or Other Chinese	Portuguese	Spanish	Vietnamese	Other	Total Bilingual
# Respondents	1	2	28	1	6	32
% Respondents	3%	6%	88%	3%	19%	100%

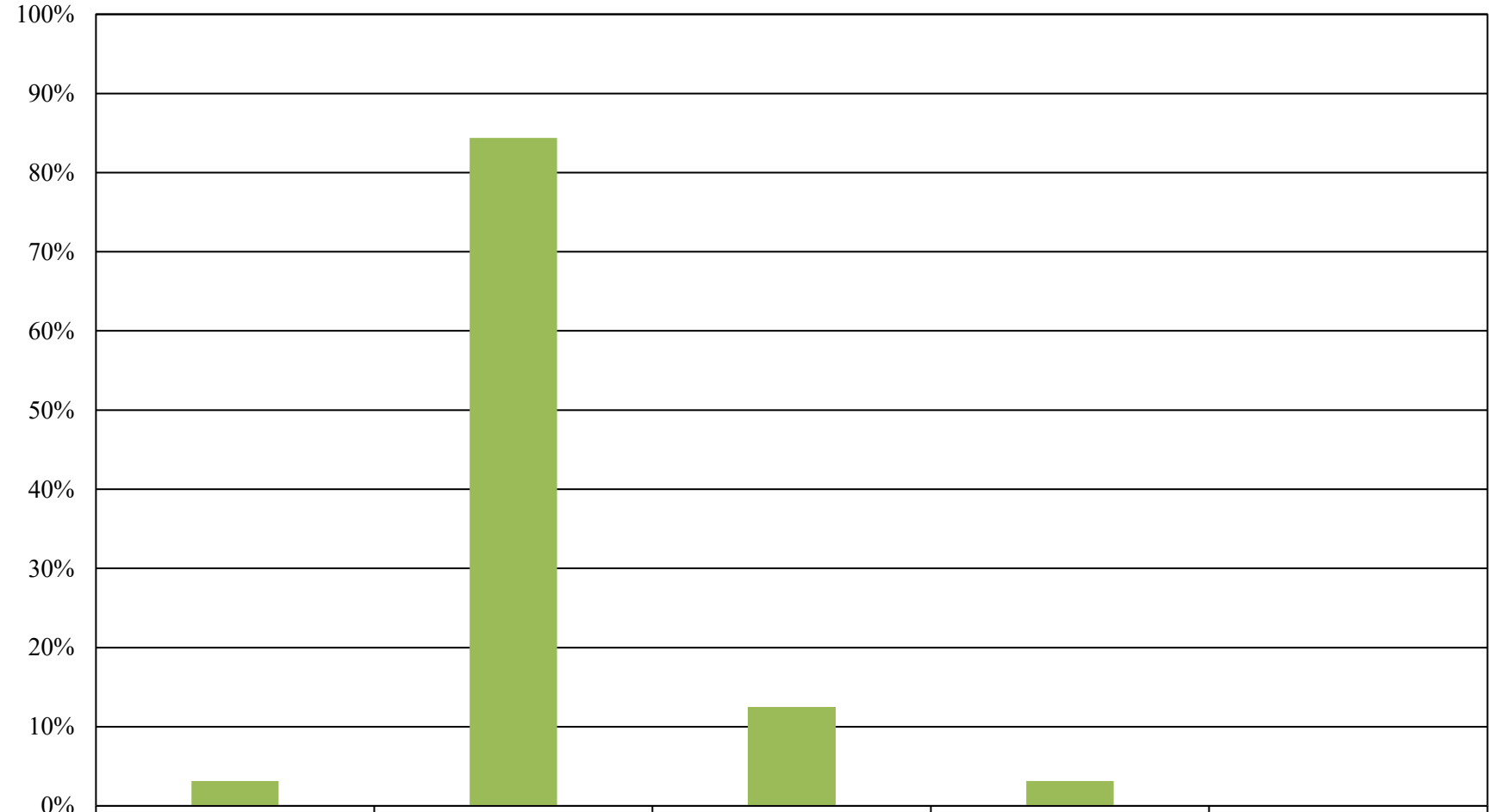
Marin County Behavioral Health and Recovery Services

***Staff and Org. Provider* Cultural Humility Survey**

2025

If Bilingual, which language(s) are you proficient in reading and writing? (N=32)

(Respondents may choose multiple answers.)



	Portuguese	Spanish	Other	Not proficient	Total Bilingual
# Respondents	1	27	4	1	32
% Respondents	3%	84%	13%	3%	100%

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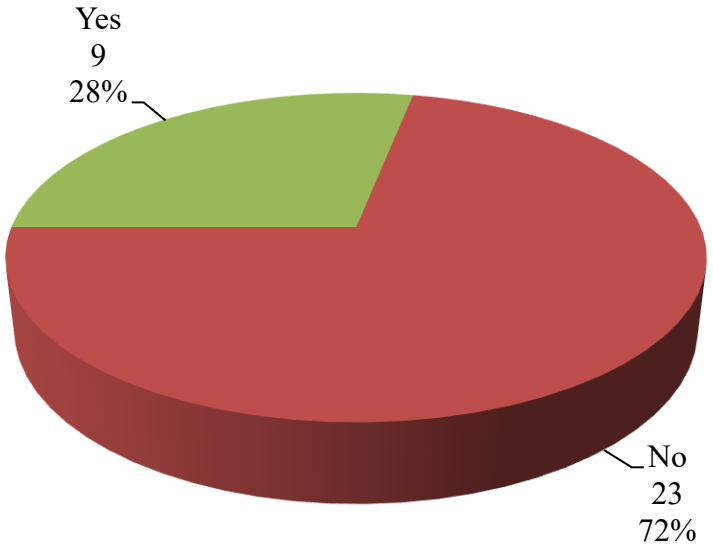
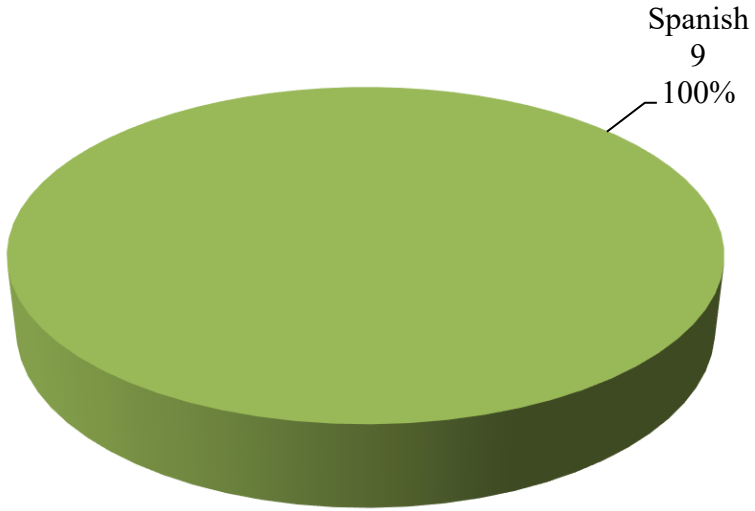
Marin County Behavioral Health and Recovery Services
Staff and Org. Provider Cultural Humility Survey
2025

Do you act as an Interpreter as part of your Job Function? (N=32)



If you act as an Interpreter, which language(s)? (N=9)



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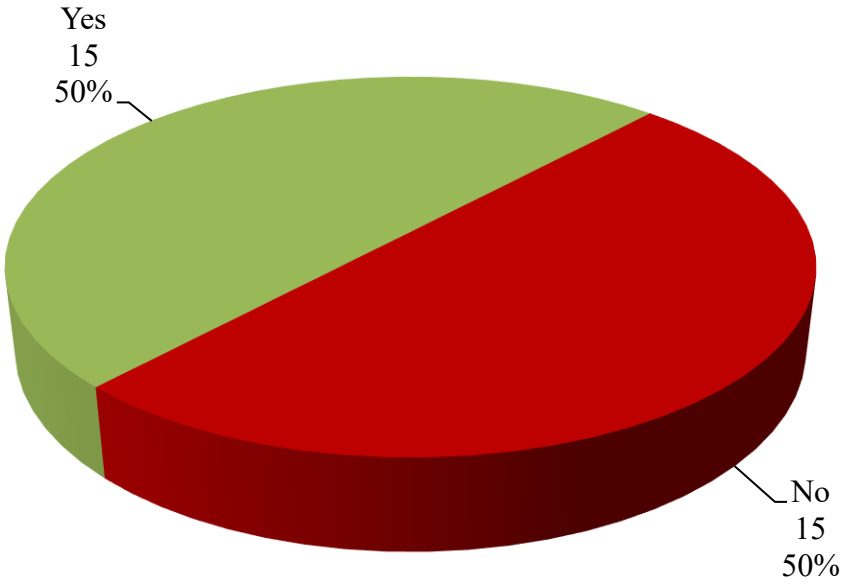
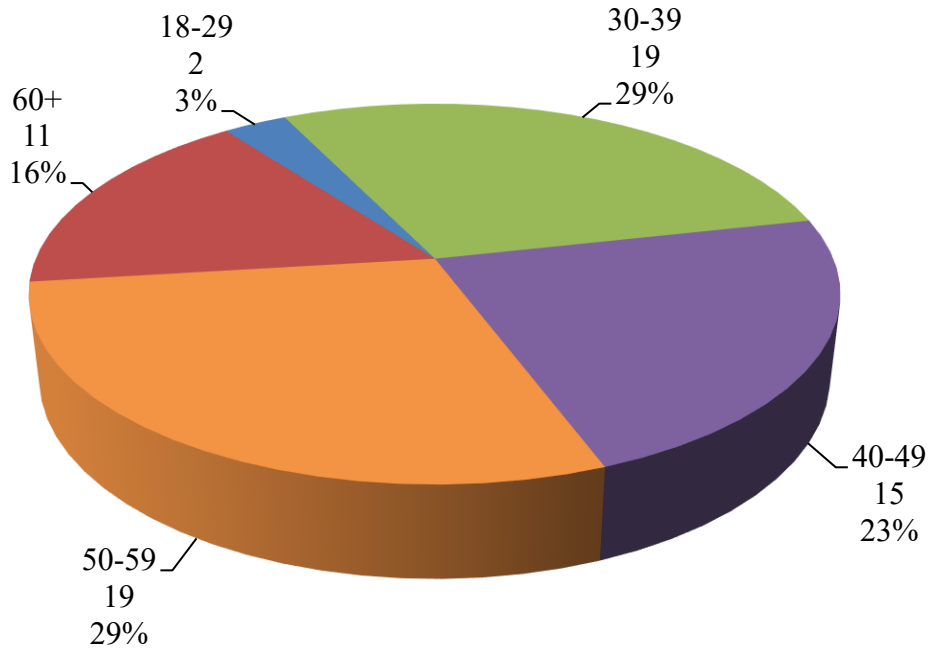
Staff and Org. Provider Cultural Humility Survey
2025

Do you receive Bilingual Pay (e.g., stipend or differential pay)? (N=30)



Marin County Behavioral Health and Recovery Services
Staff and Org. Provider Cultural Humility Survey
2025

Age (N=66)



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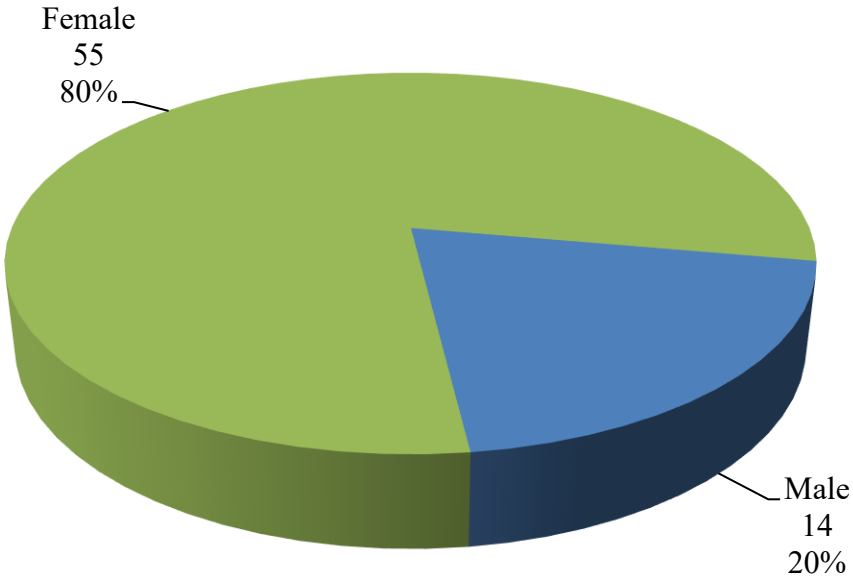
Marin County Behavioral Health and Recovery Services
***Staff and Org. Provider* Cultural Humility Survey**
2025

Sex at Birth (N=69)



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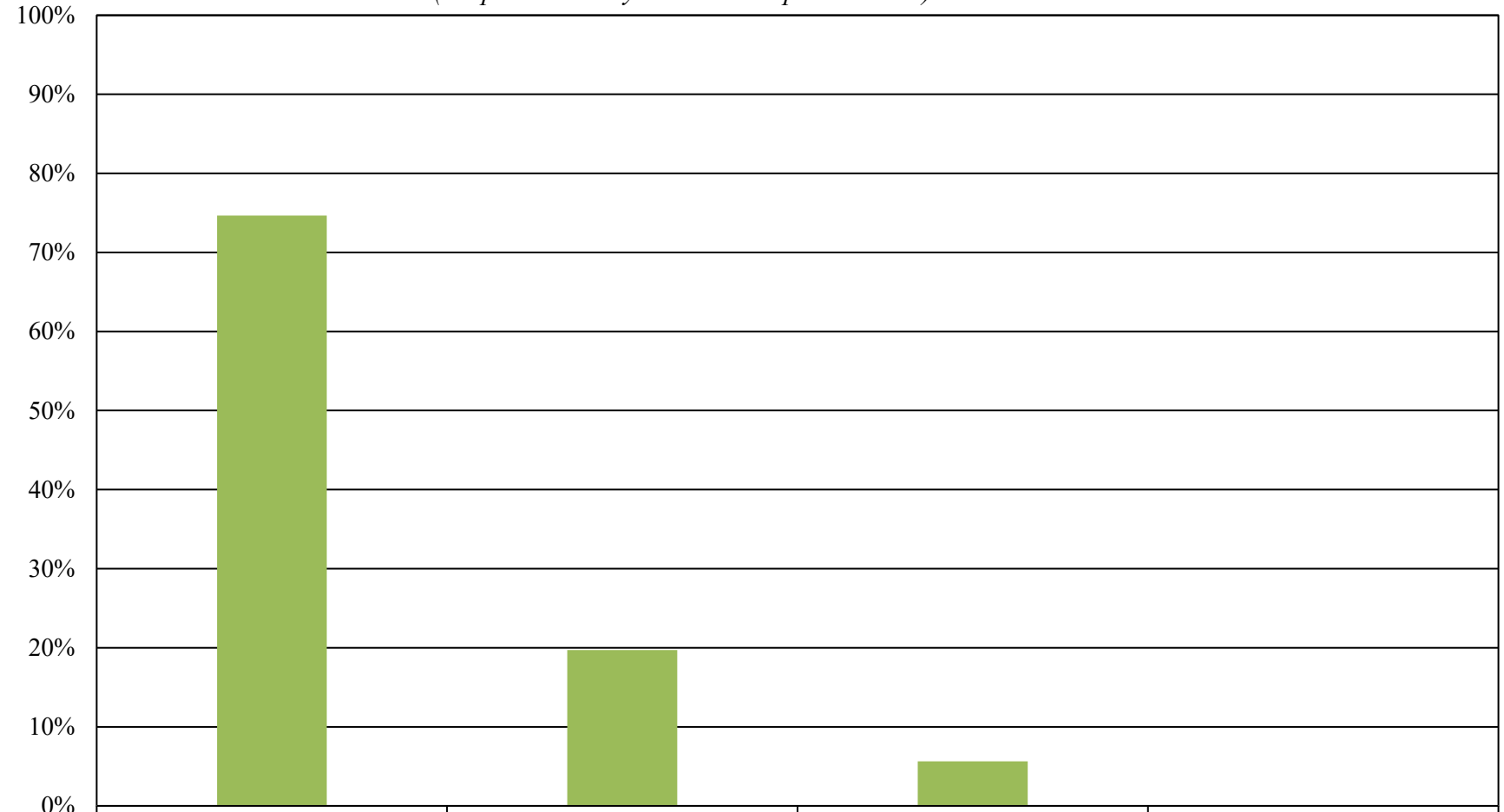
Staff and Org. Provider Cultural Humility Survey

2025

Gender Identity (N=71)

(Respondents may choose multiple answers.)



	Female	Male	Nonbinary	Total Respondents
# Respondents	53	14	4	71
% Respondents	75%	20%	6%	100%

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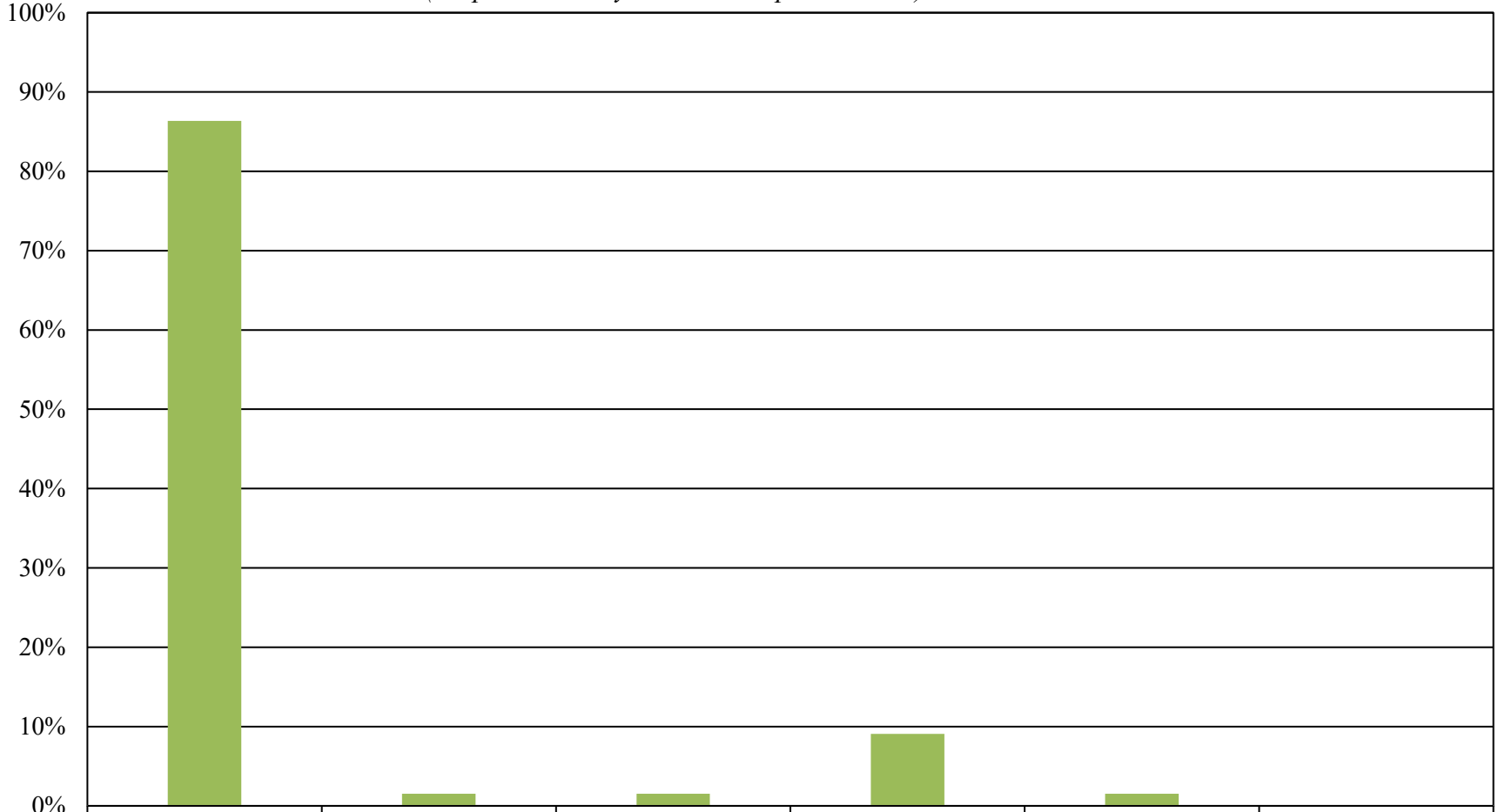
Staff and Org. Provider Cultural Humility Survey

2025

Sexual Orientation (N=66)

(Respondents may choose multiple answers.)



	Heterosexual/ Straight	Gay or Lesbian	Bisexual	Queer	Questioning	Total Respondents
# Respondents	57	1	1	6	1	66
% Respondents	86%	2%	2%	9%	2%	100%

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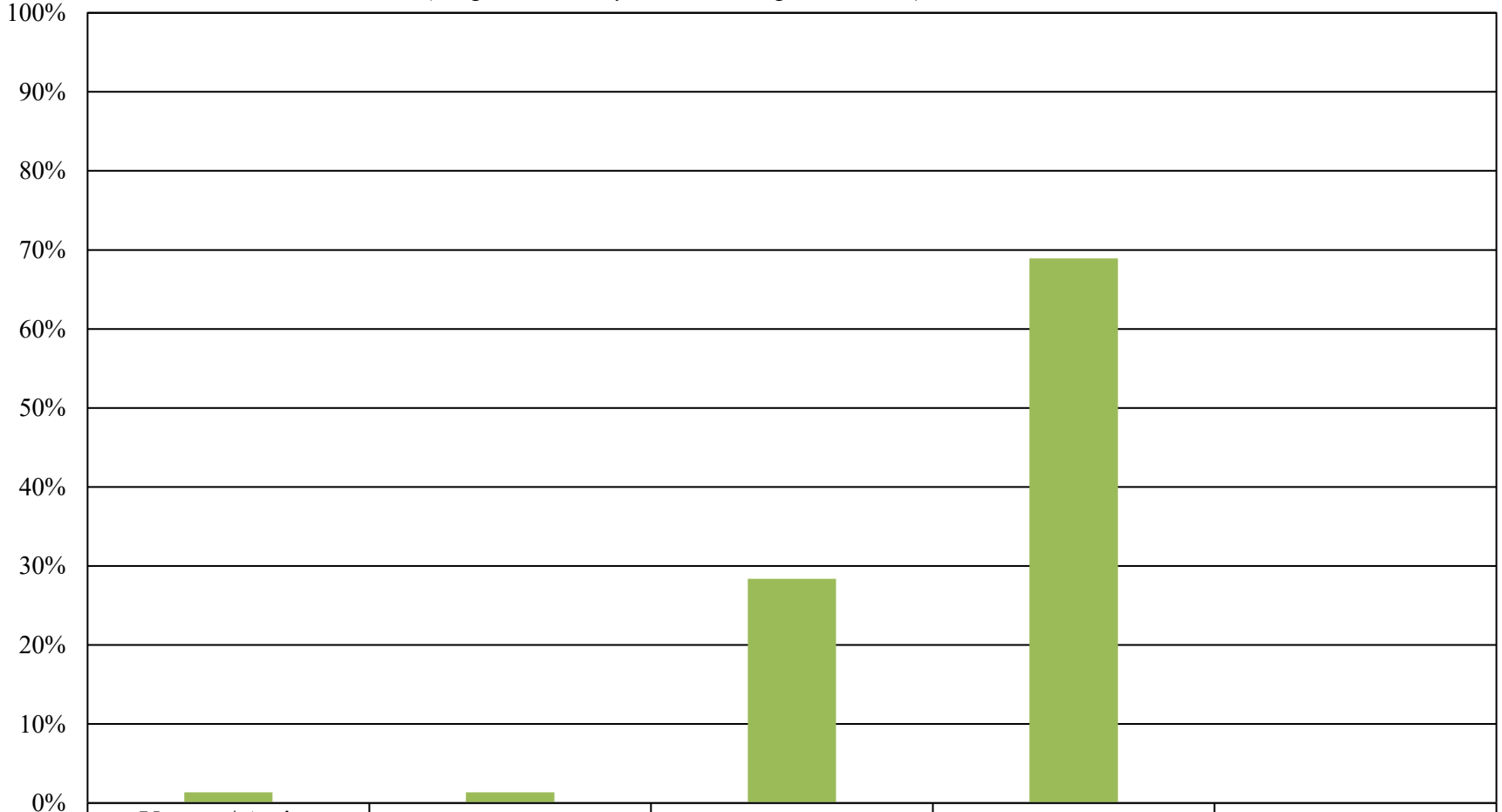
Staff and Org. Provider Cultural Humility Survey

2025

Military/Service Involvement (N=74)

(Respondents may choose multiple answers.)



	Veteran/ Active Military	Served	Family Member	No Involvement	Total Respondents
# Respondents	1	1	21	51	74
% Respondents	1%	1%	28%	69%	100%

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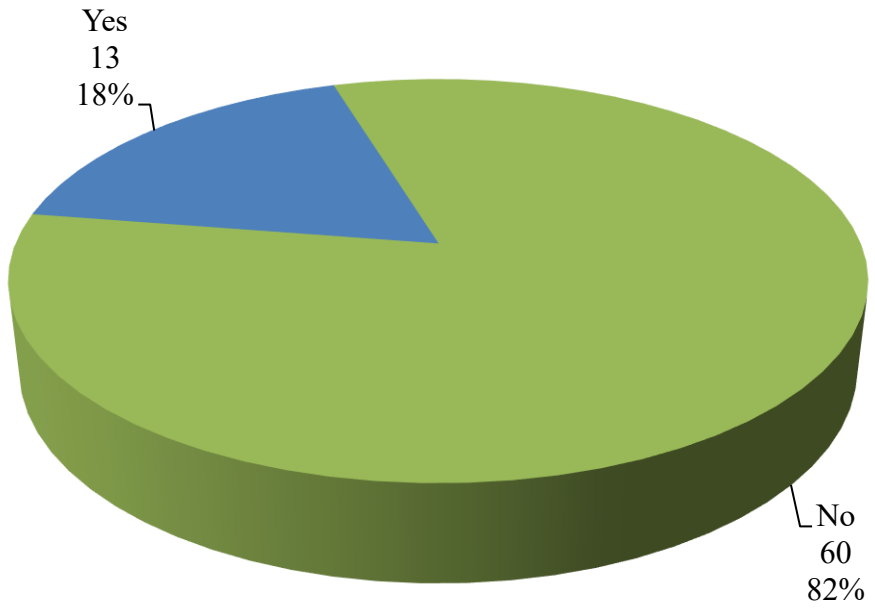
Marin County Behavioral Health and Recovery Services
Staff and Org. Provider Cultural Humility Survey
2025

Do you have a disability? (N=73)



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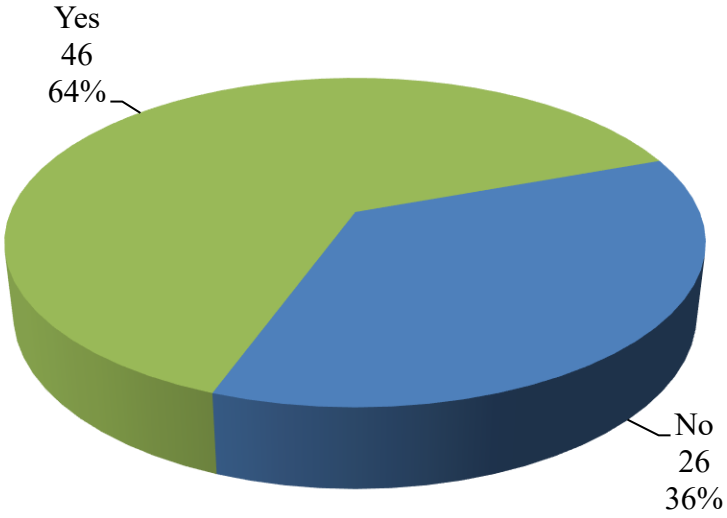
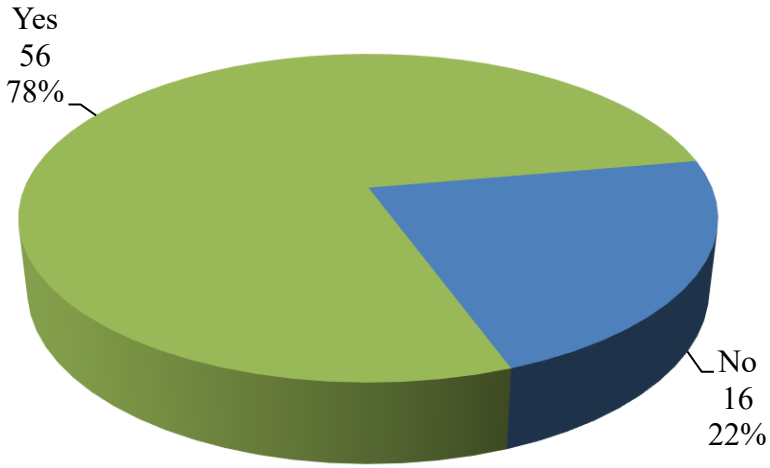
Staff and Org. Provider Cultural Humility Survey
2025

Do you consider yourself to be a person with lived Mental Health experience? (N=72)



Are you a Family Member of a person with lived Mental Health experience? (N=72)



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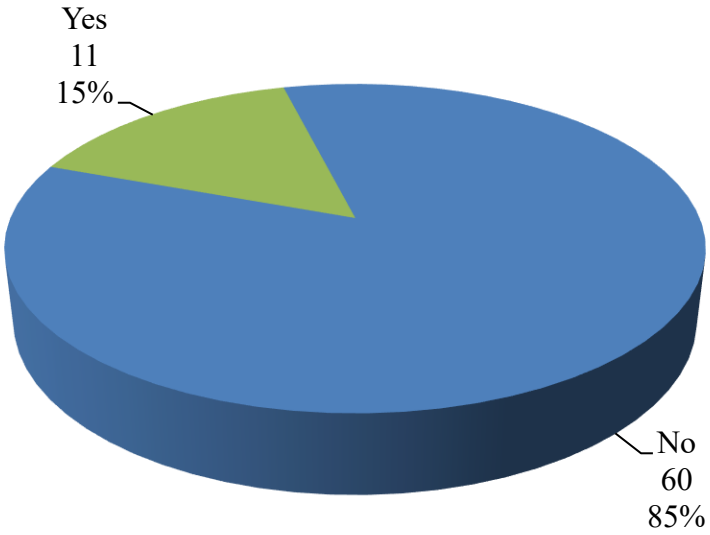
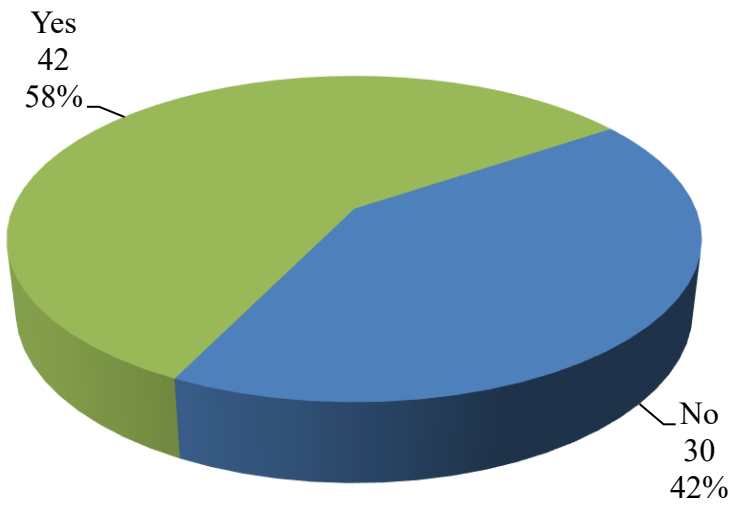
Staff and Org. Provider Cultural Humility Survey
2025

Do you consider yourself to be a person with lived Substance Use Disorder experience? (N=71)



Are you a Family Member of a person with lived Substance Use Disorder experience? (N=72)



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Appendix F: Digital Accessibility Fact Sheet

NEW DIGITAL ACCESSIBILITY CONTRACTOR REQUIREMENTS

WHAT IS HAPPENING?

In 2024, the U.S. Department of Justice issued its final rule revising title II of the Americans with Disabilities Act ("ADA") to establish specific requirements, including the adoption of specific technical standards, for making accessible the services, programs, and activities offered by State and local government entities to the public through the web and mobile applications ("apps").The deadline for compliance is April 24, 2026.

All electronic content and web-based systems that are developed, maintained, or procured under a County contract must meet Web Content Accessibility Guidelines (WCAG) 2.2 Level AA conformance, including PDFs, forms, applications, and embedded media.

In addition, 'Section 504 of the Rehabilitation Act of 1973 Final Rule: Section by Section Fact Sheet for Recipients of Financial Assistance from HHS' passed in 2024 and includes requirements on Web, Mobile, and Kiosk Accessibility, §§ 84.82 - 84.89 and includes social media posts.

WHY ARE WE MAKING THIS CHANGE?

It is the right thing to do; everyone should be able to access and engage with public services.

WHO IS IMPACTED?

The County of Marin, its contractors, vendors, and consultants who develop or provide websites, digital content, documents, public meetings, trainings, telehealth and kiosk services, or marketing materials for the County are impacted.

Program and contract managers responsible for overseeing externally developed digital deliverables.

Any departments issuing Requests for Proposals (RFPs) or awarding grants that involve public-facing or internally used digital content.

WHAT DO I NEED TO DO?

1. Help inform vendors about accessibility requirements.
2. **Ensure contracts include the appropriate digital accessibility contract exhibit with the minimum requirements for accessibility and remove any outdated language from templates.**
3. Ensure contracts involving digital media, training materials, and/or software services are approved by the County Digital Accessibility team during the planning stage of developing a contract, prior to contract approval and execution. The accessibility team will request vendors to complete a questionnaire. A copy of the questionnaire can be found on the Digital Accessibility Procurement page.
4. Provide vendors with Digital Accessibility Resources to support compliance.
5. Reach out to the County Digital Accessibility Team for support by submitting a helpdesk ticket to HelpDesk@MarinCounty.gov.

QUESTIONS?

Reach out to Suzanne Levine at Suzanne.Levine@MarinCounty.gov for digital accessibility questions.

Reach out to HHS Contracts at HHSContracts@MarinCounty.Gov for support with contract related questions or issues.