Sacramento County Behavioral Health Racial Equity Collaborative (BHREC)

Latino/Latinx/Hispanic BHREC Community Readiness Survey

Purpose

In 2020 Sacramento County established the Behavioral Health Racial Equity Collaborative (BHREC), using a targeted universalism approach with the African American/Black/Of African Descent community in Sacramento to create Racial Equity Action Plans to improve behavioral health outcomes. Following the pilot BHREC with the African American/Black/Of African Descent community, Sacramento County began implementing the BHREC with the Latino/Latinx/Hispanic community. The collaborative is sponsored by Sacramento County Behavioral Health Services (BHS) and facilitated by California Institute of Behavioral Health Services (CIBHS). Behavioral Health Data Project (BHDP) is evaluating the collaborative. This report summarizes findings from the Latino/Latinx/Hispanic Community Survey, contextualized within the Community Readiness Model (CRM) framework. The CRM framework allows community descriptions of their understanding and experiences with behavioral health to be converted into a concrete readiness stage and appropriate action steps to improve the way the community is served. This initiative is funded by Sacramento County, Division of Behavioral Health Services through the voter approved Proposition 63, Mental Health Services Act (MHSA).

Methodology

The Sacramento County BHREC conducted a survey of Latino/Latinx/Hispanic community members to assess how prepared the community is to address behavioral health service needs. The survey was adapted from the Substance Abuse and Mental Health Services Administration (SAMHSA) Community Readiness Manual on Suicide Prevention in Native Communities[1]. The Community Readiness Model[2] was developed at the Tri-Ethnic Center to assess how ready a community is to address an issue. The basic premise is that matching an intervention to a community's level of readiness is essential for success. Efforts that are too ambitious are likely to fail because community members will not be ready or able to respond. To maximize chances for success, the Community Readiness Model offers tools to measure readiness and to develop stage-appropriate strategies.

Surveys were distributed both in person, at the Tarde Social sessions, and electronically. To best reach the target community, the survey was available in both paper and online formats, in both English and Spanish. See Attachments A and B for the English and Spanish versions of the survey. 69 people responded to the survey – 60 via paper surveys at in person events held on November 3 and 4, 2023 and 9 via online surveys between December 1 and 6, 2023.

[1] SAMHSA Community Readiness Manual on Suicide Prevention in Native Communities

[2] Tri-Ethnic Center for Prevention Research Community Readiness for Community Change

Of the 69 responses, 39 responses (57%) were filled out in English with 30 responses (43%) filled out in Spanish.

BHDP scored the surveys. Two independent scorers reviewed the survey responses, then compared their scores. When the scores did not correspond, scorers discussed their scores to reach a consensus score. This report is based on consensus scores.

Summary of Survey Responses

Survey questions were broken down across six dimensions of community readiness. It is common for communities to be in different stages of readiness for each dimension. This section breaks down each dimension individually looking at both the range of answers and community readiness score. Each dimension also includes recommendations on ways to improve the community readiness score. Figure 1 on the next page shows the nine stages of community readiness as defined by the Community Readiness Model. Attachment C contains an infographic describing the Community Readiness Model.

This model was originally designed to be conducted as interviews rather than written surveys. Whereas an interviewer has the ability to ask respondents to elaborate more on a particular question, this is not possible in a written format. The nature and specificity of some questions likely led to slight variations across dimensions and areas where responses did not correlate exactly with the model's scoring rubric. Where these occurred, you will see specific notes about how the scorers scored common themes.

9 STAGES OF COMMUNITY READINESS

1. NO AWARENESS

Behavioral Health is not generally recognized by the community or leaders as a problem (or it may truly not be an issue).
Goal: Raise awareness of the issue.

2. DENIAL/RESISTANCE

At least some community members recognize that Behavioral Health is a concern, but there is little recognition that it might be occurring locally.
Goal: Raise awareness that the problem or issue exists in this community.

3. VAGUE AWARENESS

Most feel that there is local concern, but there is no immediate motivation to do anything about it.
Goal: Raise awareness that the community can do something.

4. PREPLANNING

There is clear recognition that something must be done, and there may even be a group addressing it. However, efforts are not focused or detailed.
Goal: Raise awareness with concrete ideas.

5. PREPARATION

Active leaders begin planning in earnest. The community offers modest support of efforts.
Goal: Gather existing information with which to plan more specific strategies.

6. INITIATION

Enough information is available to justify efforts. Activities are underway.
Goal: Provide community-specific information, training, and outreach.

7. STABILIZATION

Activities are supported by administrators or community decision-makers. Staff are trained and experienced.
Goal: Stabilize efforts and programs.

8. CONFIRMATION/EXPANSION

Efforts are in place. Community members feel comfortable using services, and they support expansions. Local data are regularly obtained.
Goal: Enhance and expand services.

9. HIGH LEVEL OF COMMUNITY OWNERSHIP

Detailed and sophisticated knowledge exists about Behavioral Health prevalence and consequences.
Goal: Maintain momentum and continue growth.

This initiative is funded by Sacramento County, Division of Behavioral Health Services through the voter approved Proposition 63, Mental Health Services Act (MHSA).

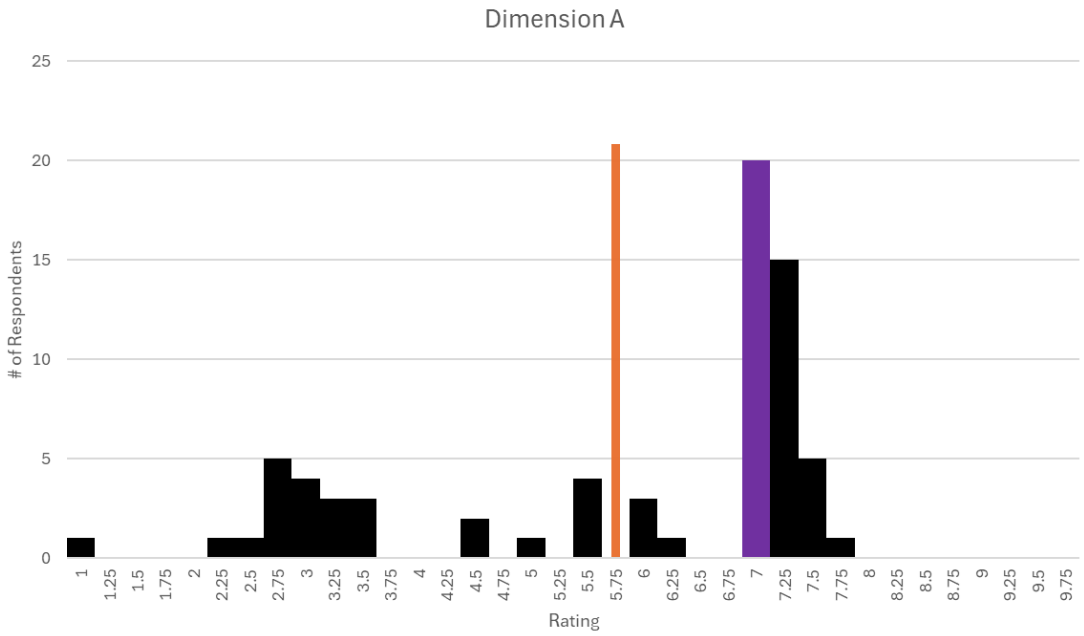
Dimension A: Community Behavioral Health Efforts

Dimension A focused on community behavioral health efforts and assessed the extent to which there are efforts, programs, and policies that address behavioral health services. This was assessed through questions 3-6 of the community survey.

Community Readiness Score Range

Dimension A had a wide range of scores that fell largely into three main groupings. The majority of responses, about 60%, corresponded to a readiness score around 7.25, which indicates efforts (programs or activities) have been running for at least 4 years or more. This aligns with the fact that Sacramento County has been providing services to the Latino/Latinx/Hispanic community for significantly longer than 4 years. However, 25% of responses corresponded to a readiness rating of approximately 3, which indicates a few community members recognize the need to initiate some type of effort, but there is no immediate motivation to do anything. Another 16% of responses corresponded to a readiness score of 5.5, which indicates efforts (programs or activities) are being planned. Figure 2 depicts the full range of scores for Dimension A with both the median and mode represented by the thick purple line and the mean represented by the thin orange line.

Figure 2. Dimension A Score Breakdown



Community Readiness Score

The average score of 5.76 for Dimension A puts Sacramento County in the preparation stage of community readiness around community efforts. In this stage you typically see active leaders planning in earnest with the community offering modest support. Some recommendations for

this stage are to have public forums for grassroots input on developing strategies, use key leaders and influential people to speak to groups, and participate in local radio and television shows to gain support. Table 1 shows the Community Readiness Model's breakdown of this stage.

Table 1. Community Readiness: Community Efforts

Readiness Stage: Community Efforts[3]	**5, Preparation**
Description	Active leaders begin planning in earnest. Community offers modest support of efforts.
Goal	Gather existing information with which to plan more specific strategies.
Types of Strategies	1. Seek out local data sources about behavioral health.
	2. Conduct more formal community surveys.
	3. Sponsor a community health event to kick off the effort.
	4. Conduct public forums to develop strategies from the grassroots level.
	5. Utilize key leaders and influential people to speak to groups and participate in local radio and television shows to gain support.
	6. Plan how to evaluate the success of your efforts

While the Community Readiness Model uses the average score to indicate what stage the community is in, the median score is a 7. Respondents routinely cited specific, established behavioral health service providers when answering questions corresponding to this dimension. Table 2 shows the mean, median, and mode scores for Dimension A along with the total number of responses.

Table 2. Dimension A Response Breakdown

Dimension A – Community Efforts			
	All Responses	English	Spanish
Mean	5.76	5.75	5.78
Median	7.00	7.00	7.00
Mode	7.00	7.25	7.00
Number of responses	68	39	29

[3] SAMHSA Community Readiness Manual on Suicide Prevention in Native Communities

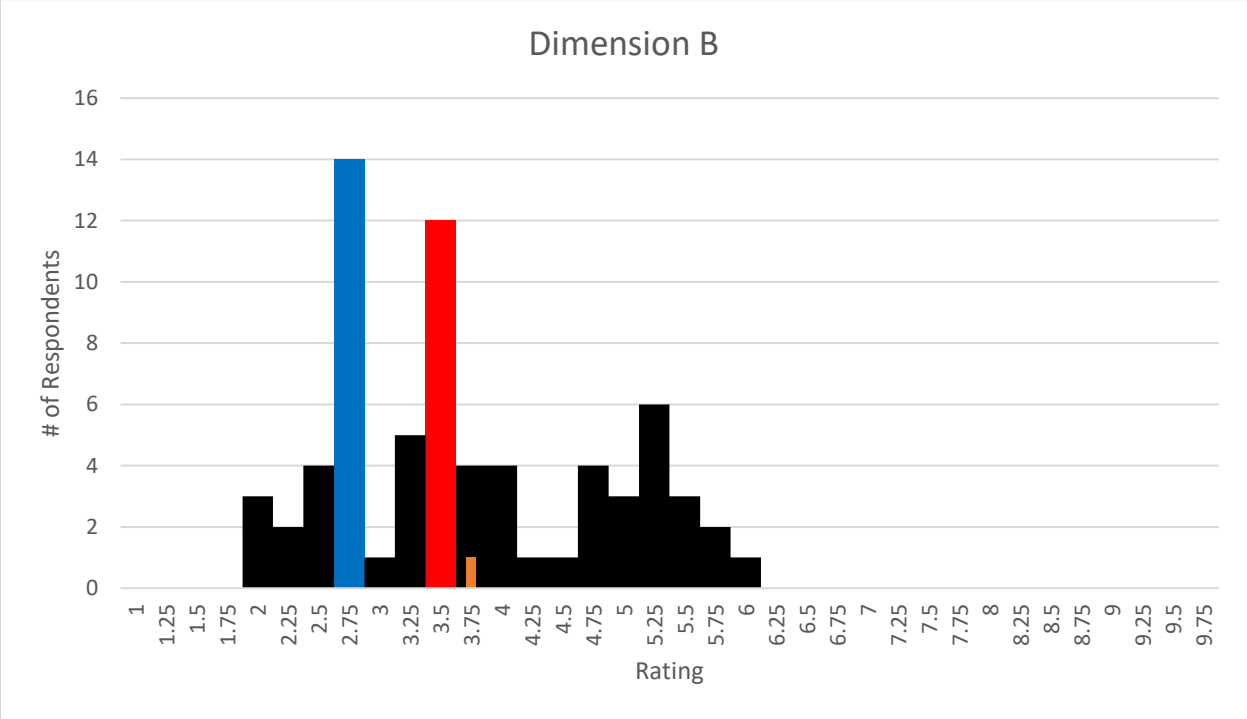
Dimension B: Community Knowledge of Behavioral Health Efforts

Dimension B focused on community knowledge of behavioral health services efforts and assessed the extent to which community members knew about local efforts and their effectiveness, and if the efforts are accessible to all segments of the community. This was assessed through questions 7-9 of the community survey.

Community Readiness Score Range

Scores for Dimension B ranged from 2 to 6. 34% of responses fell between a 2 and 2.75, which indicates that respondents did not think the community knew about efforts addressing the topic. 32% of responses were between a 3 and 3.75, indicating that respondents believed that a few members of the community have heard about efforts, but the extent of their knowledge is limited. 15% of responses scored between a 4 and 4.75, indicating that some members of the community know about local efforts. 21% of respondents scored between a 5 and 5.75, which indicates that members of the community have basic knowledge about local efforts. Figure 3 depicts the full range of scores for Dimension B with the median represented by the thick red line, the mean represented by the thin orange line, and the mode represented by the blue line.

Figure 3. Dimension B Score Breakdown



Community Readiness Score

The mean score of 3.72 for Dimension B puts Sacramento County in the vague awareness stage of community readiness around community knowledge of efforts. In this stage, there is

typically local concern, but not an immediate motivation to act on it. The main goal for this stage is to raise awareness that the community can do something. It is important to raise this dimension's score to be more in line with other dimension's scores. Some strategies to improve community awareness of behavioral health efforts include participating in local community events for your Latino/Latinx/Hispanic community, posting flyers and posters, and initiating or continuing to hold community health events to spread information about behavioral health services. Table 3 shows the Community Readiness Model's breakdown of this stage.

Table 3. Community Readiness: Community Knowledge of Efforts

Readiness Stage: Community Knowledge of Efforts[4]	**3, Vague Awareness**
Description	Most feel that there is local concern, but there is no immediate motivation to do anything about it.
Goal	Raise awareness that the community can do something.
Types of Strategies	1. Get on meeting agendas and present information on behavioral health at local community events and to unrelated community groups.
	2. Post flyers, posters, and billboards.
	3. Begin to initiate your own community health events (potlucks,) and use those opportunities to also present information on behavioral health.
	4. Conduct informal local surveys and interviews with community people by phone or door-to-door about attitudes and perceptions related to behavioral health.
	5. Utilize key leaders and influential people to speak to groups and participate in local radio and television shows to gain support.
	6. Publish newspaper editorials and human interest articles with general information and local implications.

Table 4 shows the mean, median, and mode scores for Dimension B along with the total number of responses.

[4] SAMHSA Community Readiness Manual on Suicide Prevention in Native Communities

Table 4. Dimension B Response Breakdown

Dimension B – Community Knowledge of Efforts			
	All Responses	English	Spanish
Mean	3.72	3.71	3.75
Median	3.50	3.50	3.50
Mode	2.75	3.50	2.75
Number of responses	68	39	29

The contrast between the high rating for Dimension A, showing established local efforts exist, and Dimension B, showing vague awareness of those efforts, highlights the importance of increasing awareness of behavioral health services available to the Latino/Latinx/Hispanic community in Sacramento. Respondents' ability to name an established behavioral health program, provider, or activity in Sacramento County corresponded to a score of 7 or higher in Dimension A. Question 4 of the survey directly asked for respondents to name behavioral health programs in the community, which led to many directly meeting the criteria for a 7. To achieve a score of 6 or higher for Dimension B, respondents needed to describe ways in which community members were attempting to increase community knowledge about these programs. While this may be happening, only one survey response described these efforts. Additionally, respondents routinely rated community knowledge of behavioral health services poorly, indicating that many community members were unaware of services available to them.

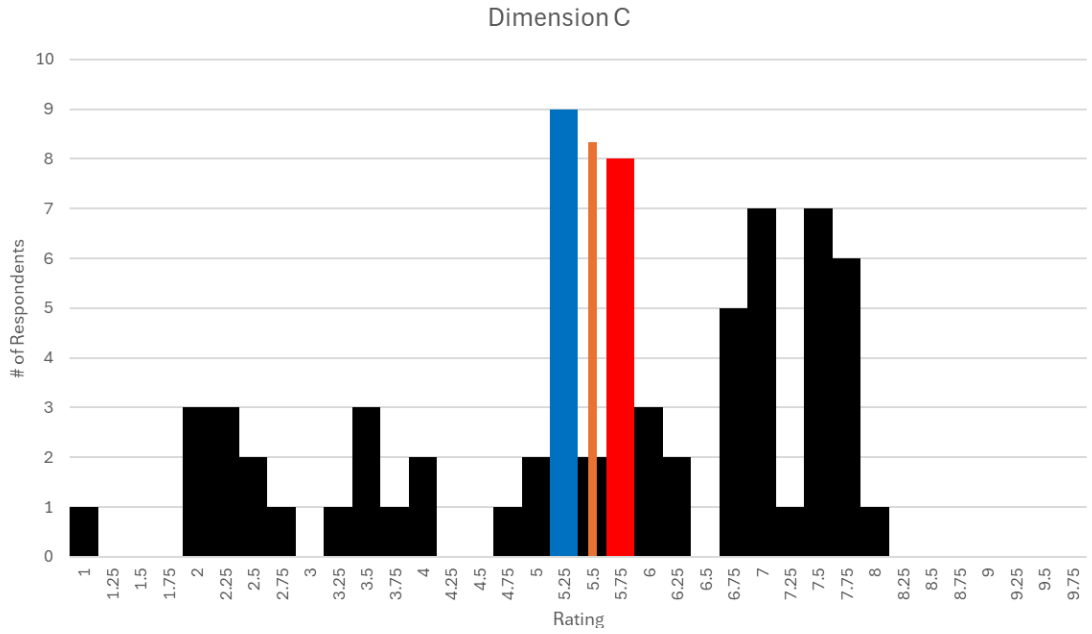
Dimension C: Leadership

Dimension C focused on community leaders and assessed the extent to which appointed and influential community members were supportive of behavioral health services. This was assessed through questions 10-12 of the community survey.

Community Readiness Score Range

Scores for Dimension C ranged from 1 to 8 and largely fell into three main groupings. 23% of responses scored around a 3, which indicates that leaders recognize the need to do something regarding behavioral health services. 39% of responses scored around a readiness score of 5.5, which indicates leaders are part of a committee or group that addresses behavioral health services. Another 39% of responses scored around 7.5, which indicates leaders are supportive of continuing basic efforts and are considering resources available for self-sufficiency. Figure 4 depicts the full range of scores for Dimension C with the median represented by the thick red line, the mean represented by the thin orange line, and the mode represented by the blue line.

Figure 4. Dimension C Score Breakdown



Community Readiness Score

The mean score of 5.5 for Dimension C puts Sacramento County in the preparation stage of community readiness around leadership. In this stage you typically see active leaders planning in earnest with the community offering modest support. At this point, Sacramento County should focus efforts on raising the scores of other dimensions. Table 5 shows the Community Readiness Model's breakdown of this stage.

Table 5. Community Readiness: Leadership

Readiness Stage: Leadership[5]	5, Preparation
Description	Active leaders begin planning in earnest. Community offers modest support of efforts.
Goal	Gather existing information with which to plan more specific strategies.
Types of Strategies	1. Seek out local data sources about behavioral health.
	2. Conduct more formal community surveys.
	3. Sponsor a community health event to kick off the effort.
	4. Conduct public forums to develop strategies from the grassroots level.
	5. Utilize key leaders and influential people to speak to groups and participate in local radio and television shows to gain support.
	6. Plan how to evaluate the success of your efforts

Table 6 shows the mean, median, and mode scores Dimension C along with the total number of responses. While both Spanish and English responses fell in the same readiness level, Spanish responses were slightly higher than English ones, suggesting that Spanish-speakers have slightly greater trust in leadership related to behavioral health.

Table 6. Dimension C Response Breakdown

Dimension C – Leadership			
	All Responses	English	Spanish
Mean	5.50	5.33	5.81
Median	5.75	5.75	6.13
Mode	5.25	5.75	7.50
Number of responses	69	39	30

Dimension D: Community Climate

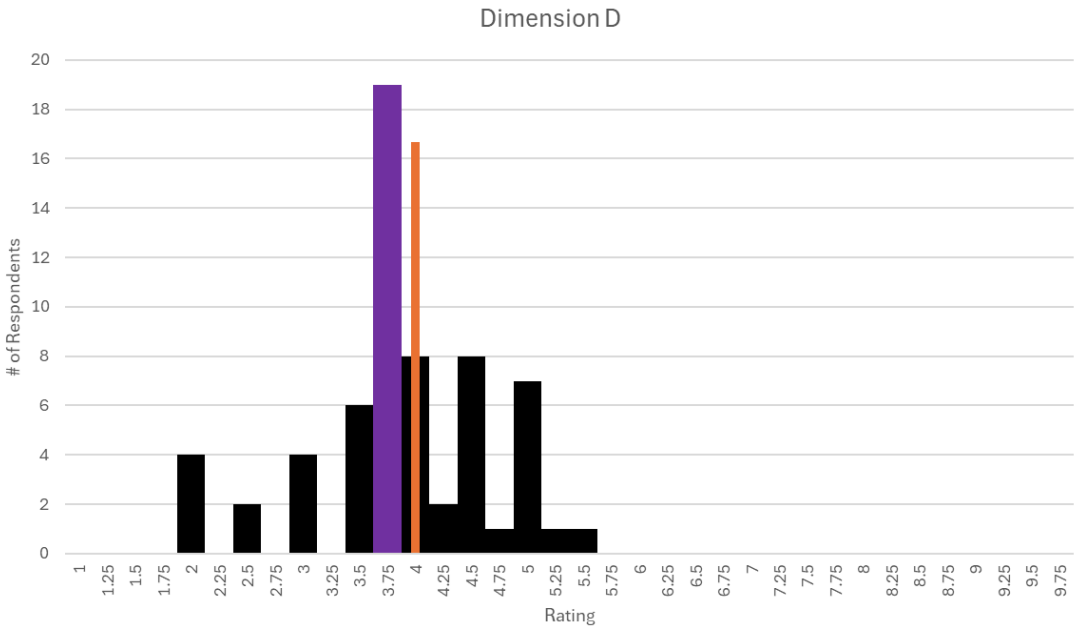
Dimension D focused on the community climate around behavioral health services and assessed the prevailing attitude of the community toward behavioral health services, ranging from feelings of community helplessness towards feelings of responsibility and empowerment. This dimension was assessed through questions 13-14 of the community survey.

[5] SAMHSA Community Readiness Manual on Suicide Prevention in Native Communities

Community Readiness Score Range

Dimension D was more tightly clustered than most other dimensions. Over half of the scores were between 3.5 and 4. Scores in the 3 range indicate that the community climate is neutral, disinterested, or believes that behavioral health does not affect the community as a whole. Scores in the 4 range represent that the attitude in the community is now beginning to reflect interest in behavioral health and that they know they need to do something but don't know what to do. This cluster is largely centered around the prevalence of stigma in the community with 31% of respondents directly or indirectly referencing it. 10% of scores were between 2 and 2.5, which indicates a perceived community attitude of not being able to do anything about behavioral health or feelings that behavioral health does not affect their community. 15% of scores were between a 5 and 5.5, which indicates that the community's attitude is one of concern about behavioral health and that community members show modest support for behavioral health efforts. Figure 5 depicts the full range of scores for Dimension D with both the median and mode represented by the thick purple line and the mean represented by the thin orange line.

Figure 5. Dimension D Score Breakdown



Community Readiness Score

The mean score of 3.88 for Dimension D puts Sacramento County in the vague awareness stage of community readiness around community climate. The key takeaway from this dimension is the need to combat community stigma around behavioral health services. This will be crucial to raising overall community readiness. Table 7 shows the Community Readiness Model's breakdown of this stage.

Table 7. Community Readiness: Community Climate

Readiness Stage: Community Climate[6]	3, Vague Awareness
Description	Most feel that there is local concern, but there is no immediate motivation to do anything about it.
Goal	Raise awareness that the community can do something.
Types of Strategies	1. Get on meeting agendas and present information on behavioral health at local community events and to unrelated community groups.
	2. Post flyers, posters, and billboards.
	3. Begin to initiate your own community health events (potlucks,) and use those opportunities to also present information on behavioral health.
	4. Conduct informal local surveys and interviews with community people by phone or door-to-door about attitudes and perceptions related to behavioral health.
	5. Utilize key leaders and influential people to speak to groups and participate in local radio and television shows to gain support.
	6. Publish newspaper editorials and human interest articles with general information and local implications.

Table 8 shows the mean, median, and mode scores for Dimension D along with the total number of responses. Community climate was the only dimension in which English responses had a higher average score than Spanish responses. While the mean scores do not differ by much, English language response scores align with a higher readiness stage (Stage 4, Preplanning) than Spanish ones and the community overall.

Table 8. Dimension D Response Breakdown

Dimension D – Community Climate			
	All Responses	English	Spanish
Mean	3.88	4.03	3.72
Median	3.75	4.00	3.75
Mode	3.75	3.75	3.75
Number of responses	61	32	29

[6] SAMHSA Community Readiness Manual on Suicide Prevention in Native Communities

Dimension E: Community Knowledge of Behavioral Health

Dimension E focused on community knowledge of behavioral health and assessed the extent to which community members knew about or had access to behavioral health services, and understood their consequences as well as how behavioral health impacts the community. This was assessed through questions 15-16 of the community survey.

Community Readiness Score Range

Dimension E had a continuum of scores between 2 and 5.5. Respondent answers and the scoring rubric often did not align closely for this dimension which led to a lot of discussion between the scorers.

31% of scores were in the 2 range. This range indicated that respondents had no knowledge about behavioral health services. For this range, respondent answers and the scoring rubric aligned closely.

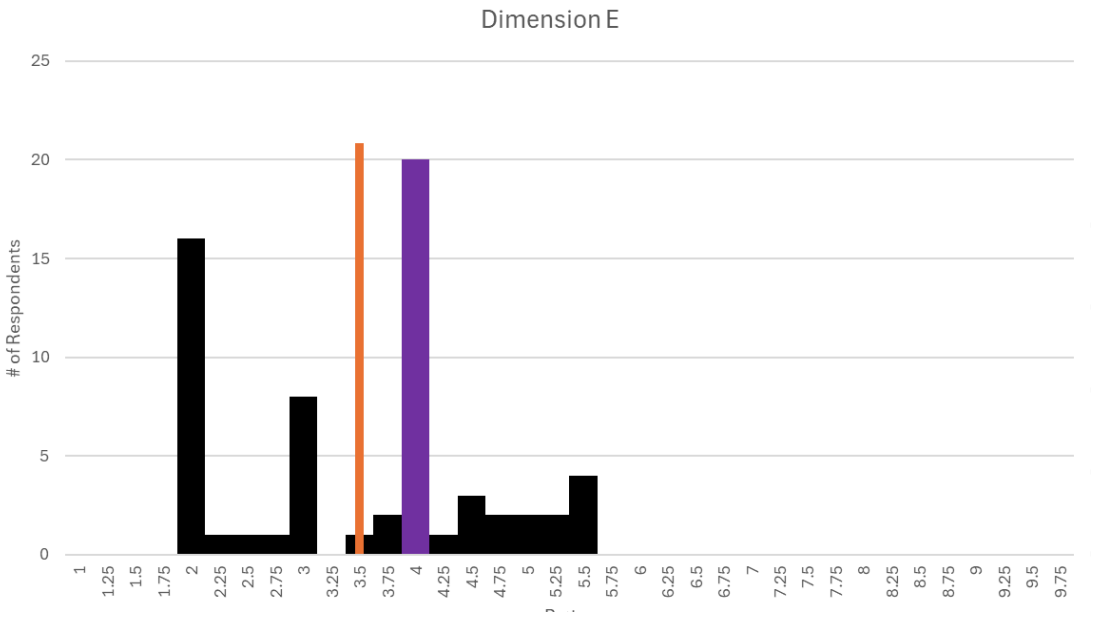
18% of scores were between 3 and 3.75. The scoring rubric indicated this range corresponded to a few members of the community having basic knowledge of behavioral health services, and recognition that some people might be affected by behavioral health services. Question 15 asked what types of information are available about behavioral health services and scorers placed answers of vague information such as online resources or flyers in this range.

42% of scores were between 4 and 4.75. The scoring rubric indicated this corresponded to some community members having basic knowledge and recognizing that behavioral health services occur locally, but information and/or access to information is lacking. Scorers assigned this range to answers that either included references to general behavioral health services such as doctors' offices or that described that local resources existed but there wasn't much information about them.

13% of scores were between 5 and 5.5. The scoring rubric indicated that this range corresponds to some community members having basic knowledge, including signs and symptoms, with general information on the behavioral health services being available. Scorers put responses in this range that indicated specific local behavioral health services or had references to signs and symptoms of behavioral health.

Figure 6 depicts the full range of scores for Dimension E with both the median and mode represented by the thick purple line and the mean represented by the thin orange line.

Figure 6. Dimension E Score Breakdown



Community Readiness Score

The mean score of 3.48 for Dimension E puts Sacramento County in the vague awareness stage of community readiness around community knowledge of behavioral health services. 26% of respondents indicated that they did not know what types of information are available about behavioral health and public behavioral health services. To improve this dimension, Sacramento County should speak informally with people in the community, create awareness campaigns, and work with local news sources to get information out there, including how behavioral health affects the community. Table 9 shows the Community Readiness Model's breakdown of this stage.

Table 9. Community Readiness: Community Knowledge of Behavioral Health

Readiness Stage: Community Knowledge of Behavioral Health[7]	**3, Vague Awareness**
Description	Most feel that there is local concern, but there is no immediate motivation to do anything about it.
Goal	Raise awareness that the community can do something.
Types of Strategies	1. Get on meeting agendas and present information on behavioral health at local community events and to unrelated community groups.
	2. Post flyers, posters, and billboards.
	3. Begin to initiate your own community health events (potlucks,) and use those opportunities to also present information on behavioral health.
	4. Conduct informal local surveys and interviews with community people by phone or door-to-door about attitudes and perceptions related to behavioral health.
	5. Utilize key leaders and influential people to speak to groups and participate in local radio and television shows to gain support.
	6. Publish newspaper editorials and human interest articles with general information and local implications.

Table 10 shows the mean, median, and mode scores for Dimension E along with the total number of responses. While both Spanish and English responses fell in the same readiness level, Spanish responses were higher than English responses, corresponding to a higher level of community knowledge about behavioral health among responses in Spanish.

Table 10. Dimension E Response Breakdown

Dimension E – Community Knowledge about Behavioral Health			
	All Responses	English	Spanish
Mean	3.48	3.21	3.85
Median	4.00	3.00	4.00
Mode	4.00	2.00	4.00
Number of responses	62	35	27

[7] SAMHSA Community Readiness Manual on Suicide Prevention in Native Communities

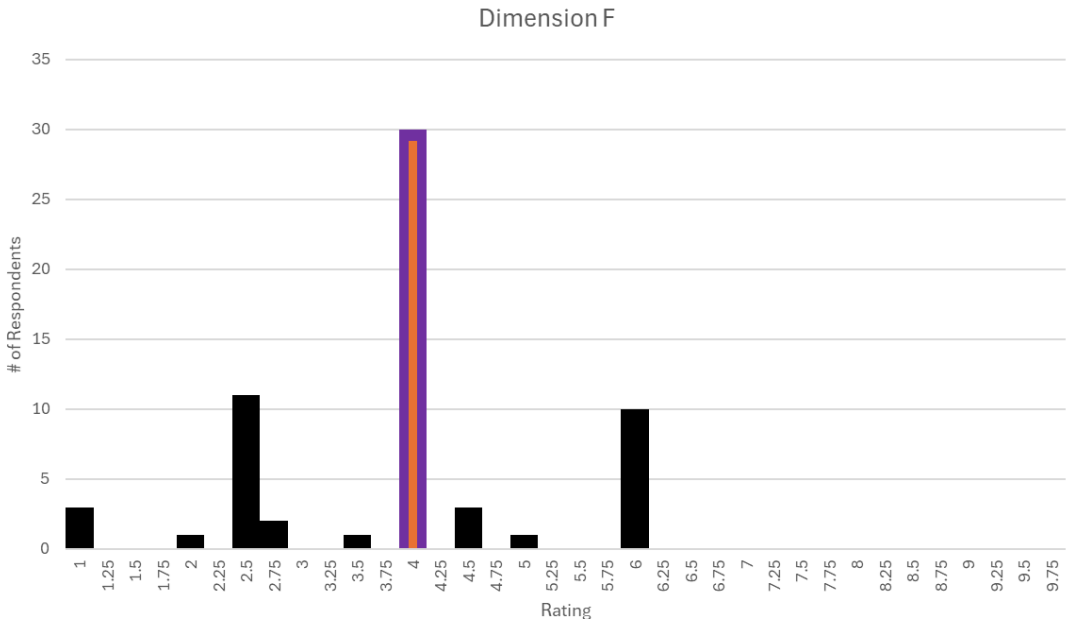
Dimension F: Resources

Dimension F focused on the resources related to behavioral health services and assessed the extent to which local resources are available to support behavioral health. This was assessed through question 17 of the community survey.

Community Readiness Score Range

Dimension F was scored based on responses to only one question and the answers were generally clear cut. Question 17 asked respondents who they would turn to first if they needed behavioral health support. 18% of responses were scored a 2.5 because they identified a non-professional, close personal relationship such as a family member or friend. 50% of responses were rated a 4 because they identified a medical professional or insurance company that would provide a path to behavioral health services. 17% of responses were scored a 6 because they identified a behavioral health professional or behavioral health organization. Figure 7 depicts the full range of scores for Dimension F with both the median and mode represented by the thick purple line and the mean represented by the thin orange line.

Figure 7. Dimension F Score Breakdown



Community Readiness Score

The mean score of 3.87 for Dimension F puts Sacramento County in the vague awareness stage of community readiness around resources related to behavioral health services. Table 11 shows the Community Readiness Model's breakdown of this stage.

Table 11. Community Readiness: Resources Related to Behavioral Health

Readiness Stage: Resources Related to Behavioral Health [8]	**3, Vague Awareness**
Description	Most feel that there is local concern, but there is no immediate motivation to do anything about it.
Goal	Raise awareness that the community can do something.
Types of Strategies	1. Get on meeting agendas and present information on behavioral health at local community events and to unrelated community groups.
	2. Post flyers, posters, and billboards.
	3. Begin to initiate your own community health events (potlucks, =) and use those opportunities to also present information on behavioral health.
	4. Conduct informal local surveys and interviews with community people by phone or door-to-door about attitudes and perceptions related to behavioral health.
	5. Utilize key leaders and influential people to speak to groups and participate in local radio and television shows to gain support.
	6. Publish newspaper editorials and human interest articles with general information and local implications.

Table 12 shows the mean, median, and mode scores for Dimension F along with the total number of responses. For Dimension F, Spanish responses were higher than English responses. While the mean scores do not differ by much, Spanish language response scores align with a higher readiness stage (Stage 4, Preplanning) than English ones and the community overall.

[8] SAMHSA Community Readiness Manual on Suicide Prevention in Native Communities

Table 12. Dimension F Response Breakdown

Dimension F – Resources Related to Behavioral Health Services			
	All Responses	English	Spanish
Mean	3.87	3.71	4.08
Median	4.00	4.00	4.00
Mode	4.00	4.00	4.00
Number of responses	60	35	25

Final Stage of Community Readiness

A composite was made from scores across all dimensions to determine a Final Stage of Community Readiness. With a mean score of 4.41 Sacramento County falls firmly into the preplanning stage of community readiness. Spanish and English responses had similar overall mean scores. Table 13 shows the mean, median, and mode scores for all dimensions combined along with the total number of responses.

Table 13. Dimension F Response Breakdown

All Dimensions			
	All Responses	English	Spanish
Mean	4.41	4.31	4.54
Median	4.50	4.25	4.63
Mode	4.50	4.00	4.50
Number of responses	69	39	30

Table 14 below describes the Preplanning stage based on the Community Readiness Model. Some of the strategies outlined may already be implemented or in the process of being implemented.

Table 14. Community Readiness Overall

Final Stage of Community Readiness[9]	4, Preplanning
Description	There is a clear recognition that something must be done, and there may even be a group addressing it. However, efforts are not focused or detailed.
Goal	Raise awareness with concrete ideas.
Types of Strategies	1. Introduce information about public behavioral health services through presentations and media. Focus on reducing stigma and raising general awareness.
	2. Visit and invest community leaders in the cause.
	3. Review existing efforts in the community (curriculum, programs, activities) to determine who the focused populations are and consider the degree of success of the efforts.
	4. Conduct local focus groups to discuss public behavioral health services and related issues and develop some basic strategies.
	5. Increase media exposure through radio and television public service announcements.

Recommendations

Reading through the surveys led to a few key takeaways beyond the ones recommended by the Community Readiness Model.

To effectively reach the Latino/Latinx/Hispanic community work must be done around combatting stigma. Question 13 of the survey specifically asked about the community's feelings about behavioral health and responses gave some of the clearest indications of what respondents felt. Question 18 also asked how BHS can best serve respondents in a culturally and linguistically appropriate manner. Stigma is perceived as one of the biggest barriers to the community receiving behavioral health services.

Create a broad reaching education campaign around behavioral health services, the cost (or lack of cost) of services, and the availability of services for people who are undocumented. Respondents frequently stated that they thought most people in their community didn't have much information about or knowledge of behavioral health services available to them. They felt that for the community a lack of insurance and the perceived high

[9] SAMHSA Community Readiness Manual on Suicide Prevention in Native Communities

cost prevented people from receiving services. Further, they often cited distrust generally or fear based on client's immigration status as reasons people didn't receive services.

The community wants more community engagement activities, culturally knowledgeable providers, and Spanish-speaking providers. Questions 18 and 20 sought general feedback and the most common responses were for more engagement both as behavioral health services and outreach activities.

Create shorter surveys and use more accessible language. Several participants noted that either they themselves struggled with completing the survey or that they thought other community members would struggle with completing the survey. They said both that the survey was too long and that some of the language was too complex, regardless of whether it was in English or Spanish.

Conclusion

Sacramento County Behavioral Health Services Division has a solid framework to increase trust and partnership with the Latino/Latinx/Hispanic community but change will take time. BHS should continue to work through BHREC to engage the community and increase overall awareness of behavioral health in Sacramento.

Attachment A: Sacramento County BHREC Latino/Latinx/Hispanic Community Survey – English Version

Sacramento County
Behavioral Health Racial Equity Collaborative (BHREC)

Latino/Latinx/Hispanic Community Survey

Sacramento County Behavioral Health Services Division (BHS) is conducting this survey of Latino/Latinx/Hispanic community members to ask questions about behavioral health and wellness. Sacramento County BHS provides behavioral health services to people who are diagnosed with a serious mental illness and/or struggling with substance use. BHS also provides prevention and early intervention programs to help minimize serious behavioral health challenges in our community. Sometimes these programs and services are provided by BHS directly, and sometimes BHS contracts other organizations in the community to provide them. All together, these programs and services are called public behavioral health services.

The purpose of this survey is to learn how prepared our community is to address behavioral health challenges. Your participation is completely anonymous and voluntary. You can skip any questions you prefer not to answer. Your responses will be used to help plan for future activities to improve our ability to serve our community. If you have any questions about this survey or Sacramento County's public behavioral health services, please contact DHS-BHS-BHREC@SacCounty.gov.

Getting Started

1. Our communities are made up of diverse members from Mexico, South and Central America, the Caribbean, and Spain. How do you identify yourself? For example: Latino/a, Hispanic, Latinx, Latine, Chicano/a.

2. Envision the perfect care system, what would it look like for you to access and receive mental health and/or substance use services for you or your family?

Community Efforts and Community Knowledge of the Efforts

3. On a scale from 1 to 10, how much of a concern is behavioral health in our community. (With 1 being "not at all" and 10 being "a great concern"). Please explain your rating.

1 2 3 4 5 6 7 8 9 10

Behavioral Health Data Project

SACRAMENTO COUNTY

CIBHS CALIFORNIA INSTITUTE for BEHAVIORAL HEALTH SOLUTIONS

4. What behavioral health programs or services are available in our community? Who provides those programs or services?

5. Generally, do people in the community use these services?

   ☐ Yes ☐ No

6. Can you describe efforts to involve the community, including youth and elders, in the planning of public behavioral health services (meaning those provided by or on behalf of Sacramento County BHS)?

7. On a scale from 1 to 10, how aware is the general community of behavioral health programs and services available through Sacramento County BHS, like the names of programs, the services provided, how to access services, who they serve, and whether they treat both mental health and substance use (With 1 being “not at all” and 10 being “a great deal”). Please explain your rating.

   1 2 3 4 5 6 7 8 9 10

8. What are the strengths of the available public behavioral health programs and services?

9. What are the limitations of the available public behavioral health programs and services?

Leadership

10. On a scale from 1 to 10, how concerned do you think our ***County leaders*** are with providing behavioral health services for community members? With 1 being "not at all" and 10 being "a great concern"). Please explain your rating.

    1 2 3 4 5 6 7 8 9 10

11. On a scale from 1 to 10, how concerned do you think our ***trusted community leaders*** are with providing behavioral health services for community members? With 1 being "not at all" and 10 being "a great concern"). Please explain your rating.

    1 2 3 4 5 6 7 8 9 10

12. Would the ***trusted community leadership*** support additional efforts to address behavioral health challenges in our community? Please explain.

    ☐ Yes ☐ No

Community Climate, Knowledge, and Resources

13. What are the community's feelings about behavioral health and behavioral health services?

14. What are the primary obstacles to obtaining public behavioral health services in our community?

15. In our community, what types of information are available about behavioral health and public behavioral health services?

16. Are you aware of any local data on behavioral health in our community or the effectiveness of public behavioral health programs and services available in our community? If so, are you aware of how to access that data? Please explain.

17. Who would you turn to first for help if you needed behavioral health support?

General Feedback

18. How can Sacramento Behavioral Health Services best serve you (or your Latino/Latinx/ Hispanic clients) in a culturally and linguistically appropriate manner?

19. Sacramento County BHS is interested in interviewing some community members to understand ways to serve the community better. If you know someone that you think we should interview, please provide their name and any available contact information here.

20. These are all of the questions we have for you today, do you have anything else to add?

Thank you for completing this survey. Please share the link to this survey with anyone else in the community. We are asking for people to complete the survey by Friday, November 17th. If you have any questions about this survey or Sacramento County's public behavioral health services, please contact DHS-BHS-BHREC@SacCounty.gov.

Attachment B: Sacramento County BHREC Latino/Latinx/Hispanic Community Survey – Spanish Version

Condado de Sacramento
Colaborativo de Equidad Racial de Salud Mental (BHREC)

Encuesta a la comunidad latina/latinx/hispana

La División de Servicios de Salud Mental del Condado de Sacramento lleva a cabo esta encuesta a los miembros de la comunidad latina/latinx/hispana para preguntar sobre la salud mental y el bienestar. La División de Servicios de Salud Mental del Condado de Sacramento proporciona servicios de salud mental a las personas diagnosticadas con una enfermedad mental grave y/o que luchan con el uso de sustancias de drogas. La División de Servicios de Salud Mental del Condado de Sacramento también ofrece programas de prevención e intervención temprana para ayudar a reducir problemas graves de salud mental en nuestra comunidad. A veces, estos programas y servicios son proporcionados directamente por la División de Servicios de Salud Mental del Condado de Sacramento, y a veces la División de Servicios de Salud Mental del Condado de Sacramento contrata a otras organizaciones de la comunidad para que los proporcionen. En conjunto, estos programas y servicios se llaman servicios públicos de salud mental.

El propósito de esta encuesta es entender qué tan preparada está nuestra comunidad para conversar sobre salud mental. Su participación es completamente anónima y voluntaria. Puede omitir cualquier pregunta que prefiera no contestar. Sus respuestas se utilizarán para ayudar a planificar actividades futuras que mejoren nuestra capacidad de servir a la comunidad. Si tiene alguna pregunta sobre esta encuesta o los servicios públicos de salud mental del Condado de Sacramento, comuníquese con DHS-BHS-BHREC@SacCounty.gov.

Empezando

1. Nuestras comunidades están compuestas por diversos miembros de México, América del Sur y Central, el Caribe y España. ¿Cómo te identificas? Por ejemplo: Latino/a, Hispano, Latinx, Latine, Chicano/a.

2. Imagine el sistema de atención perfecto, ¿cómo sería para usted acceder y recibir servicios de salud mental y/o uso de sustancias para usted o su familia?

Iniciativas comunitarias y conocimiento de estas iniciativas por parte de la comunidad

3. En una escala del 1 al 10, qué tan preocupante es la salud mental en nuestra comunidad. (Donde 1 es "nada en absoluto" y 10 es "una gran preocupación"). Explique su calificación.

1 2 3 4 5 6 7 8 9 10

4. ¿Cuales son los servicios y programas de salud mental disponibles en nuestra comunidad? ¿Quién ofrece esos programas o servicios?

5. En general, ¿son utilizados estos servicios por las personas de la comunidad?

☐ Sí ☐ No

6. ¿Puede describir las iniciativas existentes que incluyen a la comunidad, así como jóvenes y personas mayores, en la planificación de los servicios públicos de salud mental (es decir, los proporcionados por o en nombre de la División de Servicios de Salud Mental del Condado de Sacramento del Condado de Sacramento)?

7. En una escala del 1 al 10, qué tan consciente es la comunidad general de programas y servicios de salud mental disponibles a través de la División de Servicios de Salud Mental del Condado de Sacramento, como los nombres de los programas, los servicios proporcionados, cómo acceder a los servicios, a quién sirven y si tratan tanto la salud mental y el uso de sustancias de drogas (donde 1 es "nada en absoluto" y 10 es "mucho"). Explique su calificación.

1 2 3 4 5 6 7 8 9 10

8. ¿Cuáles son los puntos fuertes de los programas y servicios públicos de salud mental disponibles?

9. ¿Cuáles son las limitaciones de los programas y servicios públicos de salud mental disponibles?

Liderazgo

10. En una escala del 1 al 10, ¿qué tan preocupados cree que están nuestros ***líderes del Condado*** por brindar servicios de salud mental a los miembros de la comunidad? (Donde 1 es "nada en absoluto" y 10 es "una gran preocupación"). Explique su calificación.

    1 2 3 4 5 6 7 8 9 10

11. En una escala del 1 al 10, ¿qué tan preocupados cree que están nuestros ***líderes comunitarios de confianza*** por brindar servicios de salud mental a los miembros de la comunidad? (Donde 1 es "nada en absoluto" y 10 es "una gran preocupación"). Explique su calificación.

    1 2 3 4 5 6 7 8 9 10

12. ¿Los ***líderes comunitarios de confianza*** apoyarían esfuerzos adicionales para dirigir salud mental en nuestra comunidad? Explique su respuesta.

    ☐ Sí ☐ No

Ambiente, conocimiento y recursos comunitarios

13. ¿Qué opinan los miembros de la comunidad acerca de la salud mental y los servicios de salud mental?

14. ¿Cuáles son los principales obstáculos para obtener servicios públicos de salud mental en nuestra comunidad?

15. En nuestra comunidad, ¿qué clase de información hay disponible sobre salud mental y servicios para el público?

16. ¿Conoce algún dato local sobre salud mental en nuestra comunidad o la efectividad de los programas y servicios públicos de salud mental disponibles en nuestra comunidad? Si es así, ¿sabe cómo acceder a esos datos? Justifique su respuesta.

17. ¿A quién recurriría primero en busca de ayuda si necesitara apoyo de salud mental?

Comentarios generales

18. ¿Cómo pueden los Servicios de Salud del Comportamiento de Sacramento servirle mejor a usted (o a sus clientes Latinos/Latinx/Hispanos) de una manera cultural y lingüísticamente apropiada?

19. La División de Servicios de Salud Mental del Condado de Sacramento está interesado en entrevistar a algunos miembros de la comunidad para entender de qué manera puede servir mejor a la comunidad. Si conoce a alguien a quien cree que deberíamos entrevistar, proporcione su nombre y cualquier información de contacto disponible aquí.

20. Estas son todas las preguntas que tenemos para usted hoy, ¿tiene algo más que agregar?

Gracias por contestar esta encuesta. Comparta el enlace a esta encuesta con cualquier otra persona de la comunidad. Pedimos a las personas que completen la encuesta antes del viernes 17 de noviembre. Si tiene alguna pregunta sobre esta encuesta o los servicios de salud mental para el público del Condado de Sacramento, comuníquese con DHS-BHS-BHREC@SacCounty.gov.

Attachment C: Community Readiness Model Infographic

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SACRAMENTO COUNTY

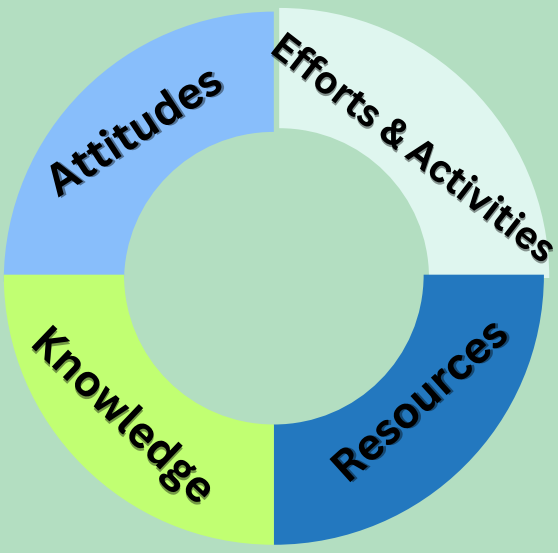
COMMUNITY READINESS MODEL

LATINO/LATINX/HISPANIC BEHAVIORAL HEALTH RACIAL EQUITY COLLABORATIVE (BHREC)

This infographic illustrates the community readiness model, community engagement principles, and activities implemented as part of Sacramento County, Division of Behavioral Health Services, Latino/Latinx/Hispanic BHREC.

THE COMMUNITY READINESS MODEL (CRM)

MEASURES



Community Members + **Leadership**

IN ORDER TO ASSESS

Sacramento Co. Readiness to Address Latino Behavioral Health Needs in 6 Key Dimensions:

- Community Efforts
- Community Knowledge of Efforts
- Leadership
- Community Climate
- Community Knowledge About the Issue
- Resources Related to the Issue

CRM KEY COMPONENTS INCLUDE:

COMMUNITY SURVEY INCLUDING KEY INFORMANT INTERVIEW & FOCUS GROUPS

CRM uses key respondents to answer questions and provide information about how the community views the issue. Key informant interviews and focus groups are qualitative interviews with people who know what is going on in the community. We conducted a community survey, key informant interviews, and focus groups with the purpose of collecting information from a wide range of people—including community leaders, professionals, and individuals with lived experience—who have firsthand knowledge about the community. These individuals, with their particular knowledge and understanding, can provide insight on the nature of the issue.

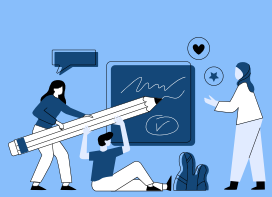
SCORING

Each interview is scored to provide a readiness level for each dimension. Two individuals score each interview independently.

CALCULATION OF READINESS SCORES ON 6 DIMENSIONS

Just like with individual change, the CRM utilizes appropriate actions and techniques to move communities forward in addressing an issue. Matching a community intervention to the community's level of readiness is key to achieving success. The CRM can help a community move forward and be more successful in its efforts to change in a variety of ways. This includes measuring a community's readiness levels on several dimensions that will help diagnose where we need to put our initial efforts.

DEVELOPMENT OF A PLAN FOR ACTION



With the information gained in terms of dimensions and overall readiness, we are now ready to develop strategies that will be appropriate for your community. This may be done in a small group or community workshop format.

The CRM was developed by researchers at the Tri-Ethnic Center for Prevention Research to help communities be more successful in their efforts to address a variety of issues. In part, it is based upon the principles of the Personal Readiness for Change.