



Alpine County Behavioral Health Services

Cultural and Linguistic Competence Plan
Annual Update
2018

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Alpine County Behavioral Health Services (ACBHS) mission is to provide safe, ethical and accessible services that inspire personal growth and development through strength-based behavioral health programs and supportive connections.

OVERVIEW

It is the value, mission and practice of Alpine County Behavioral Health Services (ACBHS) to deliver services in a culturally competent manner that is responsive to diverse cultures, reflects the health beliefs and practices of the communities we serve and demonstrates cultural humility. This approach includes providing effective, equitable, understandable, and respectful services that are responsive to diverse cultural beliefs and practices and preferred languages. This vision is reflected in our world view, informing materials, and client treatment plans. Integration of these values creates a forum for ensuring that we continually assess and enhance our services in an effort to be culturally and linguistically relevant for our youth and adult clients and their families. Staff members continually discuss opportunities to promote the delivery of culturally sensitive services at staff meetings, clinical team meetings and cultural competence committee meetings.

ACBHS strives to deliver culturally, ethnically, and linguistically appropriate services to behavioral health clients and their families. In addition, we recognize the importance of developing services that are sensitive to other cultures, including American Indian, Hispanic and other racial and ethnic groups; persons with disabilities; consumers in recovery (from mental health or substance use); LGBTQI2-S community; various age groups (Transition Age Youth – TAY, Older Adults); faith-based; and persons involved in the correctional system.

Developing a culturally and linguistically competent system requires the commitment and dedication from leadership, staff, and the community to continually strive to learn from each other. This goal also requires ongoing training and education at all staff levels. The following Cultural and Linguistic Competence Plan (CLCP) reflects ACBHS’ ongoing commitment to

improving services to expand access to services, quality care, and improved outcomes. The CLCP addresses the requirements from the Department of Health Care Services (DHCS) for both Mental Health and Substance Use Disorder services, including the Cultural and Linguistic Standards (CLAS).

“Recovery emerges from hope. The belief that recovery is real provides the essential and motivating message of a better future, that people can and do overcome the internal and external challenges, barriers, and obstacles that confront them.” From “Guiding Principles of Recovery (SAMHSA) Engaging Native Wellness; Healing Communities of Care Curriculum Workbook”, Art Martinez, 2014.

Before the advent of the Cultural Competence Committee, the members have been involved in participating and providing leadership to the MHSA planning process from the initial funding and stakeholder meetings. In this small county, staff and community members serve multiple roles. As a result, the promotion of culturally relevant services is an ongoing continuous improvement project. We are involved in developing strategies for improving access and quality of services for individuals who are underserved. This population includes TAY youth, persons who are American Indian, older adults, young children, the geographically isolated and LGBTQI2-S and veterans.

Cultural discussions are an integrated part of our child, youth, adult, and older adult service delivery systems. We discuss how diverse backgrounds influence outcomes, and the importance of understanding an individual’s culture and unique perspective to better combine and understand traditional healing methods with western methodologies and philosophies.

Planning activities for MHSA include a discussion that promotes culturally sensitive services. Our planning discussions have outlined the importance of integrating a person’s culture and community, including involving families in treatment, whenever possible.

In addition to the MHSA planning process and updates, culture is an important component of each Client Care Plan meeting, where the client, family, staff and support persons come together to develop a comprehensive plan for ensuring that the individual is successful in treatment. Working as a team, we are able to understand how culture shapes the choices and goals for each of our community members. As part of the planning process we discuss how to incorporate cultural leaders into our services as a support network for those receiving services with our agency. This team work is consistent for our System of Care, during staff and clinical team meetings. We work closely with our allied partner agencies to help promote a learning environment.

I. DEMONSTRATING CULTURAL AND LINGUISTIC COMPETENCE

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

- Mission Statement;
- Statements of Philosophy;
- Strategic Plans, including Alpine County's MHSA Plans, Implementation Plan and Substance Abuse Prevention Plan; and
- Policies and procedures.

The documents listed above are currently available at all ACBHS clinics. Copies of these documents are available on site during compliance reviews.

ACBHS department and staff are committed to constantly improving services to meet the needs of culturally diverse individuals seeking and receiving services. A number of objectives were developed as a component of our Mental Health Services Act (MHSA) Plan, and have been expanded as we have integrated Substance Use Disorder Treatment Services into our overall programming.

These goals and objectives are outlined below and provide the framework for developing this CLCP.

Goal 1: To provide culturally and linguistically appropriate behavioral health services to improve access for persons who are American Indian, Hispanic and other race/ethnicity groups; TAY and older adults; veterans and their families; Lesbian, Gay, Bisexual, Transgender, Questioning, Intersex, and Two Spirit (LGBTQI2-S) individuals; persons released from jail and their families; and additional cultures.

- **Objective 1a:** ACBHS will provide informing materials in the county's threshold language (currently only English) in our clinics and wellness center. In addition, ACBHS will provide all informing materials in Spanish as well.
- **Objective 1b:** When appropriate, ACBHS will hire diverse or bilingual staff to work in our programs in order to provide services and information to the client and family in their preferred language and preferred cultural setting.
- **Objective 1c:** ACBHS will ensure that the crisis line is culturally sensitive to all persons utilizing these services, and clients receive services in their preferred language.

Goal 2: To create a work climate where dignity and respect are encouraged and modeled so that everyone enjoys equitable opportunities for professional and personal growth.

- **Objective 2a:** ACBHS will provide cultural and linguistic competency trainings for ACBHS staff a minimum of four (4) times per fiscal year.
- **Objective 2b:** ACBHS will discuss and provide trainings on topics including but not limited to cultural humility, local American Indian traditions, equity, diversity, relevant cultural narratives, social determinants of behavioral health,

local consumer culture, recovery culture, access barriers and sustainable partnerships on a monthly basis at staff or clinical team meetings.

- **Objective 2c:** ACBHS will hire clients and family members, whenever possible, who are reflective of the Alpine County community, especially American Indians or bilingual/bicultural individuals, to help address barriers for culturally diverse populations.

Goal 3: To deliver behavioral health services in collaboration with other community organizations and co-locate services whenever possible, including in diverse community settings (e.g., tribal community, schools, and other rural community locations).

- **Objective 3a:** ACBHS will deliver services in the least restrictive environment (e.g., home, schools, tribal community, senior center, and other rural community locations) when needed and as appropriate.
- **Objective 3b:** ACBHS will retain a presence in the Hung-A-Lel-Ti community, providing services and programs open to all Alpine County residents, as determined by the local tribal community council.
- **Objective 3c:** ACBHS will work closely with local schools including Douglas High School in Minden, Nevada, to engage youth and TAY in the development of strategies to prevent alcohol and drug abuse and intervene early in the onset of behavioral health issues.
- **Objective 3d:** ACBHS will collaborate with the Native Wellness Advocate and a community partner to promote the well-being of native children and families.
- **Objective 3e:** ACBHS will collaborate with local providers and educational institutions who serve people with disabilities to teach and enhance social and life skills, in addition to providing behavioral health support.

Goal 4: To collect and maintain accurate and reliable demographic and service-level data to monitor and evaluate the impact of services on health equity and outcomes.

- **Objective 4a:** ACBHS will gather data to provide objective and consistent evaluation and feedback to leadership, staff, and clients regarding program impact and outcomes to best support and meet the needs of the community, individuals and family. Data will be collected ongoing and reviewed quarterly by the clients, staff, and partner agencies at staff, clinical team, cultural competence and quality improvement meetings.

II. DATA, ANALYSIS, AND OBJECTIVES

A. County Geographic and Socio-Economic Profile

1. Geographical location and attributes of the county

Alpine County is the smallest county by population, in California, with a population of approximately 1,175 (2010 Census). This rural county is located in the Central Sierra Nevada mountain range, south of Lake Tahoe and bordering the State of Nevada, with a total area of 738 square miles. In the winter, due to the Highway 4 closure, the distance between the two Alpine County clinics, in Markleeville and Bear Valley is 131 miles, which takes 3 hours and 20 minutes. In the summer, with Highway 4 open, the distance between the two towns is 36 miles. Due to the road conditions, this drive is still 1 hour and 33 minutes. The census designated places include Markleeville, the county seat, (population 210), Alpine Village (population 114), Bear Valley (population 121), Kirkwood (population 158), and Mesa Vista (population 200). With a population of less than two (2) persons per square mile, it is still considered a “frontier” county. Ninety-six percent (96%) of the county’s territory is designated “public land,” managed by the U. S. government’s Department of Agriculture, Forest Service, and Bureau of Indian Affairs.

Alpine County has no incorporated cities; instead, the county residents recognize five distinct communities: On the eastern slope are communities of Hung-A-Lel-Ti (Southern Band of the Washoe Tribe); Markleeville, which is the county seat; Woodfords; and Kirkwood recreation and ski resort, with a population of 96. On the western slope is the Bear Valley community. The three most populated areas of Alpine County are geographically distant and isolated from one another; it is virtually impossible to share or access services among the three communities, especially during the winter months. Alpine County has no stoplight, no large grocery store, no bank, no hospital, and no pharmacy. All highways have only two lanes, except for an occasional passing lane.

Alpine County does not have a threshold language. Within the county is an American Indian Washoe Tribe community with a population of approximately 250 people. Alpine County’s small population size offers the potential of being able to get “arms around the problems,” to identify and reach virtually every individual in need. From the perspective of BHS professionals and their partners, its small population size provides Alpine County an opportunity for meaningful collaboration and timely identification and resolution of both system- and client-related issues and challenges. The few numbers of staff comprising the department tend to wear multiple hats, making it feasible (and sometimes necessary) for them to understand issues comprehensively, and take a multidisciplinary approach.

2. Demographics of the county

Figure 1 shows age and race/ethnicity, and gender of the general population. Of the 1,175 residents who live in Alpine County, 18.7% are children ages 0-14; 9% are TAY ages 15-24; 48.8% are adults ages 25-59; and 23.5% are older adults ages 60 years and older. The majority of persons in Alpine County are Caucasian (72.5%) and American Indian (17.9%). There are a comparable number of males (51.6%) and females (48.4%) in the county.

Figure 1
Alpine County Residents
By Gender, Age, and Race/Ethnicity
 (Population Source: 2010 Census)

Alpine County Population 2010 Census		
Age Distribution	Number	Percent
0 - 14 years	220	18.7%
15 - 24 years	106	9.0%
25 - 59 years	573	48.8%
60+ years	276	23.5%
Total	1,175	100.0%
Race/Ethnicity Distribution	Number	Percent
African American/ Black	-	0.0%
Alaska Native/ American Indian	210	17.9%
Asian/ Pacific Islander	7	0.6%
Caucasian/ White	852	72.5%
Hispanic	84	7.1%
Other	1	0.1%
Two or More Races	21	1.8%
Total	1,175	100.0%
Gender Distribution	Number	Percent
Male	606	51.6%
Female	569	48.4%
Total	1,175	100.0%

3. Socio-economic characteristics of the county

Alpine County is a relatively poor county, with the per capita income for all residents in 2012-2016 at \$26,783. In comparison, the statewide per capita income was \$31,458 (U.S. Census Bureau). This data shows that, on average, each person in Alpine County earns approximately \$4,500 less than the average person in the state.

The census data also shows the median household income for Alpine County and statewide. Alpine County's median household income in 2012-2016 was \$62,375, which is lower than the statewide average of \$63,783 (U.S. Census Bureau).

4. Penetration rates for mental health services

Figure 2 shows the percentage of the population who access mental health services. Figure 2 shows the same county population data shown in Figure 1, and also provides information on the number of persons who received mental health services (FY 2016/17). From this data, a penetration rate was calculated, showing the percent of persons in the population that received mental health services in FY 2016/17. This data is shown by age, race/ethnicity, and gender. Primary Language was not available for the general population.

There were 77 people who received one or more mental health services in FY 2016/17. Of these individuals, 13.0% were children ages 0-14; 7.8% were Transition Age Youth (TAY) ages 15-24; 59.7% were adults ages 25-59; and 19.5% were 60 and older. There were 63.6% of the clients who were Caucasian, 26.0% Alaska Native/ American Indian, and 6.5% Hispanic. All other race/ethnicity groups represented a small number of individuals. All clients have a primary language of English. The majority of clients are females (66.2%) compared to males (33.8%).

The penetration rate data shows that 6.6% of the Alpine County population received mental health services, with 77 individuals out of the 1,175 residents. Of these individuals, children ages 0-14 had a penetration rate of 4.5%, TAY ages 15-24 had a penetration rate of 5.7%, adults ages 25-59 had a penetration rate of 8.0%, and older adults ages 60 and older had a penetration rate of 5.4%.

For race/ethnicity, persons who are Caucasian had a penetration rate of 5.8% and persons who are Alaska Native/ American Indian had a penetration rate of 9.5%. The other race/ethnicity groups had small numbers of people in the county, so there is a large variability in the data. Males had a lower mental health penetration rate (4.3%), compared to females (9.0%).

Figure 2
Alpine County Mental Health Penetration Rates
By Age, Race/Ethnicity, Language, and Gender

(Population Source: 2010 Census)

	Alpine County Population 2010 Census		All Mental Health Clients Served FY 2016/17		Alpine County Population Mental Health Penetration Rate
Age Distribution					
0 - 14 years	220	18.7%	10	13.0%	10 / 220 = 4.5%
15 - 24 years	106	9.0%	6	7.8%	6 / 106 = 5.7%
25 - 59 years	573	48.8%	46	59.7%	46 / 573 = 8.0%
60+ years	276	23.5%	15	19.5%	15 / 276 = 5.4%
Total	1,175	100.0%	77	100.0%	77 / 1,175 = 6.6%
Race/Ethnicity Distribution					
African American/ Black	-	0.0%	-	0.0%	-
Alaska Native/ American Indian	210	17.9%	20	26.0%	20 / 210 = 9.5%
Asian/ Pacific Islander	7	0.6%	-	0.0%	0 / 7 = 0.0%
Caucasian/ White	852	72.5%	49	63.6%	49 / 852 = 5.8%
Hispanic	84	7.1%	5	6.5%	5 / 84 = 6.0%
Other	1	0.1%	1	1.3%	1 / 1 = 100.0%
Two or More Races	21	1.8%	2	2.6%	2 / 21 = 9.5%
Total	1,175	100.0%	77	100.0%	77 / 1,175 = 6.6%
Language Distribution					
English	-	-	77	100.0%	-
Spanish	-	-	-	0.0%	-
Other	-	-	-	0.0%	-
Total	-	-	77	100.0%	-
Gender Distribution					
Male	606	51.6%	26	33.8%	26 / 606 = 4.3%
Female	569	48.4%	51	66.2%	51 / 569 = 9.0%
Total	1,175	100.0%	77	100.0%	77 / 1,175 = 6.6%

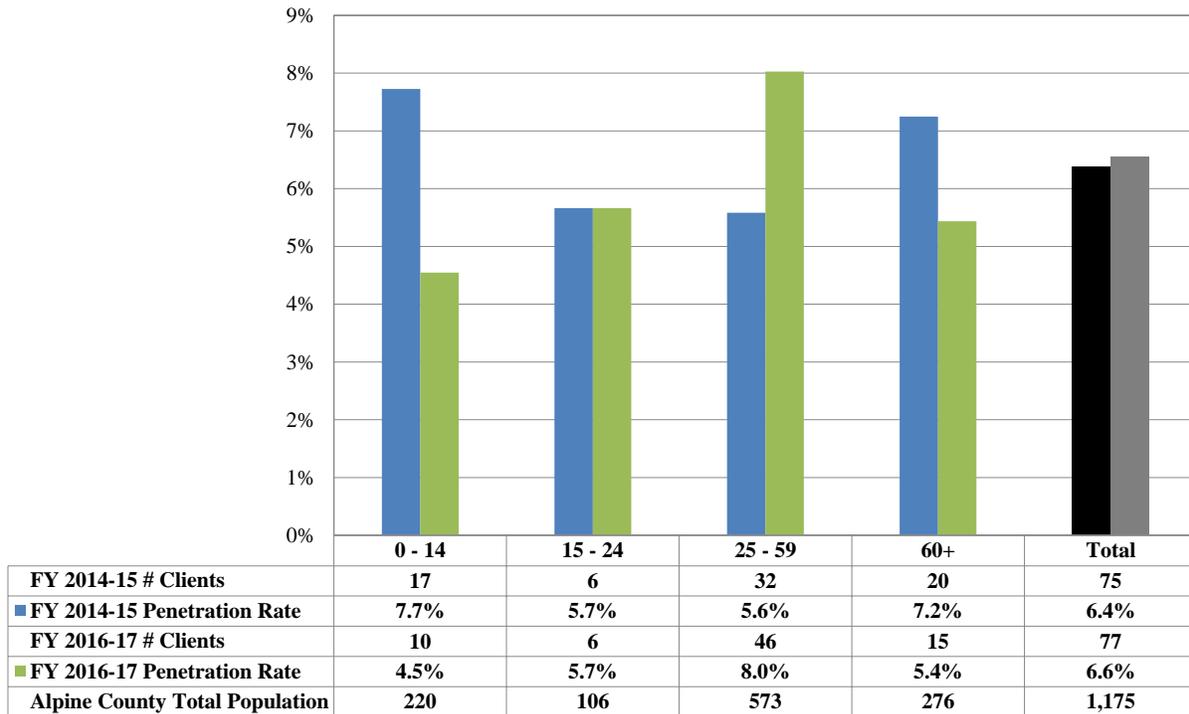
5. Analysis of disparities identified in penetration rates

The small numbers of persons served and in the population creates variability in the data and is therefore difficult to interpret. The penetration rate data for age shows that there are a higher proportion of adults served, compared to children, TAY, and older adults. The proportion of females (9.0%) is higher than males (4.3%). This data is consistent across many small counties. In addition, it is important to note that most high school students travel across state lines to attend high school in Nevada, making outreach and engagement with this age group, and subsequently the older TAY population, more difficult to access.

6. Penetration rate trends for two years

We have also analyzed our penetration rates for FY 2014-15 and FY 2016-17 (see Figure 3). This shows the number of clients by age served in FY 2014-15 and FY 2016-17. The total number of clients increased from 75 to 77 clients between these two years. In addition, the number of adults served increased (32 to 46). TAY stayed the same (6). Children decreased (17 to 10) and older adults decreased (20 to 15).

Figure 3
Alpine County Mental Health Services
 FY 2014-15 and FY 2016-17
Mental Health Penetration Rate, by Age



The TAY population is small. As stated, most TAY youth who are in school, travel to a high school in Nevada. As a result, these youth spend the majority of their time outside of the county. In addition, most of ACBHS' clinicians are not licensed to practice in Nevada, making school time inaccessible to ACBHS programs and services.

7. Mental Health Medi-Cal population

Figure 4 shows the percentage of Medi-Cal eligibles who accessed mental health services in FY 2016/17. From this data, a penetration rate was calculated, showing the percent of persons who are Medi-Cal eligible who received mental health services in FY 2016/17. This data is shown by age, race/ethnicity, and gender.

There were 40 Medi-Cal clients who received one or more mental health services in FY 2016/17. Of these individuals, 12.5% were children ages 0-17; 15.0% were TAY ages 18-24; 65.0% were

adults ages 25-64; and 7.5% were older adults ages 65 and older. There were 47.5% of the clients who were Caucasian, and 42.5% who were Alaska Native/ American Indian. All other race/ethnicity groups represented a small number of individuals. The majority of clients were females (62.5%) compared to males (37.5%).

The penetration rate data shows that 13.3% of the Alpine County Medi-Cal eligibles received mental health services, with 40 individuals out of the 301 Medi-Cal eligibles. Of these individuals, children had a penetration rate of 6%, TAY had a penetration rate of 18.8%, adults had a penetration rate of 17.1%, and older adults had a penetration rate of 8.8%.

For race/ethnicity, persons who are Caucasian had a penetration rate of 17.4%, and persons who are Alaska Native/ American Indian had a penetration rate of 10.7%. All other race/ethnicity groups represented a small number of individuals. Males had a penetration rate of 10.4%, and females had a penetration rate of 15.9%.

Figure 4
Alpine County Medi-Cal Mental Health Penetration Rates
By Age, Race/Ethnicity, and Gender

(Medi-Cal Eligible Source: Kings View Penetration Report FY2016/17)

	Alpine County Average Number of Medi-Cal Eligibles		Number of Medi-Cal Mental Health Clients Served		MH Medi-Cal Penetration Rate
Age Group					
Children	83	27.6%	5	12.5%	5 / 83 = 6.0%
Transition Age Youth	32	10.6%	6	15.0%	6 / 32 = 18.8%
Adults	152	50.5%	26	65.0%	26 / 152 = 17.1%
Older Adults	34	11.3%	3	7.5%	3 / 34 = 8.8%
Total	301	100.0%	40	100.0%	40 / 301 = 13.3%
Race/Ethnicity					
African American/ Black	-	0.0%	-	0.0%	-
Alaska Native/ American Indian	159	52.8%	17	42.5%	17 / 159 = 10.7%
Asian/ Pacific Islander	2	0.7%	-	0.0%	0 / 2 = 0.0%
Caucasian/ White	109	36.2%	19	47.5%	19 / 109 = 17.4%
Hispanic	15	5.0%	2	5.0%	2 / 15 = 13.3%
Other	2	0.7%	-	0.0%	0 / 2 = 0.0%
Two or More Races	-	0.0%	2	5.0%	-
Unknown	14	4.7%	-	0.0%	0 / 14 = 0.0%
Total	301	100.0%	40	100.0%	40 / 301 = 13.3%
Gender					
Male	144	47.8%	15	37.5%	15 / 144 = 10.4%
Female	157	52.2%	25	62.5%	25 / 157 = 15.9%
Total	301	100.0%	40	100.0%	40 / 301 = 13.3%

8. Analysis of disparities identified in Medi-Cal clients

The Medi-Cal penetration rates show trends and service utilization patterns that are similar to the total Mental Health penetration. The Medi-Cal penetration rates are proportionally higher, with

an overall penetration rate of 13.3% (compared to 6.6%). Approximately 51.9% of all participants are Medi-Cal.

9. Penetration rates for Substance Use Disorder services

Figure 5 shows the number of persons in the county population (2010 Census) and the number of persons who received Substance Use Disorder (SUD) services (FY 2016/17). From this data, a penetration rate was calculated, showing the percent of persons in the population that received SUD services in FY 2016/17. This data is shown by age, race/ethnicity, and gender. Primary Language was not available for the general population. According to MEDS, there is no threshold language other than English in Alpine County.

For the 1,175 residents who live in Alpine County, 18.7% are children ages 0-14; 9.0% are TAY ages 15-24; 48.8% are adults ages 25-59; and 23.5% are older adults ages 60 years and older. The majority of persons in Alpine County are Caucasian (72.5%) and Alaska Native/American Indian (17.9%). Persons who are Hispanic represent 7.1% of the population. There are a comparable number of males (51.6%) and females (48.4%) in the county.

As expected, the proportion of persons receiving SUD services shows a different proportion of individuals by age. There were 16 people who received one or more SUD services in FY 2016/17. Of these individuals, none were children ages 0-14; 25.0% were TAY ages 15-24; 68.8% were adults ages 25-59; and 6.3% were 60 and older. The proportion of SUD clients by race/ethnicity include Alaska Native/American Indian (43.8%), Caucasian (50.0%) and Hispanic (6.3%). All clients have a primary language of English. There was a higher number of males (56.3%) than females (43.8%).

The penetration rate data shows that 1.4% of the Alpine County population received SUD treatment services. Of these individuals, TAY ages 15-24 had a penetration rate of 3.8%, adults ages 25-59 had a penetration rate of 1.9% and older adults ages 60 and older had a penetration rate of 0.4%. There were no children enrolled in SUD services. For race/ethnicity, persons who are Alaska Native/ American Indian had a penetration rate of 3.3%, persons who were Caucasian had a penetration rate of 0.9%, and persons who were Hispanic had a penetration rate of 1.2%. Males had a penetration rate of 1.5% while females had a penetration rate of 1.2%.

Figure 5
Alpine County Substance Use Disorder Services Penetration Rates
By Age, Race/Ethnicity, Language, and Gender

(Population Source: 2010 Census)

	Alpine County Population 2010 Census		All Substance Use Clients Served FY 2016/17		Alpine County Population Substance Use Penetration Rate
Age Distribution					
0 - 14 years	220	18.7%	-	0.0%	0 / 220 = 0.0%
15 - 24 years	106	9.0%	4	25.0%	4 / 106 = 3.8%
25 - 59 years	573	48.8%	11	68.8%	11 / 573 = 1.9%
60+ years	276	23.5%	1	6.3%	1 / 276 = 0.4%
Total	1,175	100.0%	16	100.0%	16 / 1,175 = 1.4%
Race/Ethnicity Distribution					
African American/ Black	-	0.0%	-	0.0%	-
Alaska Native/ American Indian	210	17.9%	7	43.8%	7 / 210 = 3.3%
Asian/ Pacific Islander	7	0.6%	-	0.0%	0 / 7 = 0.0%
Caucasian/ White	852	72.5%	8	50.0%	8 / 852 = 0.9%
Hispanic	84	7.1%	1	6.3%	1 / 84 = 1.2%
Other	1	0.1%	-	0.0%	0 / 1 = 0.0%
Two or More Races	21	1.8%	-	0.0%	0 / 21 = 0.0%
Total	1,175	100.0%	16	100.0%	16 / 1,175 = 1.4%
Language Distribution					
English	-	-	16	100.0%	-
Spanish	-	-	-	0.0%	-
Other	-	-	-	0.0%	-
Total	-	-	16	100.0%	-
Gender Distribution					
Male	606	51.6%	9	56.3%	9 / 606 = 1.5%
Female	569	48.4%	7	43.8%	7 / 569 = 1.2%
Total	1,175	100.0%	16	100.0%	16 / 1,175 = 1.4%

10. Analysis of disparities identified in Substance Use Disorder services

Figure 5 data also shows that the majority of SUD clients are adults (68.8% compared to the population of 48.8%) and TAY (25.0% compared to 9.0% in the population). There are also a higher proportion of SUD clients that are Alaska Native/ American Indian (43.8% compared to 17.9% of the population). Clients who are Caucasian represent 50.0% of the clients (compared to 72.5% of the population). There is a slightly higher proportion of clients who are male (56.3% compared to 51.6% of the population). Females represent 43.8% of the clients compared to 48.4% of the population.

This data illustrates the need to provide culturally-sensitive services to clients receiving SUD services. Developing strategies for serving the TAY population and the American Indian population, and developing appropriate recovery services for these two populations will be the goal of the CLC Plan.

11. Analysis of disparities in Drug Medi-Cal clients

Alpine County does not participate in the Drug Medi-Cal program.

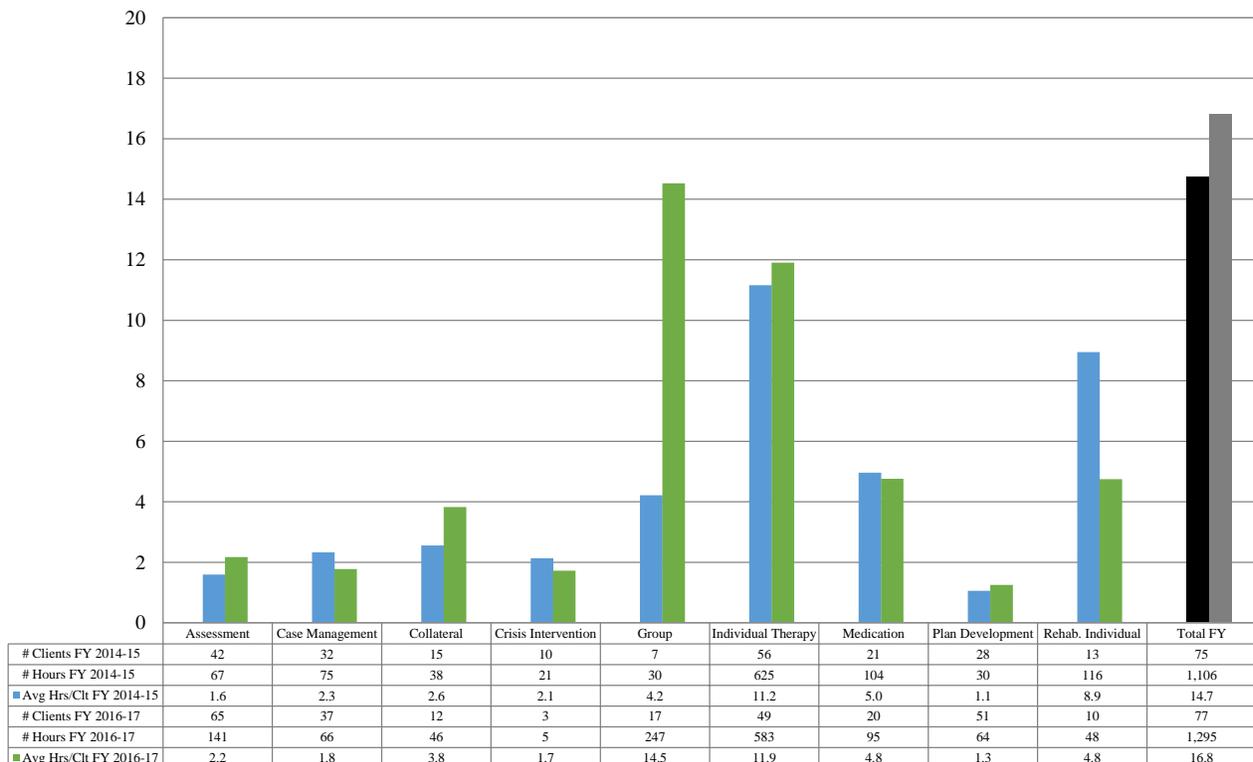
B. Utilization of Mental Health and Substance Use Disorder Services

1. Utilization of Mental Health Services

Figure 6 shows the total number of hours, by type of mental health service, clients, and hours per client for FY 2014/15 and FY 2016/17. This data shows that the 77 mental health clients received 1,295 hours of services in FY 2016/17, which calculates into 16.8 hours per client. This data also shows the number of clients and average hours for each type of service. Clients can receive more than one type of service. Not all clients received all services. The number of clients varies by type of service.

Clients who received an assessment averaged 2.2 hours; case management averaged 1.8 hours; collateral averaged 3.8 hours; crisis intervention averaged 1.7 hours; group averaged 14.5 hours; individual therapy averaged 11.9 hours; medication averaged 4.8 hours; plan development averaged 1.3 hours; and rehab. individual averaged 4.8 hours.

Figure 6
Alpine County Mental Health Services
Total Mental Health Hours, Clients, and Hours per Client per Year, by Service Type
All Mental Health Clients
FY 2014-15 and FY 2016-17



2. Analysis of population assessment and utilization data for Mental Health; conclusions

This data shows that there is an increase in the number of persons receiving mental health services across the two-year period. It is important to note that prior to the 2014-2015 fiscal year, group therapy was not available in Alpine County. ACBHS listened to stakeholder input regarding confidentiality and privacy in group settings and since that time, groups have been very successful.

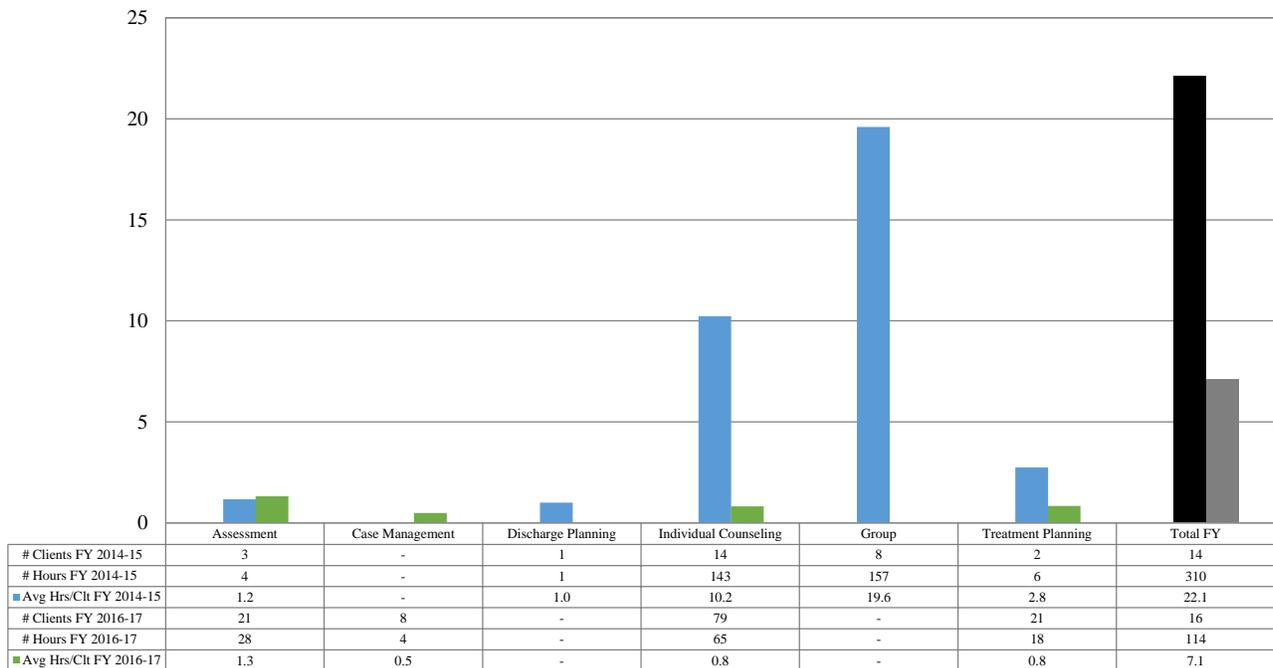
ACBHS has been holding Dual Diagnosis groups since 2016 and this group has always used the Seeking Safety Model. Also, since March, 2015 ACBHS holds a Talking Circle Group which specifically engages with the Hung-A-Lel-Ti Community, with cultural aspects brought to the discussion.

C. Utilization and Analysis of Substance Use Disorder Services

1. Utilization of Substance Use Disorder Services

Figure 7 shows the total number of hours, by type of substance use treatment service, clients, and hours per client for FY 2014/15 and FY 2016/17. This data shows that the 16 substance use treatment clients received 114 hours of services in FY 2016/17, which calculates into 7.1 hours per client. This data also shows the number of clients and average hours for each type of service. Clients can receive more than one type of service. Not all clients received all services. The number of clients varies by type of service. Clients who received an assessment averaged 1.3 hours; case management averaged 0.5 hours; individual counseling averaged 0.8 hours; and treatment planning averaged 0.8 hours.

Figure 7
Alpine County Substance Use Disorder Services
Total Substance Use Hours, Clients, and Hours per Client per Year, by Service Type
All Substance Use Clients
FY 2014-15 and FY 2016-17



2. Analysis of population assessment and utilization data for Substance Use; conclusions

For SUD services, there was an increase in the number of persons receiving services (14 to 16). There was a decrease in the total number of hours delivered (310 to 114) and the average number of hours per person (22.1 to 7.1). The increase in the number of persons served is due to better outreach efforts by the SUD Program Specialist. The decrease in delivered hours may be due to the SUD Program Specialist position being vacant for 5 months and encouraging some individuals to participate more in dual diagnosis group sessions, shown under Mental Health Groups, than individual sessions.

III. MEETING CULTURAL AND LINGUISTIC REQUIREMENTS

A. Outline the culturally-specific services available to meet the needs of diverse populations, including peer-driven services; identify issues and methods of mitigation

Alpine County recognizes the need to be culturally responsive to American Indians and other minority and under-represented populations. By providing treatment in a manner that is responsive and demonstrates an understanding of the client's heritage, history, traditions, worldview and beliefs we hope to engage more members of our community and the diverse populations within it.

It is the value and mission of ACBHS to involve underserved communities in planning and management committees. These committees provide leadership and opportunities to give voice to consumers, persons of diverse racial backgrounds, family members, youth, and other cultural groups. This leadership creates a forum for ensuring that we continually enhance our services to be culturally relevant for our youth, adult clients and their families. We have individuals from different ethnic and cultural backgrounds represented in many of our committees. Our Mental Health Board is comprised of two consumers/family members, including one member of the Washoe Hung-a-lel-ti community. The Mental Health Board is very active and involved; in the last year we have had three new members join, including one person from Bear Valley representing the most geographically isolated areas of the county. In addition, another member of the Washoe tribal community and employee of the Public Health Department joined the Board in 2015.

During the most recent stakeholder meetings for the three-year MHSA plan in April 2017, there were 17 participants: 49% adults and 45% older adults; 78% identified as female, 16% identified as male, and 6% identified as other or preferred not to answer; and 83% identified as White/Caucasian, 10% identified as American Indian/Native Alaskan, and 6% identified as other.

Alpine County's Wellness Projects are designed to provide targeted programming for a variety of distinct populations. These programs will provide continued support to prevent the development and onset of mental health issues among Alpine County residents. The following activities will be included within the Wellness Projects: Parenting Workshops: ACBHS will provide targeted support for parents regarding early screening and support for children with severe emotional disturbances (SED); Men and Youth Wellness Project: ACBHS will continue to provide this project to increase emotional relationship building between father figures and children; Women and Youth Wellness Project: ACBHS will implement this project to mirror the Men and Youth Project; Children and TAY Wellness Project: ACBHS will continue to provide summer story time and play groups for children and will continue to support and leverage existing children and TAY programming occurring in nearby locations.

American Indians

"The core principles for alleviating mental health disparities of American Indians in California must directly correlate to the root causes of the disparities: Respect sovereign rights of tribes...;

Support rights for self-determination; Value American Indian cultural practices as stand-alone practices; Incorporate the use of American Indian specific research and evaluation methods unique to each community.” – Native Vision (2011) from “Healing Communities of Care Curriculum Workbook.”

In an effort to reduce disparities in access to treatment services, ACBHS continues to expand services in Hung-A-Lel-Ti, the American Indian community in the county. For example, most of the MHSAs programs are located at our Wellness Center located in a Tribal owned property, leased by the county. The wellness center located in Hung-A-Lel-Ti is decorated in an inviting and culturally relevant manner. Photographs of local elders adorn the walls. These welcoming centers reduce stigma and create a comfortable setting for offering supportive services to individuals and their families. This partnership encourages collaboration and interconnected services. Some of these programs include: exercise classes for older adults, cultural crafts, gathering trips dictated by the American Indian calendar, weekly Talking Circle recovery groups, monthly elder’s luncheon and a weekly luncheon open to the Alpine County community. Currently, the BHS Director, Senior Account Clerk, Behavioral Health Services Coordinator, MHSAs Coordinator, MHSAs Program Specialist, Native Wellness Advocate, BHS Driver, and Administrative Assistant I all have their offices at the Wellness Center. This location creates the opportunity for ACBHS to easily meet with Tribal TANF, the Woodfords Washoe Community Council, and the Woodfords Indian Education Center on at least a monthly basis to coordinate programming and discuss barriers to services for the community.

“If you use the metaphor of water, therapy is only one river. History and culture are an ocean.”
– *Community Member from “Healing Communities of Care Curriculum Workbook.”*

Combining Past and Present is a cultural program for Alpine County residents of all ages, with a goal of preventing the development of depression and anxiety related to lack of socialization and identity confusion. The program includes such activities as acorn, willow, onion and pine nut gatherings; basket making; snow shoe making; Native cooking and food preparation; and singing cultural songs.

In addition, ACBHS will collaborate with the Native Wellness Advocate and Live Violence Free to provide a program that promotes the well-being of native children and families. This program will come from a place where adults and communities are responsible for the well-being of children and families. It will teach that all forms of abuse can be prevented by changing the structural system from one of oppression to one of shared equity and justice for all living beings. The program will begin with light hearted movies, which will progress to more serious content. At the movie nights there will be open discussion, which will offer coping skills, resources, and a safe environment to process the information.

Following the movie series, there will be a 12 module curriculum, “Walking in Balance with all our relations,” based on indigenous values and traditions. This curriculum provides historical perspective; promotes fundamental structural change as necessary for harmonious relationships to be the norm; and includes the healing treatment of those who harm as a key piece of primary prevention. There will also be a community training: Strong Oak Lefebvre B.E.A.R Visioning.

Children and TAY

ACBHS strives to offer a variety of engagement activities and services for children and TAY, including counseling services provided at the only school in the county. In addition, we provide play groups for parents with young children, a youth leadership group, TAY movie nights, family movie nights, family weekend movie events and father and mother wellness activities. ACBHS also contracts with a local non-profit provider to operate the Primary Intervention Program at the school to identify and intervene early with young children experiencing behavioral health issues. ACBHS partners with Tahoe Youth & Family Services to provide a monthly drop in center evening where runaway, homeless, and disconnected youth can get a hot meal, basic needs items, such as toiletries and clothing, information about resources, and respect. ACBHS also partners with the Washoe Tribe Recreation Department to provide youth activities on school breaks and weekends.

Older Adults

ACBHS focuses many programs on older adults including weekly Senior Soak, where older adults gather at the local hot springs for fellowship; monthly 50+ potluck events; yoga; Elder's lunch; and meditation classes. The Senior Socialization and Exercise Program focuses on improving the healthy attitudes, beliefs, skills, and lifestyles of older adults in Alpine County through participation in meaningful activities and utilization of services. It also serves to reduce stigma associated with seeking behavioral health services; reduce isolation, depression, fear, anxiety, and loneliness among seniors; increase referrals to and knowledge about supportive services; provide a warm, caring environment where seniors can develop a sense of connection and belonging; encourage development of new skills and creative abilities; and support active, healthy lifestyles. ACBHS partners with the Washoe Tribe Senior Center to provide a monthly Elder's Luncheon and Activity.

Rural Communities

ACBHS works to include our smaller communities within the county by offering events, outreach, and programming in Kirkwood (yoga, substance use prevention, outreach), and Bear Valley (yoga, and weekly Create the Good events).

“Create the Good” began as a luncheon geared towards adults and seniors, featuring presentations on topics related to health, wellness, and parenting. It promotes socialization, awareness of health and wellness subjects, and learning opportunities. The program has expanded to include more early intervention opportunities by hosting an open support group; providing alternative therapies, such as therapeutic nature walks; and making opportunities for “meet and greets” between participants and ACBHS staff. In addition, Create the Good observes all holidays by incorporating the food, culture, and customs of the holiday into the day's luncheon. For example, ACBHS has commemorated Veteran's Day, St. Patrick's Day, Chinese New Year, and Valentine's Day.

LGBTQI2-S Community

ACBHS strives to offer a variety of services for the LGBTQI2-S Community. ACBHS offers training and promotional materials at the local school and other community events to help reduce bullying, suicides, and stigma. We offer promotional materials to support the LGBTQI2-S community. These anti-stigma campaigns aim to reduce the effects of stigma and discrimination in our community.

Recovery Community

For the recovery community, ACBHS offers a weekly open family night where dinner is served and recovery principles are discussed. In addition, the weekly Talking Circle group is focused primarily on engaging the American Indian recovery community.

Persons with Disabilities

ACBHS provides transportation to ACBHS services and programs for all clients and members of the community when needed. Transportation for people with disabilities is also available through the county Dial a Ride program at no cost. TDD is available for persons with hearing impairments. Audio versions of our beneficiary guide will be made available soon for the visually impaired.

Staff are scheduled during regular business hours, Monday through Friday, 8:00 am to 5:00 pm. The majority of services are offered during these business hours. However, services and activities are available in the evening or weekend, in special circumstances.

All of ACBHS facilities that serve clients are ADA accessible. We strive to provide a warm and welcoming environment that is comfortable to diverse cultural backgrounds.

B. Describe the mechanisms for informing clients of culturally-competent services and providers, including culturally-specific services and language services; identify issues and methods of mitigation

ACBHS utilizes the Crisis Support Services of Alameda County, a non-profit provider for our crisis line. Individuals who staff this 24/7 Access Line are trained to be familiar with the culturally-competent services that we offer and are able to provide interpreter services or link clients to language assistance services as needed.

The Alpine County Behavioral Health *Guide to County Mental Health Services* brochure (in English and Spanish) highlights available services, including culturally-specific services. In addition, the guide informs clients of their right to FREE language assistance, including the availability of interpreters. This brochure is provided to clients at intake, and is also available at our clinics and wellness centers throughout the county.

A *Provider Directory* is available to clients which lists provider names and contact information; facility ADA compliance; client/population specialty (children, adult, veterans, LGBTQI2-S, etc.); service specialties; language capability and interpreter availability; and whether or not the provider is accepting new clients. This directory is provided to clients upon intake and is available at our clinics and the wellness center. The Provider Directory is updated monthly.

In addition, ACBHS uses the following informal mechanisms to inform clients and potential clients of culturally competent services and providers:

- ACBHS Website and partner websites
- ACBHS Facebook page and partner social media sites
- ACBHS monthly calendar that is delivered door to door in the community
- ACBHS informal brochures and rack cards identifying available services and how to access them for targeted groups such as TAY, older adults, and American Indians.

- Local newsletters
- Interagency Meetings

C. Outline the process for capturing language needs and the methods for meeting those needs; identify issues and methods of mitigation

Our 24/7 Access Log documents a client's need for interpreters. This form is forwarded to clinical staff for the intake assessment and the Director and QI Coordinator to ensure compliance. This information is also utilized during case assignments and clinical team meetings, to help assign the appropriate staff to provide ongoing services in the individual's primary language, whenever possible.

ACBHS has a policy in place that outlines the requirements and processes for meeting a client's request for language assistance and an interpreter, including the documentation of providing that service.

D. Describe the process for reviewing grievances and appeals related to cultural competency; identify issues and methods of mitigation

The Quality Improvement Committee (QIC) reviews complaints and grievances. The grievance log records if there are any issues related to cultural competency. The QIC reviews all issues and determines if the resolution was culturally appropriate. The QIC and CC (Cultural Competence) Committee work together as many members are on both committees. These committees meet alternating months and therefore have the ability to identify additional issues and objectives to help improve services during the coming year.

In addition, ACBHS has a policy and form to allow beneficiaries to file a problem with MHSA programs, and has a resolution process in place to address these identified issues.

IV. STAFF AND SERVICE PROVIDER ASSESSMENT

A. Current Composition

1. Ethnicity by Function

ACBHS staff by function:

- Director: Caucasian
- Clinical Coordinator: Caucasian
- Behavioral Health Services Coordinator: Caucasian
- Clinician (2 FTE): Caucasian
- Driver: Caucasian
- Senior Account Clerk: Caucasian
- Administrative Assistant (3 FTE): Caucasian
- SUD Program Specialist: Caucasian
- MHSa Program Coordinator: Caucasian
- MHSa Program Specialist (1.8 FTE): Caucasian
- Native Wellness Advocate: American Indian

2. Staff Proficiency in Reading and/or Writing in a Language Other Than English By Function and Language:

ACBHS staff are not proficient in reading or writing in a language other than English.

3. Staff and Volunteer Ethnicity and Cultural Competence Survey

In an effort to assess the cultural awareness of our workforce, we asked staff to complete the Staff and Volunteer Ethnicity and Cultural Competence Survey in December 2017. The complete results are shown in Attachment A.

There were 13 staff who completed the survey. Of the respondents, 33% were direct service staff and 67% were administration and management staff. For those who completed the survey, 92% were Caucasian and one was American Indian or Alaska Native. None of the staff identified as bilingual or acted as interpreters. Of the staff who responded, 38% consider themselves to be consumers of Mental Health Services, and 58% are family members of consumers. All of the respondents were female. Ninety two percent (92%) were heterosexual, and 8% were gay/lesbian.

The survey response options included Almost Always; Often; Sometimes; and Almost Never. The CCC will review and analyze these results early in 2019 and develop new goals based upon these results. We also plan to administer the survey again in the Fall of 2019 and compare the results.

There are some interesting results when examining those questions where the responses were “Almost Never.” Those responses will be briefly outlined below.

Across all staff:

- I examine my own cultural background and biases (including race, culture, sexual orientation, etc.) and how they may influence my behavior toward others (Almost Never=8%).
- I intervene, in an appropriate manner, when I observe other staff exhibit behaviors that appear to be culturally insensitive or reflect prejudice (Almost Never=8%).
- I attempt to learn a few key words in the client's primary language (Almost Never=23%).
- I have developed skills to utilize an interpreter effectively (Almost Never=31%).
- I utilize different methods of communication to help improve communication with consumers and family members (Almost Never=15%).
- I write public reports and communicate in a style and reading level that can be easily understood by consumer sand family members (Almost Never=8%).

There was also a question about participation in cultural awareness activities over the past six (6) months. The responses will be reviewed by the CCC over the next few months to discuss any signification findings from the responses. All staff will be encouraged to complete the survey in the fall.

B. Analyze staff disparities and related objectives

ACBHS strives to hire staff members who at least reflect the cultural diversity of our county. This goal has been extremely difficult for several reasons. The first is that we have a very small staff with only 15 positions. Only one of those is held by an individual who identifies as American Indian. For future positions at ACBHS, a priority will be placed on hiring more American Indians within the Alpine County hiring protocols. There are very few residents of Alpine County who speak Spanish or who identify Spanish as their primary language. All clients are currently receiving services in their primary language.

The diversity of our workforce is not equal to our client population or our general population. As a result, we will continue to identify opportunities to recruit and retain American Indian staff. To achieve this objective, it is our goal to have the department's employee demographics be representative of our client and community population, whenever possible. We also will expand to support individuals in the community to pursue careers in social work and related fields, through our WET program.

The staff survey results also highlight areas for staff training. Although this is not an identified need by our population and demographics, additional training on utilizing an interpreter effectively will be developed in the next few months. In addition, developing training on how to create a secure environment so staff feel safe in providing feedback when they see or experience other staff exhibiting behaviors that appear to be culturally insensitive or reflect prejudice.

ACBHS' Native Wellness Advocate has been working with the Native community to design and implement a "Cultural Courtesy" training for all staff based on local stakeholder input, history, knowledge and best practices related to working with and engaging the Native community. Additional training opportunities will be identified as the CC Committee reviews the results of the survey and "Cultural Courtesy" training and discussions.

ACBHS strives to incorporate discussions of delivering culturally relevant services within our weekly staff meetings, as well as during clinical and staff supervision and the topic has been added as a permanent agenda item. We take advantage of any regional and/or state trainings offered on promoting and delivering culturally-relevant services. We treat each client as an individual, all having differing needs and cultural backgrounds. In addition to delivering services at the person's preferred location, we understand that age, health, gender, community, and lifestyle have an important role in meeting the individual needs of each client. As circumstances and needs change over time, staff is sensitive to evaluating and implementing services that best fit the client at any given time.

ACBHS has designated Melanie Smokey, Native Wellness Advocate, as the county's Cultural Competence/Ethnic Services Manager. This individual is responsible for promoting mental health services that meet the needs of our diverse population. She is a member of the Washoe tribe and has been on staff since March, 2017. She promotes the delivery of culturally sensitive services and provides leadership and mentoring to other staff on cultural competence related issues. The Cultural Competency/Ethnic Services Manager, who is also the Native Wellness Advocate, will report to, and/or have direct access to, the Behavioral Health Director regarding issues impacting mental health issues related to the racial, ethnic, cultural, and linguistic populations and services.

Our Cultural Competence Committee began again in October 2014 and is a cross-agency and community committee that has representatives from mental health, substance use, and public health services. Six people attended the first meeting and four others have expressed interest in attending future meetings. Members include 3 people who identify as American Indian, African American and Caucasian. The members of the Cultural Competence Committee represent different departments in Alpine county including the Board of Supervisors and Health and Human Services. In addition, there are members serving on both the Mental Health Board and the Cultural Competence committee. Working closely together, the committee will review data, organize culturally competent activities and trainings that promote healing through engagement of one's cultural background. At the last committee meeting several items were reviewed and suggestion made to increase services to elders, children under 5, the Hung A lel ti community, LGBTQI2-S and geographically isolated persons. All minutes of the meetings are shared with ACBHS staff to implement programmatic and procedural changes.

C. Identify barriers and methods of mitigation

The primary barrier to meeting our goal of expanding our culturally representative staff is our limited size and requirements to fill current positions. As a result, it is difficult to recruit potential staff members that meet the qualifications for the professional positions that become available.

V. TRAINING IN CULTURAL AND LINGUISTIC COMPETENCE (FY 2016/2017)

This section describes cultural and linguistic competence training for staff and contract providers in fiscal year 2016/17.

A. List of cultural and linguistic competence trainings

Training Event	Description of Training	Number of Attendees	Date
Hate Promotes Hate	Discussion focused on people's reactions to tragic events happening around the country (mass shootings, police targeted, etc.); awareness and tips for interacting with people experiencing trauma	12	7/20/16
Psychological First Aid (webinar)	Recognition of warning signs, intervention techniques specific to the psychological approach for people in crisis	1	8/11/16
Youth Mental Health First Aid	Recognition of warning signs, intervention techniques for mental health crisis specific to youths	2	8/16/16-8/17/16
Inside the Manipulator's Mind (by Crystal Pitts)	Inside the Manipulator's Mind (by Crystal Pitts)	2	8/17/16
SafeTalk (by Suicide Prevention Network)	Alertness training that prepares people to become a suicide-alert helper	1	8/20/16
Cultural Competence and Caring (by Robert Luis Hernandez)	Specific to individuals with first episode psychosis	1	8/29/16
Bridges Out of Poverty (by Foodbank of Northern Nevada)	Awareness of families in poverty level and how to interact with the specific culture	6	9/22/16
Approaching the Signs of Suicide (webinar by Brian Gibbs and Doreen Marshall)	Warning signs, recognition	1	9/27/16
Cultural Humility Policies and Procedures (by Alissa Nourse)	Review of policies and procedures and awareness of Cultural Humility	1	9/28/16
Psychological First Aid (webinar)	Recognition of warning signs, intervention techniques specific to the psychological approach for people in crisis	1	9/30/16
Innovations in Integration (by CIBHS)	Focused on integrated healthcare for specific populations	2	10/5/16-10/7/16
Historical Trauma	Focused on the trauma experienced by Native Americans through history and how it affects the culture today	1	10/5/16
History of the Washoe People	Focused on awareness of the Native American Washoe people	1	10/12/16
Boarding School Syndrome	Focused on the Native American culture and what the Stewart Indian School was like then and today	1	10/20/16
Cultural Competency (by CBHDA)	Focused on awareness for specific cultural populations	1	10/13/16

Training Event	Description of Training	Number of Attendees	Date
Adult Mental Health First Aid	Recognition of warning signs, intervention techniques for mental health crisis specific to adults	3	10/19/16
Boarding School Syndrome	Focused on Native American culture historically when in the Stewart Indian School	1	10/20/16
Women as Change Makers (by Zawadisha)	Focused on empowering women to implement change	1	10/21/16
Bridges Out of Poverty Day 2 (by the Foodbank of Northern Nevada)	Focused on specific techniques for the poverty population	1	11/10/16
Treatment Innovations (by Rachel Werner)	Treatment Innovations (by Rachel Werner)	1	11/14/16
Youth Substance Use Disorder Treatment (by UCLA)	Specific to working with youth with substance use disorder	2	11/17/16
A Culture-Centered Approach to Recovery	This training describes the ways in which culture is central, not peripheral, to recovery. It includes a review of the many dimensions of culture, the impact of worldview on psychosocial rehabilitation (PSR) practice, as well as the steps to becoming a culturally competent service provider	1	12/1/16
Alpine County-Trafficking Victims Protection Act	A course that explains human trafficking and the Trafficking Victims Protection Act.	1	12/1/16
Trauma Informed Care	Focused on care specific to people with trauma in history	1	12/7/16
Cultural Diversity	This introductory course on cultural diversity provides an overview of cultural diversity and discusses various dimensions and issues of diversity.	1	12/16/16
Groundwork for Multicultural Care	This course examines factors that may contribute to underutilization of healthcare services, and ways to improve cultural competency in healthcare treatment.	1	12/16/16
Bridges Out of Poverty (by Foodbank of Northern Nevada)	Awareness of families in poverty level and how to interact with the specific culture	1	1/5/17
Suicide Prevention (by Suicide Prevention Network)	Focused on recognition, warning signs, and steps to take to prevent suicide	2	2/9/17
Aging Well (by SAMHSA)	Addressing Behavioral Health with Older Adults in Primary Care Settings	1	2/15/17
ASIST: Applied Suicide Intervention Skills Training (by Suicide Prevention Network)	Intervention techniques for specific situations where someone is suicidal	4	2/23/17-2/24/17
How Integrated Healthcare can Reduce Heart Disease (by SAMHSA)	Providing integrated healthcare to people at risk for heart disease	1	2/28/17
Courage Works (by Brene Brown)	Vulnerability, courage, shame, and empathy when working with specific people	1	2/28/17
Cultural Competency vs. Cultural Humility (by Nani Ellis)	Focused on being open to understanding various cultures with which we work and interact on a daily basis	12	3/1/17

Training Event	Description of Training	Number of Attendees	Date
Skills and Practice for Child and Family Teaming in Action	Focused on techniques when working with youth or families	1	3/2/17-3/3/17
The Living Brave Course (by Brene Brown)	Vulnerability, courage, shame, and empathy when working with specific people	1	3/7/17
Crisis Intervention Training	Skills and techniques when working with a person in a mental health crisis	2	3/8/17
Cultural Competence (by BCIBHS)	Focused on supporting community defined practices among specific cultural groups	1	3/15/17-3/16/17
Cultures within our Team	Each team member shared information about their own family's culture and how it has helped shape who they are today	12	3/22/17
Mandated Reporter Training	Awareness and recognition for signs of vulnerable populations and the process of reporting	7	4/12/17
Cultural Humility Training (by Michelle Kaner)	Presented information to the rest of the team regarding Judaism in a small town and promoting mental health in a small community	12	5/3/17
Traditional Indian Health Gathering	Focused on awareness of health for Native Americans	1	5/19/17-5/21/17
Kevin Hines (guest speaker)	Presentation on mental illness and suicide; recognition, warning signs	13	5/24/17
Parenting, Teaching and Treating Challenging Kids (by Dr. J Stuart Ablon)	Focused on a collaborative problem solving approach for specific youths	1	5/29/17-6/4/17
Grief and Grieving	Skills and techniques and awareness about interactions with someone in the grief process	1	5/30/17
Trauma Awareness (Webinar)	Awareness and recognition of people with trauma	1	6/1/17-6/6/17
Awaken/Sex Trafficking (by Awaken)	Awareness about sex trafficking, targeted groups, warning signs	3	6/2/17
Understanding the Impact of Trauma	Awareness of how trauma can affect specific people	1	6/13/17
"OK To Say" video and discussion (by Alissa Nourse)	Viewed video regarding a campaign happening regarding Mental Health.	11	6/21/17
Crisis Intervention (by CIBHS)	Awareness and techniques for interaction with people in crisis	1	6/22/17
Celebrate California Indian Heritage	Focused on learning about the heritage of Native Americans in CA	1	6/23/17-6/25/17
Cultural Linguistic Plan (by CIBHS)	Training on the plan and components	2	6/29/17
Bridges Out of Poverty Day 2 (by the Foodbank of Northern Nevada)	Focused on specific techniques for the poverty population	1	6/29/17

It is our system view that all staff will participate in a number of different learning experiences to help promote person-centered care and develop culturally sensitive services to all individuals in the mental health system. Staff will participate in a number of different learning opportunities that include face-to-face meetings and trainings, individual learning sessions online, and ongoing discussions during staff meetings, clinical team meetings and during supervision.

We have integrated cultural competence training and discussions in our weekly staff meetings since 2013. Over this period, ACBHS staff has expanded their knowledge of different cultures and infused this knowledge throughout rendered services. We have created a safe, learning environment where the staff members feel safe to ask questions about culture. Equally important, staff also feel comfortable in providing feedback to others regarding specific behaviors which may not have been as culturally sensitive. By creating a safe environment to ask and receive feedback, each person has the opportunity to learn and expand their services to better meet the needs of the community.

The to-be-written training plan will have a broad range of topics including knowledge of different cultures, the use of traditional spiritual leaders, traditional healing methods, in conjunction with western methodologies and medicine. Training to learn how to navigate the person's culture and broader community and support system will be discussed. In addition, training will focus on strength-based services, a person's cultural perspective, and an understanding of how treatment can incorporate an individual's traditional practices.

Psychiatry and western medicine techniques as one path to healing will be incorporated in this training. Staff will be able to understand that medications are one treatment modality that can be offered to clients as an option for helping manage risk. Staff are aware that accepting a client's perspective in healing practices will increase the likelihood the client will engage in psychiatry.

Future trainings will encompass multicultural knowledge, sensitivity awareness and understanding of diverse backgrounds beyond the traditional race/ethnicity groups (e.g. sexual orientation, age, disability, veterans and family cultures).

Training will also be provided to staff that creates an understanding of the firsthand accounts and impressions of members of those living in our community who have experienced circumstances different than our own. Use of language, how to welcome individuals, and promoting opportunities to learn from individuals with lived experience will be developed. Training will include information on children, TAY, families, family-focused treatment, and navigating multiple service agencies. In addition, trauma-focused care and creating a trauma-informed community has been an ongoing topic of current trainings in which staff have participated.

IV. GOALS AND OBJECTIVES

The following objectives have been identified to promote the development of culturally and linguistically competent services throughout our organization.

These objectives are outlined below and provide the framework for developing this CLC Plan:

Goal 1: To provide culturally and linguistically appropriate behavioral health services to improve access for persons who are American Indian, Hispanic and other race/ethnicity groups; TAY and older adults; veterans and their families; Lesbian, Gay, Bisexual, Transgender, Questioning, Intersex, and Two Spirit (LGBTQI2-S) individuals; persons released from jail and their families; and additional cultures.

- **Objective 1a:** ACBHS will provide informing materials in the county's threshold language (currently only English) in our clinics and wellness center. In addition, ACBHS will provide all informing materials in Spanish as well.
- **Objective 1b:** When appropriate, ACBHS will hire diverse or bilingual staff to work in our programs in order to provide services and information to the client and family in their preferred language and preferred cultural setting.
- **Objective 1c:** ACBHS will ensure that the crisis line is culturally sensitive to all persons utilizing these services, and clients receive services in their preferred language.

Goal 2: To create a work climate where dignity and respect are encouraged and modeled so that everyone enjoys equitable opportunities for professional and personal growth.

- **Objective 2a:** ACBHS will provide cultural and linguistic competency trainings for ACBHS staff a minimum of 4 times per fiscal year.
- **Objective 2b:** ACBHS will discuss and provide trainings on topics including but not limited to cultural humility, local American Indian traditions, equity, diversity, relevant cultural narratives, social determinants of behavioral health, local consumer culture, recovery culture, access barriers and sustainable partnerships on a monthly basis at staff or clinical team meetings.
- **Objective 2c:** ACBHS will hire clients and family members, whenever possible, who are reflective of the Alpine County community, especially American Indians or bilingual/bicultural individuals, to help address barriers for culturally diverse populations.

Goal 3: To deliver behavioral health services in collaboration with other community organizations and co-locate services whenever possible, including in diverse community settings (e.g., tribal community, schools, and other rural community locations).

- **Objective 3a:** ACBHS will deliver services in the least restrictive environment (e.g., home, schools, tribal community, senior center, and other rural community locations) when needed and as appropriate.
- **Objective 3b:** ACBHS will retain a presence in the Hung-A-Lel-Ti community, providing services and programs open to all Alpine County residents as determined by the local tribal community council.

- **Objective 3c:** ACBHS will work closely with local schools including Douglas High School, to engage youth and TAY in the development of strategies to prevent alcohol and drug abuse and intervene early in the onset of behavioral health issues.
- **Objective 3d:** ACBHS will collaborate with the Native Wellness Advocate and a community partner to promote the well-being of native children and families.
- **Objective 3e:** ACBHS will collaborate with local providers and educational institutions who serve people with disabilities to teach and enhance social and life skills, in addition to providing behavioral health support.

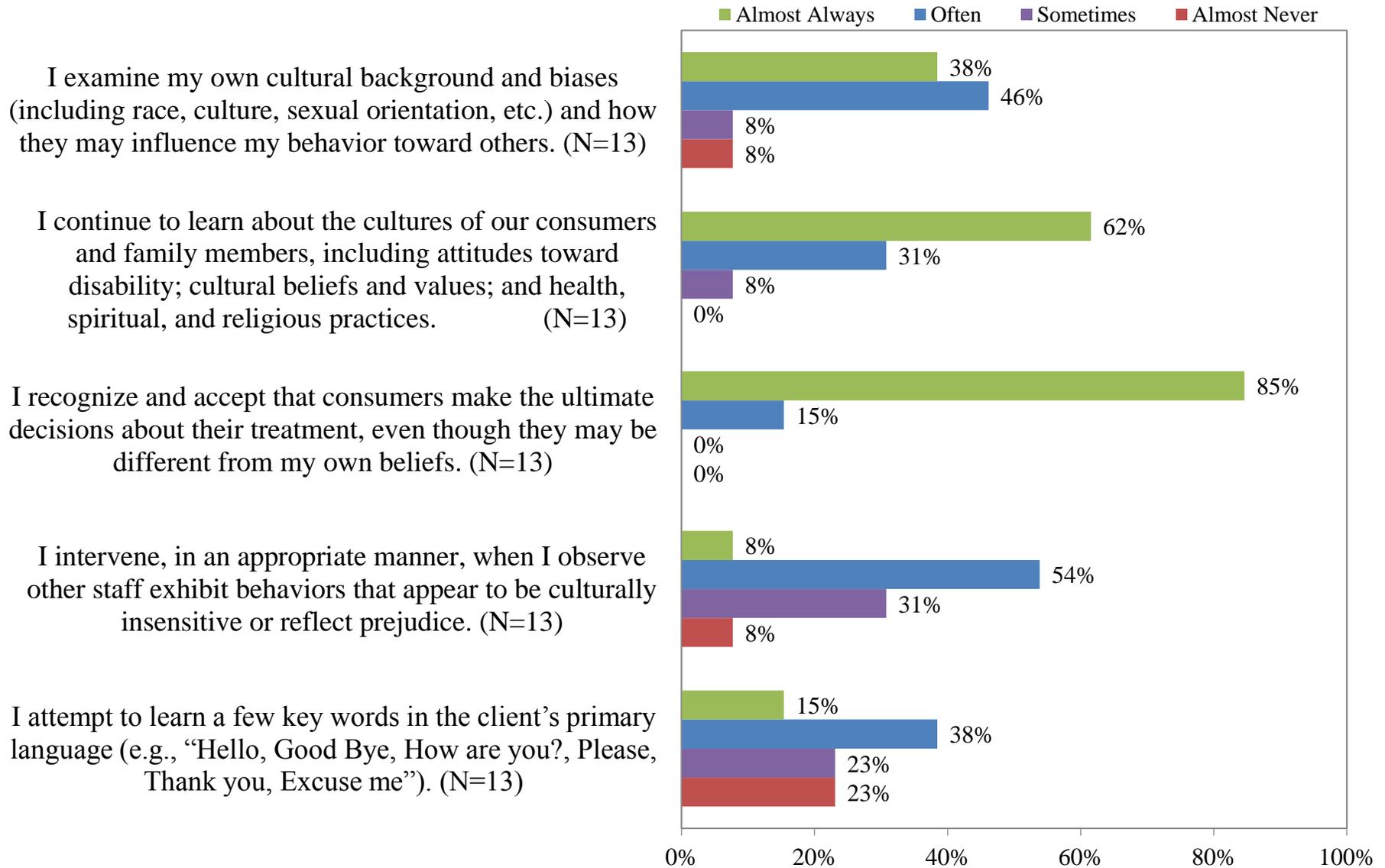
Goal 4: To collect and maintain accurate and reliable demographic and service-level data to monitor and evaluate the impact of services on health equity and outcomes.

- **Objective 4a:** ACBHS will gather data to provide objective and consistent evaluation and feedback to leadership, staff, and clients regarding program impact and outcomes to best support and meet the needs of the community, individuals and family. Data will be collected ongoing and reviewed quarterly by the clients, staff, and partner agencies at staff, clinical team, cultural competence and quality improvement meetings.

Attachment A: Ethnicity and Cultural Competence Survey Results

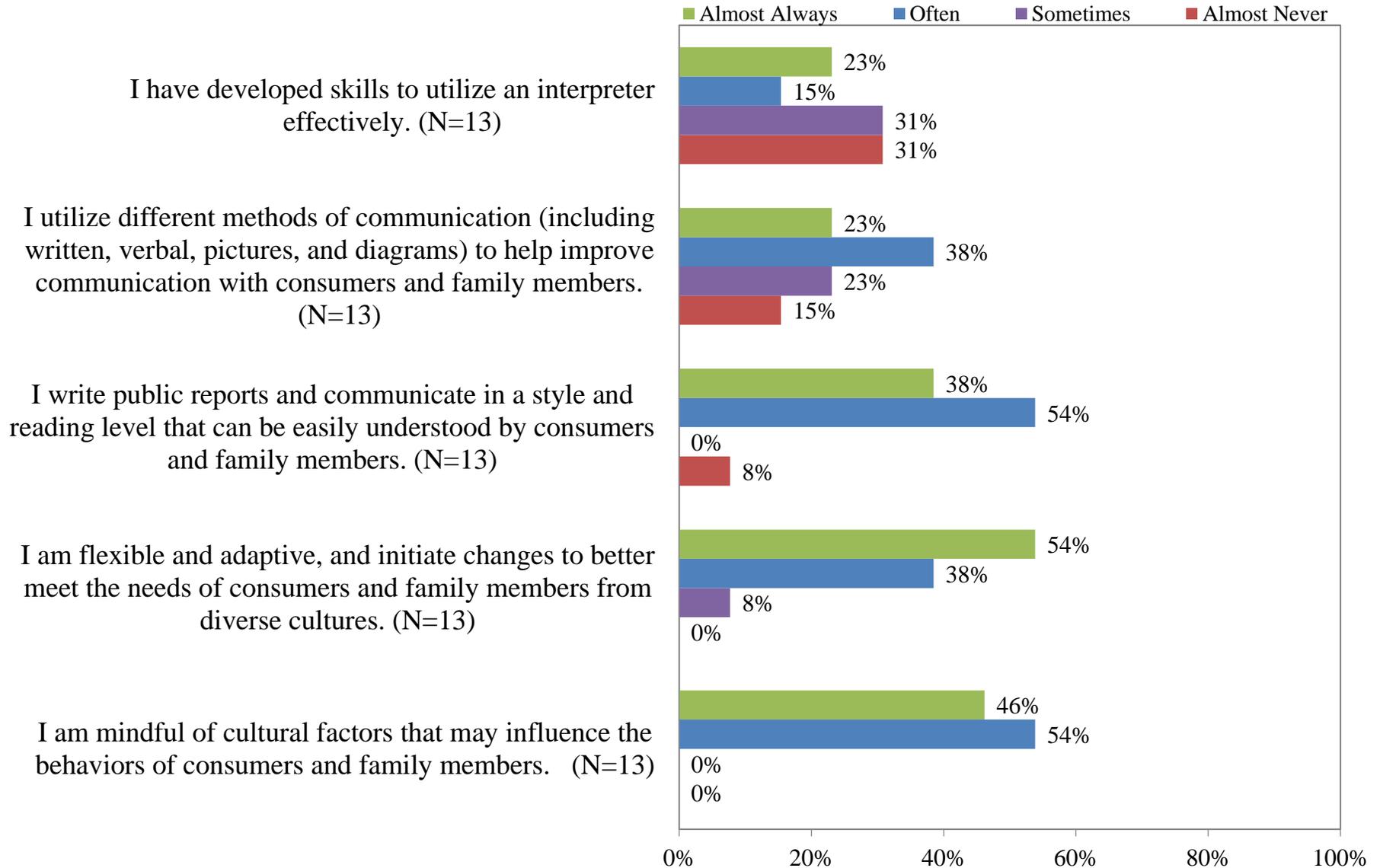
Alpine County Mental Health Services
Staff & Volunteer Ethnicity and Cultural Competence Survey

December 2017



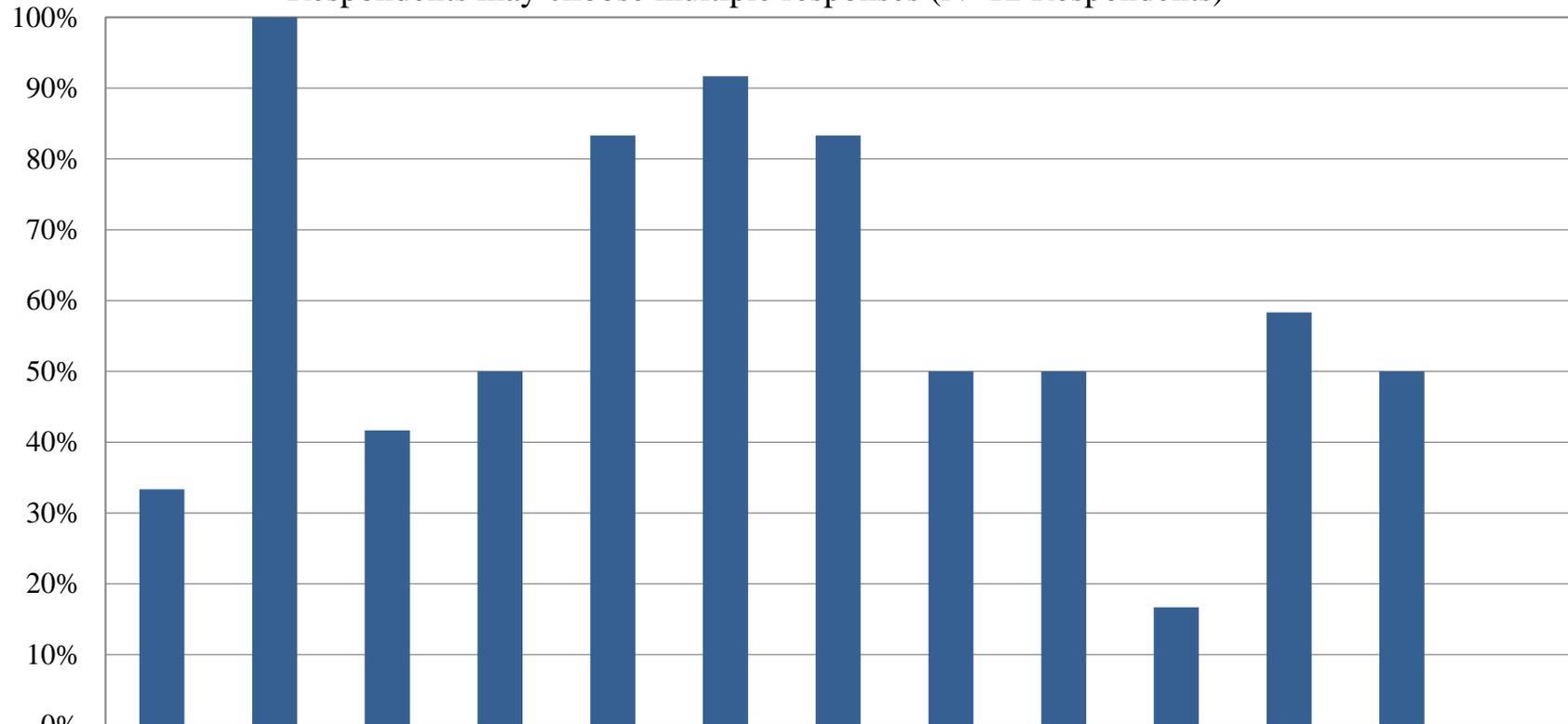
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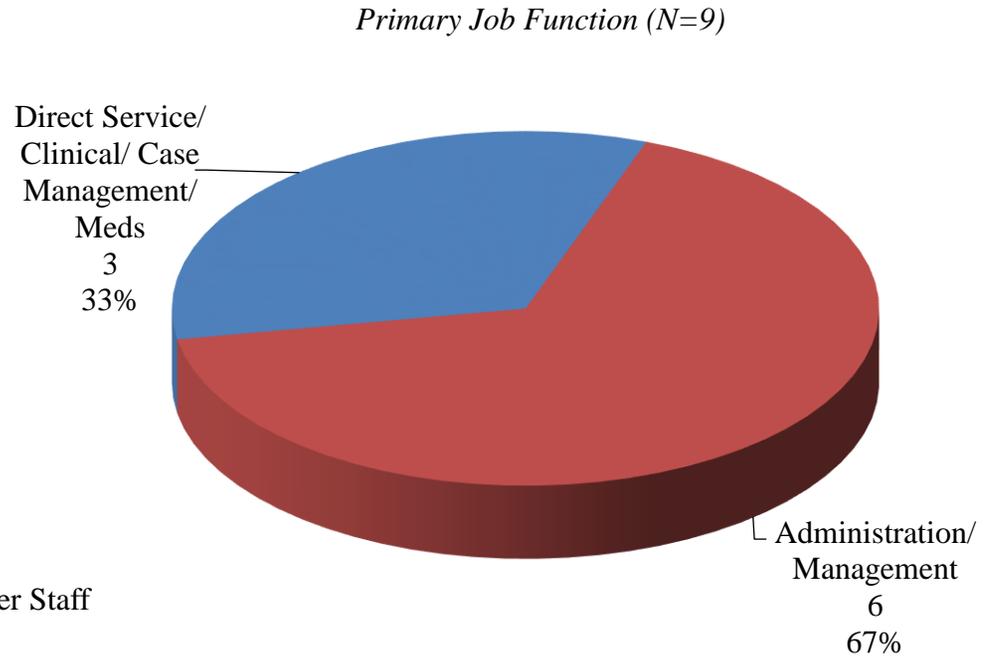
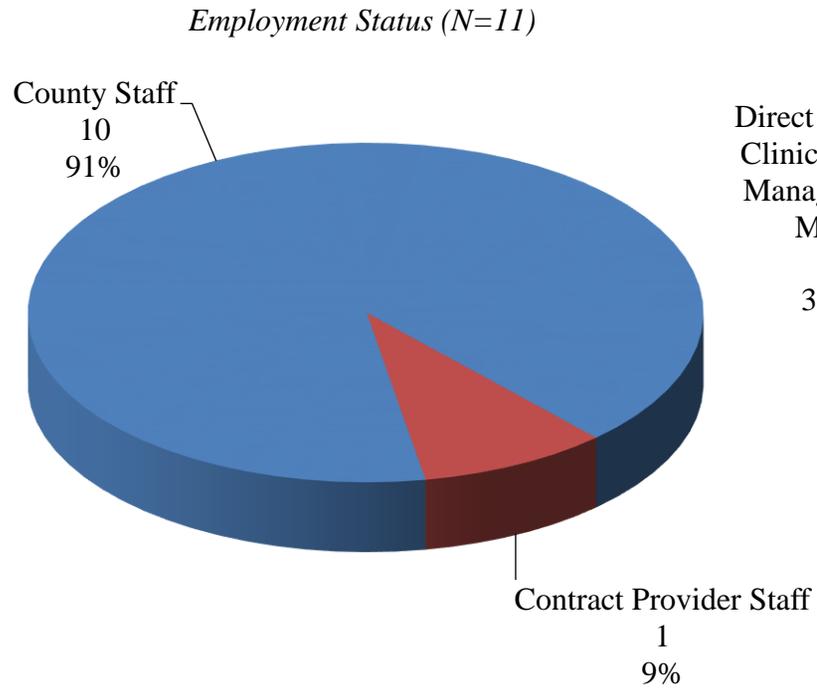
Alpine County Mental Health Services
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Participation in Cultural Awareness Activities (Past Six Months)
 Respondents may choose multiple responses (N=12 Respondents)

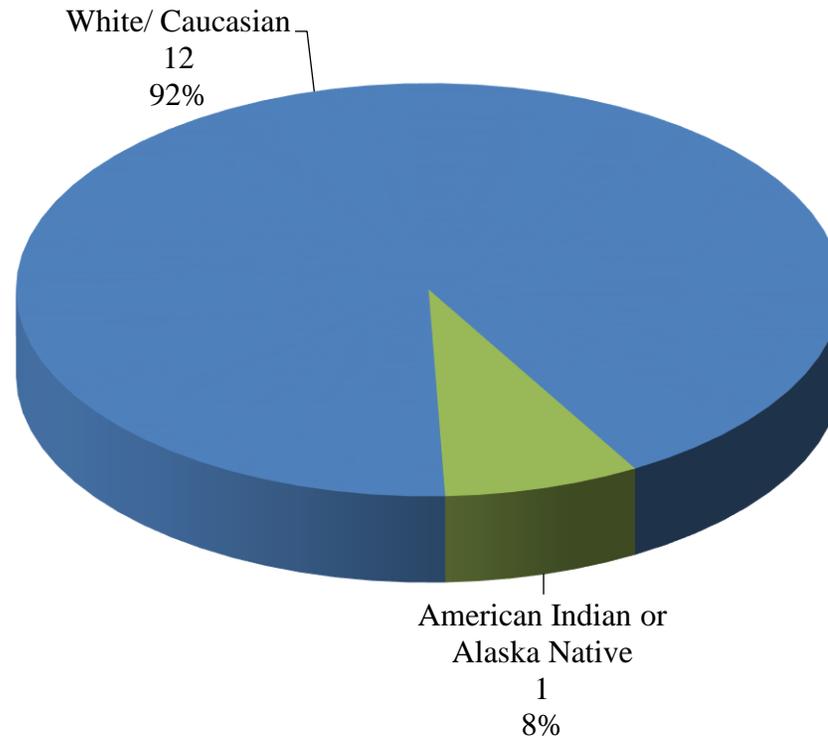


	I recognized a prejudice I have about certain people.	I talked to a colleague about a cultural issue.	I sought guidance about a cultural issue that arose during therapy/service delivery.	I attended a multi-cultural training seminar.	I attended a cultural event.	I attended an event in which most of the other people were not my race.	I reflected on my racial identity and how it affects my work with clients.	I read a chapter or an article about multicultural issues.	I read a novel about a racial group other than my own.	I sought consultation or supervision about multicultural issues.	I talked to a friend/associate about how our racial differences affect our relationship.	I challenged a racist remark - my own or someone else's.	Total
# Respondents	4	12	5	6	10	11	10	6	6	2	7	6	12
% Respondents	33%	100%	42%	50%	83%	92%	83%	50%	50%	17%	58%	50%	100%

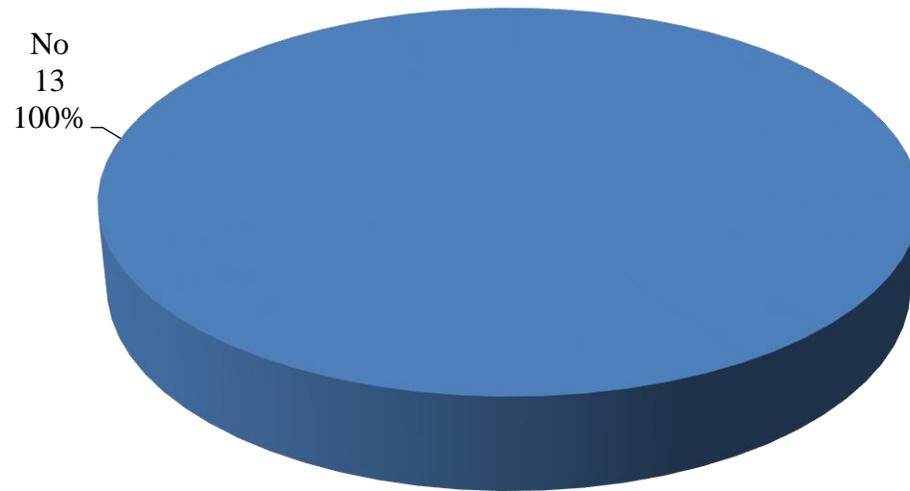
Alpine County Mental Health Services
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Alpine County Mental Health Services
Staff & Volunteer Ethnicity and Cultural Competence Survey
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Race/Ethnicity (N=13)

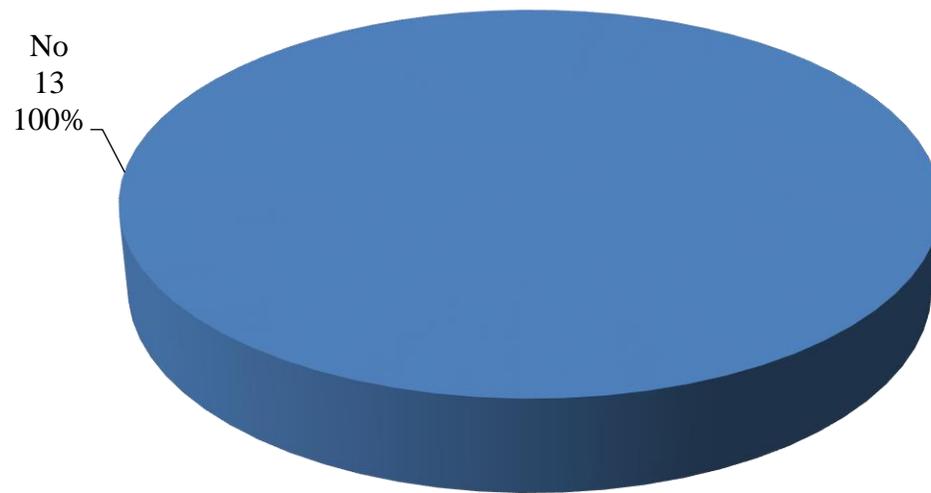


Alpine County Mental Health Services
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Do you consider yourself Bilingual? (N=13)



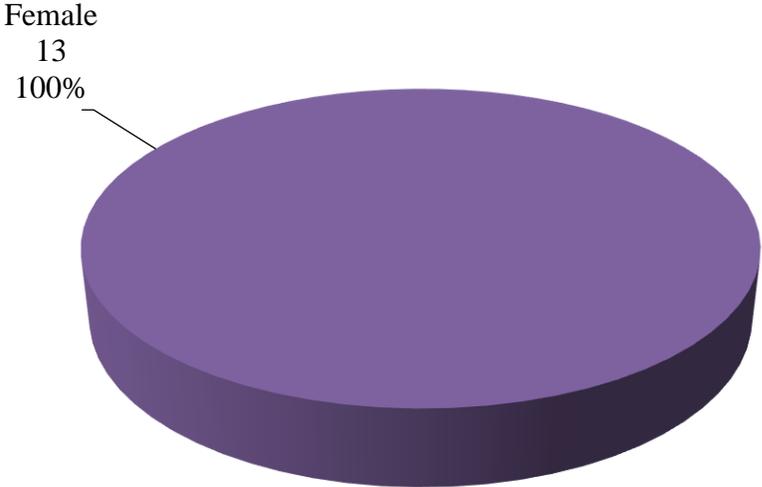
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Do you act as an Interpreter as part of your Job Function? (N=13)

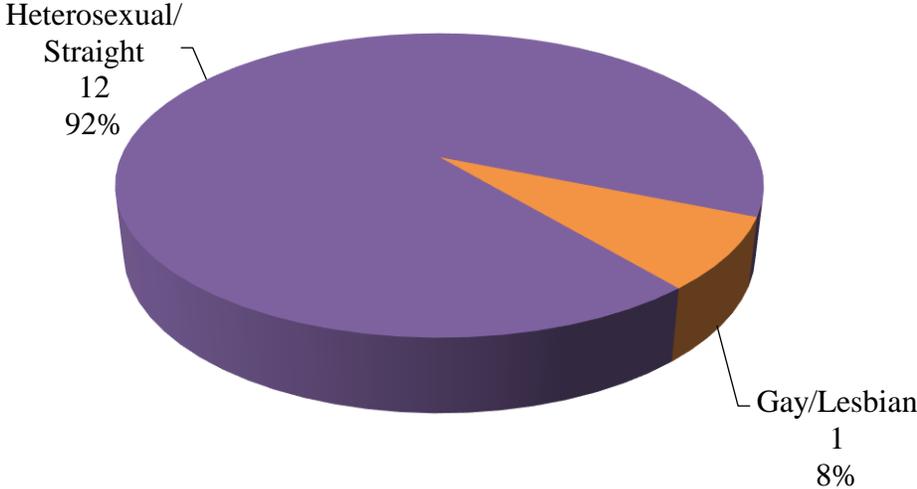


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Gender (N=13)

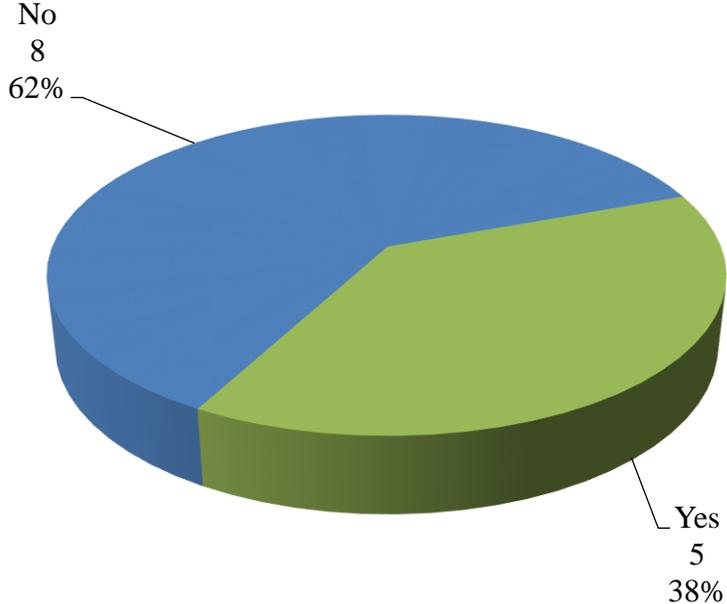


Sexual Orientation (N=13)



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Do you consider yourself to be a Consumer of Mental Health Services? (N=13)



Are you a Family Member of a Consumer of Mental Health Services? (N=12)

