Nevada County Behavioral Health

Cultural and Linguistic Proficiency Plan Annual Update 2018

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It is the mission of Nevada County Behavioral Health is to enable individuals in our community who are affected by mental illness and serious emotional disturbances to achieve the highest quality of life. To accomplish this goal, services must be delivered in the least restrictive, most accessible environment within a coordinated system of care that is respectful of a person's family, language, heritage, and culture

OVERVIEW

Nevada County Behavioral Health (NCBH) strives to deliver culturally-, ethnically-, and linguistically-appropriate services to behavioral health participants and their families. In addition, we recognize the importance of developing services that are sensitive to other cultures, including Hispanic, Asian, Native American and other racial and ethnic groups; persons with disabilities; consumers in recovery (from mental health or substance use); LGBTQ community; various age groups (Transition Age Youth – TAY, Older Adults); veterans; faith-based; physically disabled; and persons involved in the correctional system.

Developing a culturally- and linguistically-proficient 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 Proficiency (CLP) Plan reflects the NCBH ongoing commitment to improve services to expand access to services, quality care, and improved outcomes. The CLP Plan addresses the requirements from the Department of Health Care Services (DHCS) for both Mental Health and Alcohol and Drug services, including the Cultural and Linguistic Standards (CLAS).

The Cultural and Linguistic Proficiency (CLP) Committee was started in 2000 when the first CLP plan was developed. The CLP Committee is comprised of Behavioral Health staff, participants, staff for other county agencies, and interested community stakeholders. The CLP Committee meets Quarterly and reviews data, plans activities to support the development of culturally and linguistically proficient services, and identifies training and outreach activities. The CLP Committee also reviews data on access and timeliness of services, by cultural group.

The 24/7 access line is tested three times each month to ensure that persons speaking Spanish and other languages will have the call available in their preferred language.

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 includes 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 Participant Care Plan meeting, where the participant, 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 can 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. COMMITMENT TO CULTURAL AND LINGUISTIC COMPETENCE

NCBH department and staff are committed to constantly improving services to meet the needs of culturally diverse individuals seeking and receiving services. Several objectives were developed as a component of our Mental Health Services Act (MHSA) Plan. These goals and objectives are outlined below and provide the framework for developing this CLP Plan.

Nevada County Cultural and Linguistic Proficiency Goals

Goal 1: Increase the number and percent of persons served by the mental health system who are Hispanic, by a minimum of 10%. In FY 2017/18, NCBH served a total of 244 Hispanic people. Activities to increase access for Hispanic people include training staff to accurately document race and ethnicity, so we can accurately know the number of persons served; develop a culturally-diverse and welcoming environment at access points; integrate health and behavioral health care; expand membership on key committees and planning groups; and offer culturally-diverse outreach into the Hispanic community.

- We are pleased that we exceeded our goal last year. In FY 2016/17, NCBH served a total of 274 Hispanic people. In FY 2017/18, NCBH served a total of 290 Hispanic people. This data shows a 5.8% increase in the number of Hispanic people who received mental health services from FY 2015/16 to FY 2016/2017.

Goal 2: Enhance services to persons who are LGBTQ by accurately collecting and documenting each participant's sexual orientation utilizing revised documentation standards, provide training to staff on the LGBTQ culture and how to collect sexual orientation data, and develop outreach and engagement services to youth in the high school(s) who are LGBTQ.

Goal 3: Enhance services to Transition Age Youth (TAY), ages 16-25, by offering additional services for at least 10% of the TAY served.

Goal 4: Enhance services to Older Adults by strengthening linkages between mental health services and physical health care and expanding services to seniors.

Goal 5: Offer coordinated outreach services between Hospitality House, Spirit Peer Empowerment Center, and behavioral health services to engage persons who are homeless and mentally ill, and link them to needed services, including public health, physical health, legal assistance, housing, and mental health services.

Goal 6: Enhance services to persons with co-occurring disorders (serious mental illness and substance use), by offering screening and assessment for persons who have co-occurring disorders; referring persons to the appropriate provider; offering training to substance abuse staff and mental health staff on delivering services for persons with co-occurring disorders; and increasing the number of participants receiving coordinated services. Accurately collect data on the number of persons with co-occurring disorders. NCBH went 'live' with the Drug Medi-Cal Organized Delivery System (DMC/ODS) in July 2018. This will help expand services for persons needing substance use services, and subsequently expand services with persons with co-occurring disorders.

Goal 7: Increase the number and percent of persons served by the mental health system who are Veterans, by a minimum of 5%. Activities including training staff to accurately collect data on veteran status and offering outreach activities at functions for veterans, to help reduce the stigma of mental health and improve access to services. We have changed the language of the question regarding Veteran status on our demographic form. The question now reads "Have you served in the U.S. Military, National Guard or the Reserves?" in order to more adequately identify those that were in the military. In FY 2017/18, NCBH served a total of 58 Veterans.

- We are pleased that we also exceeded our goal of serving more veterans. In FY 2016/17, we served a total of 53 participants who were Veterans. In FY 2017/18, we served a total of 58 participants who were Veterans. This data shows a 9.4% increase in the number of participants who were veterans from FY 2016/17 to FY 2017/18.

II. DATA, ANALYSIS, AND OBJECTIVES

A. County Geographic and Socio-Economic Profile

1. Geographical location and attributes of the county

Nevada County is a small, rural, mountain community home to 98,764 (2010 US Census) individuals. A little over 86% of the Nevada County residents identified their race as White. Less than 3% of Nevada County residents identified their race as African American, Alaskan Native, Native American, Asian, and Pacific Islander. In addition, less than 3% identified their race as "Other." Persons who are Hispanic comprise 8.5 % of the population of Nevada County. Nevada County has one threshold language, Spanish.

The county lies in the heart of the Sierra Nevada Mountains and covers 958 square miles. Nevada County is bordered by Sierra County to the north, Yuba County to the west, Placer County to the south, and the State of Nevada to the east. The county seat of government is in Nevada City. Other cities include the city of Grass Valley and the Town of Truckee, as well as nine unincorporated cities.

In winter, it is often difficult to access the Tahoe region of the county, when inclement weather makes travel through the Sierras difficult. As a result, individuals in Tahoe may be isolated and unable to easily access services.

2. Demographics of the county

Figure 1 shows age, race/ethnicity, and gender of the general population. For the 98,764 residents who live in Nevada County, 15.3% are children ages 0-14; 10.7% are Transition Age Youth (TAY) ages 15-24; 45.7% are adults ages 25-59; and 28.4% are older adults ages 60 years and older. The majority of persons in Nevada County are Caucasian (86.5%). Persons who are Hispanic represent 8.5% of the population, Asian/Pacific Islander represent 1.2% of the population, African American/ Black represent 0.3% of the population, Alaskan Native/ Native American represent 0.8% of the population, and other/unknown represent 2.5% of the population. There are slightly more females (50.6%) than males (49.4%) in the county.

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

	Nevada County Population 2010 Census	
Age Distribution	**Number**	**Percent**
0 - 14 years	15,113	15.3%
15 - 24 years	10,530	10.7%
25 - 59 years	45,121	45.7%
60+ years	28,000	28.4%
Total	**98,764**	**100.0%**
Race/Ethnicity Distribution	**Number**	**Percent**
Black/ African American	341	0.3%
American Indian/ Alaskan Native	793	0.8%
Asian/ Pacific Islander	1,220	1.2%
White/ Caucasian	85,477	86.5%
Hispanic	8,439	8.5%
Other/ Unknown	2,494	2.5%
Total	**98,764**	**100.0%**
Gender Distribution	**Number**	**Percent**
Male	48,835	49.4%
Female	49,929	50.6%
Total	**98,764**	**100.0%**

3. Socio-economic characteristics of the county

Nevada County businesses are frequently tourist-focused due to many outdoor recreational opportunities: camping; fishing; hiking; boating; winter sports activities; gold mining and historical sites; and an active artistic and musical community.

Nearly eleven percent (10.9%) of the individuals in Nevada County were below the poverty level in 2017, compared to the statewide average of 13.3%. The median family income from 2012 to 2016 was $57,429, compared to the state-wide median family income of $63,783 during the same period.

There has been a significant increase in the number of persons who are eligible for Medi-Cal benefits from 2000 to FY 2017/18. In 2000, there were 5,277 individuals on Medi-Cal in the Nevada County area. In FY 2017/18, this number more than quadrupled to 23,679. This data shows a large increase in the number of persons needing financial support.

Low-income housing is a rare commodity in this county. In fact, unemployment and housing concerns were the two highest ranked issues for all categories of respondents in a needs assessment survey. A significant part of the unemployed work force has a high level of education and/or specialized work skills that surpass the needed level for Nevada County's

available jobs. Although under-employment is an ongoing problem in most rural counties, the severe unemployment problem that hit Nevada County in the 1990's has compounded the problem. There was a 100% increase in unemployment from 1990 to 1992 in Nevada County, at which time unemployment was 9% according to the Nevada County Planning Department. According to the U.S. Bureau of Labor Statistics, in 2017, there was 4.1% unemployment in Nevada County.

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 2017/18). From this data, a penetration rate was calculated, showing the percent of persons in the population that received mental health services in FY 2017/18. This data is shown by age, race/ethnicity, and gender. Primary Language was not available for the general population.

There were 2,029 people who received one or more mental health services in FY 2017/18. Of these individuals, 20.3% were children ages 0-14; 20.6% were TAY ages 15-24; 46.7% were adults ages 25-59; and 12.4% were 60 and older. There were 73.5% of the participants who were Caucasian/ White, 14.3% who were Hispanic, and 5.5% who were Other/Unknown. All other race/ethnicity groups represented a small number of individuals. There were 96.8% of the participants whose primary language was English and 3.0% whose primary language was Spanish. Participants with other primary languages represented a small number of individuals. A slight majority of participants were females (50.5%) compared to males (49.3%).

The penetration rate data shows that 2.1% of the Nevada County population received mental health services, with 2,029 individuals out of the 98,764 residents. Of these individuals, children had a penetration rate of 2.7%, TAY had a penetration rate of 4.0%, adults had a penetration rate of 2.1%, and older adults had a penetration rate of 0.9%.

For race/ethnicity, persons who are African American/Black had a penetration rate of 8.5%, persons who are Alaskan Native/American Indian had a penetration rate of 10.0%, persons who are Asian/Pacific Islander had a penetration rate of 2.2%, persons who are Caucasian/White had a penetration rate of 1.7%, persons who are Hispanic had a penetration rate of 3.4%, and persons who are Other/Unknown had a penetration rate of 4.5%.

Males had a mental health penetration rate of 2.0%, and females had a mental health penetration rate of 2.1%.

Figure 2
Nevada County Mental Health Penetration Rates
by Age, Race/Ethnicity, Language, and Gender
(Population Source: 2010 Census)

	Nevada County Population 2010 Census		All Mental Health Participants FY 2017/18		Nevada County Population Mental Health Penetration Rate FY 2017/18
Age Distribution					
0 - 14 years	15,113	15.3%	412	20.3%	412 / 15,113 = 2.7%
15 - 24 years	10,530	10.7%	417	20.6%	417 / 10,530 = 4.0%
25 - 59 years	45,121	45.7%	948	46.7%	948 / 45,121 = 2.1%
60+ years	28,000	28.4%	252	12.4%	252 / 28,000 = 0.9%
Total	**98,764**	**100.0%**	**2,029**	**100.0%**	**2,029 / 98,764 = 2.1%**
Race/Ethnicity Distribution					
Black/ African American	341	0.3%	29	1.4%	29 / 341 = 8.5%
American Indian/ Alaskan Native	793	0.8%	79	3.9%	79 / 793 = 10.0%
Asian/ Pacific Islander	1,220	1.2%	27	1.3%	27 / 1,220 = 2.2%
White/ Caucasian	85,477	86.5%	1,492	73.5%	1,492 / 85,477 = 1.7%
Hispanic	8,439	8.5%	290	14.3%	290 / 8,439 = 3.4%
Other/ Unknown	2,494	2.5%	112	5.5%	112 / 2,494 = 4.5%
Total	**98,764**	**100.0%**	**2,029**	**100.0%**	**2,029 / 98,764 = 2.1%**
Language Distribution					
English	-	-	1,964	96.8%	-
Spanish	-	-	61	3.0%	-
Other/ Unknown	-	-	4	0.2%	-
Total	-	-	**2,029**	**100.0%**	-
Gender Distribution					
Male	48,835	49.4%	1,000	49.3%	1,000 / 48,835 = 2.0%
Female	49,929	50.6%	1,025	50.5%	1,025 / 49,929 = 2.1%
Other/ Unknown	-	0.0%	4	0.2%	-
Total	**98,764**	**100.0%**	**2,029**	**100.0%**	**2,029 / 98,764 = 2.1%**

5. Analysis of disparities identified in penetration rates

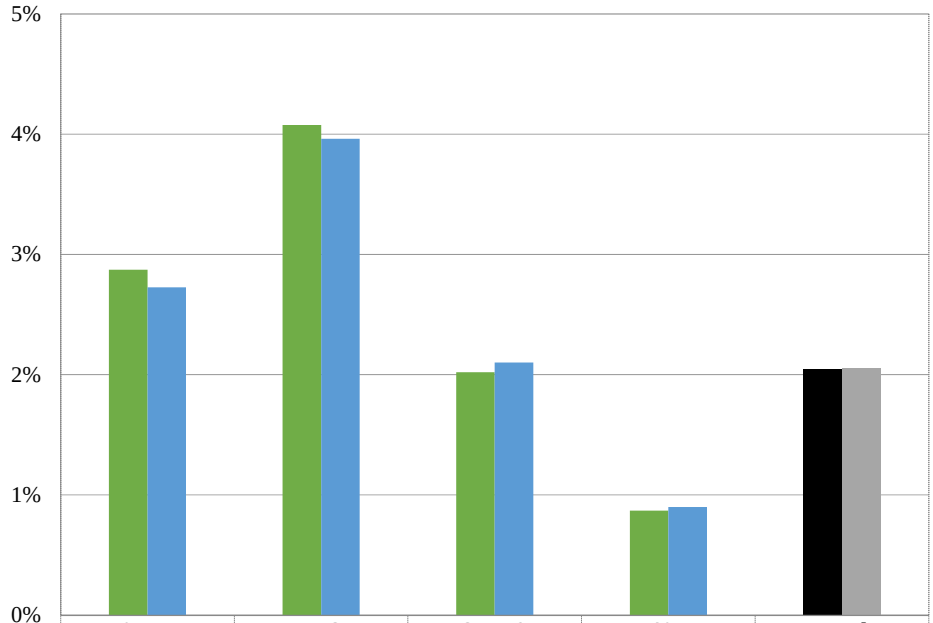
The penetration rate for Caucasian participants (1.7%) is lower than the total penetration rate (2.1%), while the penetration rate for Hispanic participants (3.4%) is higher than the total penetration rate (2.1%). The small numbers of persons served and in the population for other race/ethnicities creates variability in the data and is therefore difficult to interpret. The penetration rate data for age shows that there are a higher proportion of children and TAY served, compared to adults and older adults.

The higher penetration rates for children and TAY reflects the comprehensive children's system of care that has been developed over the past ten years. The higher penetration rate for the Hispanic population may also reflect the increased emphasis of outreach to this traditionally underserved population, through expanded PEI programs.

6. Penetration rate trends for two years

We have also analyzed our penetration rates for the past two years (see Figure 3 and Figure 4). This data shows an increase in the number of adults (912 adults to 948 adults) and older adults (244 older adults to 252 older adults) served between FY 2016/17 and FY 2017/18. There was a decrease in the number of children served (434 children to 412 children) and TAY (429 to 417) in the same period. The total number of participants increased from 2,019 – 2,029 participants in this two-year period.

Figure 3
Nevada County Mental Health <u>Penetration Rate</u> by Age
FY 2016/17 to FY 2017/18
(Population Source: 2010 Census)



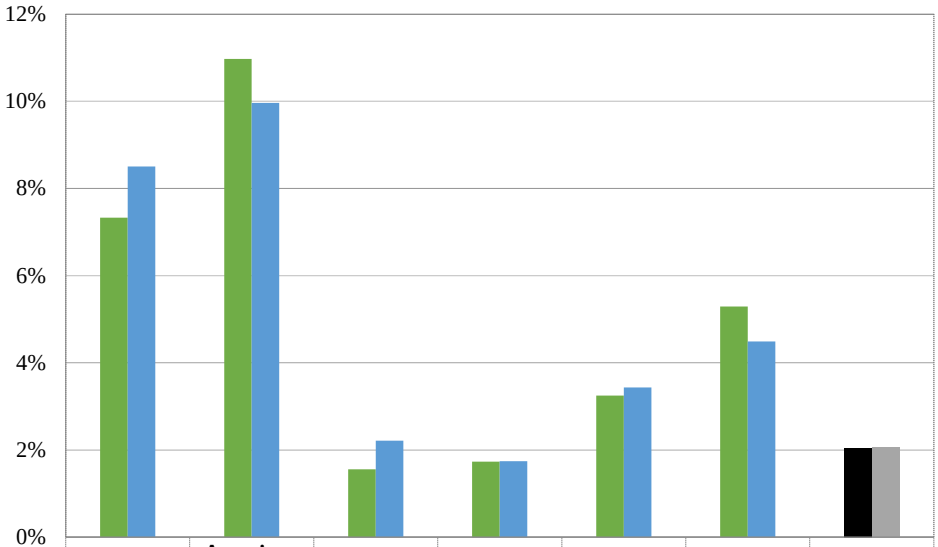
	0 - 14	15 - 24	25 - 59	60+	Total
FY 2016-17 # Participants	434	429	912	244	2,019
FY 2016-17 Penetration Rate	2.9%	4.1%	2.0%	0.9%	2.0%
FY 2017-18 # Participants	412	417	948	252	2,029
FY 2017-18 Penetration Rate	2.7%	4.0%	2.1%	0.9%	2.1%
Nevada County Census Population	15,113	10,530	45,121	28,000	98,764

There is a large older adult population in Nevada County, but a small number of individuals access services. This may be an important area of focus in the next year to reach out to both older adults and caregivers.

Figure 4 shows that there was an increase in the number of Black/African American clients served (25 to 29), Asian/Pacific Islander clients (19 to 27), White/Caucasian clients (1,482 to 1,492), and Hispanic clients (274 to 290). There was a decrease in the number of American Indian/Alaskan Native clients served (87 to 79) and Other/Unknown races (132 to 112).

While the penetration rate for Black/African American and American Indian/Alaska Native is high, there are small numbers of persons in the population. Examining this data in the next year by age group would provide additional information on access to services.

Figure 4
Nevada County Mental Health Penetration Rate by Race/Ethnicity
FY 2016/17 to FY 2017/18
(Population Source: 2010 Census)



	Black/ African American	American Indian/ Alaskan Native	Asian/ Pacific Islander	White/ Caucasian	Hispanic	Other/ Unknown	Total
FY 2016-17 # Participants	25	87	19	1,482	274	132	2,019
FY 2016-17 Penetration Rate	7.3%	11.0%	1.6%	1.7%	3.2%	5.3%	2.0%
FY 2017-18 # Participants	29	79	27	1,492	290	112	2,029
FY 2017-18 Penetration Rate	8.5%	10.0%	2.2%	1.7%	3.4%	4.5%	2.1%
Nevada County Census Population	341	793	1,220	85,477	8,439	2,494	98,764

7. Mental Health Medi-Cal population

Figure 5 shows the percentage of Medi-Cal enrollees who accessed mental health services in FY 2017/18. From this data, a penetration rate was calculated, showing the percent of persons who are Medi-Cal Enrollees who received mental health services in FY 2017/18. This data is shown by age, race/ethnicity, and gender.

There were 1,625 Medi-Cal participants who received one or more mental health services in FY 2017/18. Of these participants, 34.2% were children ages 0-17; 8.7% were TAY ages 18-24; 52.6% were adults ages 25-64; and 4.6% were older adults ages 65 and older. There were 72.8%

of the participants who were Caucasian, and 15.0% who were Hispanic. All other race/ethnicity groups represented a small number of individuals. A slight majority of participants were males (50.5%) compared to females (49.4%).

The penetration rate data shows that 6.9% of the Nevada County Medi-Cal eligibles received mental health services, with 1,625 individuals out of the 23,679 Medi-Cal eligibles. Of these individuals, children had a penetration rate of 8.6%, TAY had a penetration rate of 6.8%, adults had a penetration rate of 6.5%, and older adults had a penetration rate of 3.8%. The low penetration rate for older adults is consistent with earlier data and supports the development of a goal to increase access for older adults in the next year.

For race/ethnicity, persons who are Caucasian had a penetration rate of 6.5%, and persons who are Hispanic had a penetration rate of 9.1%. All other race/ethnicity groups represented a small number of individuals, which makes the data harder to interpret. Males had a penetration rate of 7.2%, and females had a penetration rate of 6.6%.

Figure 5
Nevada County Medi-Cal Mental Health Penetration Rates
by Age, Race/Ethnicity, and Gender
(Medi-Cal Enrollee Source: Kings View Penetration Report FY2017/18)

	Nevada County Average Number of Enrollees FY 2017/18		Number of Medi-Cal Mental Health Participants Served FY 2017/18		MH Medi-Cal Penetration Rate FY 2017/18
Age Group					
Children	6,487	27.4%	556	34.2%	556 / 6,487 = 8.6%
Transition Age Youth	2,088	8.8%	141	8.7%	141 / 2,088 = 6.8%
Adults	13,165	55.6%	854	52.6%	854 / 13,165 = 6.5%
Older Adults	1,939	8.2%	74	4.6%	74 / 1,939 = 3.8%
Total	**23,679**	**100.0%**	**1,625**	**100.0%**	**1,625 / 23,679 = 6.9%**
Race/Ethnicity					
Black/ African American	138	0.6%	25	1.5%	25 / 138 = 18.1%
American Indian/ Alaskan Native	181	0.8%	73	4.5%	73 / 181 = 40.3%
Asian/ Pacific Islander	270	1.1%	25	1.5%	25 / 270 = 9.3%
White/ Caucasian	18,093	76.4%	1,183	72.8%	1,183 / 18,093 = 6.5%
Hispanic	2,671	11.3%	244	15.0%	244 / 2,671 = 9.1%
Other/ Unknown	2,326	9.8%	75	4.6%	75 / 2,326 = 3.2%
Total	**23,679**	**100.0%**	**1,625**	**100.0%**	**1,625 / 23,679 = 6.9%**
Gender					
Male	11,451	48.4%	821	50.5%	821 / 11,451 = 7.2%
Female	12,228	51.6%	802	49.4%	802 / 12,228 = 6.6%
Other/ Unknown	-	0.0%	2	0.1%	-
Total	**23,679**	**100.0%**	**1,625**	**100.0%**	**1,625 / 23,679 = 6.9%**

8. Analysis of disparities identified in Medi-Cal participants

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 6.9 % (compared to 2.1%). Approximately 80% of all Mental Health participants are Medi-Cal. There is a large older adult population in Nevada County, but a small number of individuals access services. While the penetration rate is relatively "high" for several of the racial and ethnic groups, the small number of persons make it difficult to interpret the data. We will continue to improve access for all racial and ethnic groups. Analyzing this data by age, race/ethnicity, and gender will provide a better understanding of access.

9. Penetration rates for Substance Use Disorder services

Figure 6 shows the number of persons in the county population (2010 Census) and the number of persons who received Substance Use Disorder (SUD) services (FY 2017/18). From this data, a penetration rate was calculated, showing the percent of persons in the population that received SUD services in FY 2017/18. This data is shown by age, race/ethnicity, and gender. Primary Language was not available for the general population.

As expected, the proportion of persons receiving SUD services shows varying proportions of individuals by age. There were 611 people who received one or more SUD services in FY 2017/18. Of these individuals, 0.7% were children ages 0-14; 14.4% were TAY ages 15-24; 81.0% were adults ages 25-59; and 3.9% were 60 and older. The proportion of SUD participants by race/ethnicity includes Caucasian (84.1%) and Hispanic (8.5%). All other race/ethnicity groups represented a small number of individuals. Nearly all (99.5%) of the SUD participants in FY 2017/18 have a primary language of English. There was a higher number of males (59.2%) than females (40.6%), which is consistent with most SUD programs.

The penetration rate data shows that 0.6% of the Nevada County population received SUD treatment services. Of these individuals, children had a penetration rate of 0.0%, TAY had a penetration rate of 0.8%, adults had a penetration rate of 1.1%, and older adults had a penetration rate of 0.1%.

For race/ethnicity, persons who are Caucasian had a penetration rate of 0.6% and persons who are Hispanic also had a penetration rate of 0.6%. All other race/ethnicities represented a small number of individuals. Males had a penetration rate of 0.7%, while females had a penetration rate of 0.5%.

Figure 6
Nevada County Substance Use Disorder Services Penetration Rates
by Age, Race/Ethnicity, Language, and Gender
(Population Source: 2010 Census)

	Nevada County Population 2010 Census		All Substance Use Participants FY 2017/18		Nevada County Population Substance Use Penetration Rate FY 2017/18
Age Distribution					
0 - 14 years	15,113	15.3%	4	0.7%	4 / 15,113 = 0.0%
15 - 24 years	10,530	10.7%	88	14.4%	88 / 10,530 = 0.8%
25 - 59 years	45,121	45.7%	495	81.0%	495 / 45,121 = 1.1%
60+ years	28,000	28.4%	24	3.9%	24 / 28,000 = 0.1%
Total	**98,764**	**100.0%**	**611**	**100.0%**	**611 / 98,764 = 0.6%**
Race/Ethnicity Distribution					
Black/ African American	341	0.3%	5	0.8%	5 / 341 = 1.5%
American Indian/ Alaskan Native	793	0.8%	21	3.4%	21 / 793 = 2.6%
Asian/ Pacific Islander	1,220	1.2%	7	1.1%	7 / 1,220 = 0.6%
White/ Caucasian	85,477	86.5%	514	84.1%	514 / 85,477 = 0.6%
Hispanic	8,439	8.5%	52	8.5%	52 / 8,439 = 0.6%
Other/ Unknown	2,494	2.5%	12	2.0%	12 / 2,494 = 0.5%
Total	**98,764**	**100.0%**	**611**	**100.0%**	**611 / 98,764 = 0.6%**
Language Distribution					
English	-	-	608	99.5%	-
Spanish	-	-	2	0.3%	-
Other/ Unknown	-	-	1	0.2%	-
Total	-	-	**611**	**100.0%**	-
Gender Distribution					
Male	48,835	49.4%	362	59.2%	362 / 48,835 = 0.7%
Female	49,929	50.6%	248	40.6%	248 / 49,929 = 0.5%
Other/ Unknown	-	0.0%	1	0.2%	-
Total	**98,764**	**100.0%**	**611**	**100.0%**	**611 / 98,764 = 0.6%**

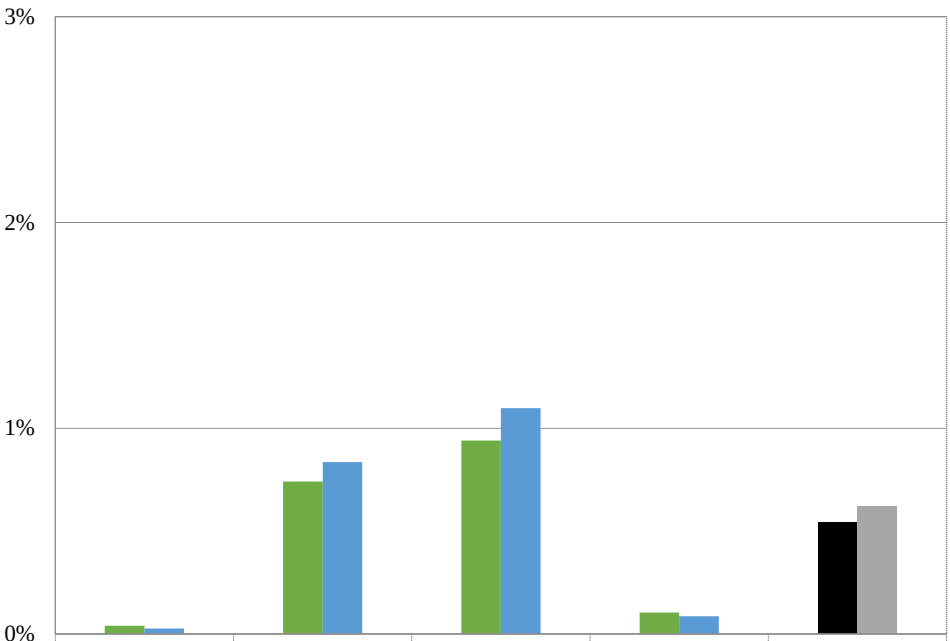
10. Analysis of disparities identified in Substance Use Disorder services

Figure 6 data also shows that the majority of SUD participants are adults (81.0%) compared to the general population of adults (45.7%). Similarly, there is a higher proportion of TAY enrolled in the SUD program (14.4%) compared to the general population (10.7%). There are a similar proportion of SUD participants that are Caucasian (84.1% compared to 86.5% of the population). The Hispanic community has the same proportion of participants, 8.5% compared to 8.5% of the population. There is a higher proportion of participants that are male (59.2% compared to 49.4% of the population). Females represent 40.6% of the participants compared to 50.6% of the general population.

The high penetration rate for TAY (0.8%) and adults (1.1%), may reflect the availability of SUD services in Nevada County. There are two organizational providers who deliver the majority of SUD services: Community Recovery Resources (CoRR) and Common Goals. These programs help improve access to SUD services in Nevada County.

We have also analyzed our penetration rates for the past two years (see Figure 7 and Figure 8). This data shows an increase in the number of TAY served across the two years (78 to 88 TAY) and adults served (424 to 495 adults) between FY 2016/17 and FY 2017/18. There was a decrease in the number of children served (6 to 4 children) and older adults (29 to 24) in the same period. The total number of participants increased from 537 to 611 participants in this two-year period.

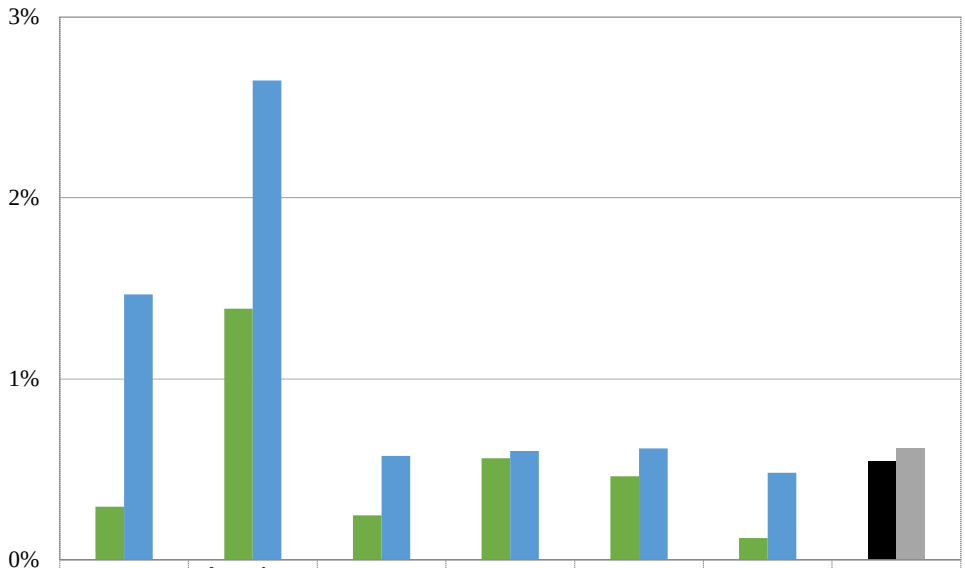
Figure 7
Nevada County Substance Use Disorder Services
<u>Penetration Rate</u> by Age
FY 2016/17 to FY 2017/18
(Population Source: 2010 Census)



	0 - 14	15 - 24	25 - 59	60+	Total
FY 2016-17 # Participants	6	78	424	29	537
FY 2016-17 Penetration Rate	0.0%	0.7%	0.9%	0.1%	0.5%
FY 2017-18 # Participants	4	88	495	24	611
FY 2017-18 Penetration Rate	0.0%	0.8%	1.1%	0.1%	0.6%
Nevada County Census Population	15,113	10,530	45,121	28,000	98,764

Figure 8 shows that there was an increase in the number of clients served by SUD across all race/ethnicities. Black/African American clients increased from 1 to 5, American Indian/Alaskan Native clients from 11 to 21, Asian/Pacific Islander clients from 3 to 7, White/Caucasian clients from 480 to 514, Hispanic clients from 39 to 52, and Other/Unknown races from 3 to 12.

Figure 8
Nevada County Substance Use Disorder Services
<u>Penetration Rate</u> by Race/Ethnicity
FY 2016/17 to FY 2017/18
(Population Source: 2010 Census)



	Black/ African American	American Indian/ Alaskan Native	Asian/ Pacific Islander	White/ Caucasian	Hispanic	Other/ Unknown	Total
FY 2016-17 # Participants	**1**	**11**	**3**	**480**	**39**	**3**	**537**
FY 2016-17 Penetration Rate	**0.3%**	**1.4%**	**0.2%**	**0.6%**	**0.5%**	**0.1%**	**0.5%**
FY 2017-18 # Participants	**5**	**21**	**7**	**514**	**52**	**12**	**611**
FY 2017-18 Penetration Rate	**1.5%**	**2.6%**	**0.6%**	**0.6%**	**0.6%**	**0.5%**	**0.6%**
Nevada County Census Population	**341**	**793**	**1,220**	**85,477**	**8,439**	**2,494**	**98,764**

11. Drug Medi-Cal population

Figure 9 shows the percentage of Medi-Cal Enrollees who accessed SUD services in FY 2017/18. From this data, a penetration rate was calculated, showing the percent of persons who are Medi-Cal Enrollees who received SUD services in FY 2017/18. This data is shown by age, race/ethnicity, and gender.

There were 492 Medi-Cal participants who received one or more SUD service in FY 2017/18. Of these individuals, 3.5% were children; 12.8% were TAY; 82.7% were adults; and 1.0% were older adults. There were 85.0% of the participants who were Caucasian, and 8.5% who were Hispanic. All other race/ethnicity groups represented a small number of individuals. The majority of participants were males (60.2%) compared to females (39.6%).

The penetration rate data shows that 2.1% of the Nevada County Medi-Cal Enrollees received SUD services, with 492 individuals out of the 23,679 Medi-Cal Enrollees. Of these individuals, children had a penetration rate of 0.3%, TAY had a penetration rate of 3.0%, adults had a penetration rate of 3.1%, and older adults had a penetration rate of 0.3%.

For race/ethnicity, persons who are Caucasian had a penetration rate of 2.3%, and persons who are Hispanic had a penetration rate of 1.6%. All other race/ethnicity groups represented a small number of individuals. Males had a penetration rate of 2.6%, and females had a penetration rate of 1.6%.

Figure 9
Nevada County Medi-Cal Substance Use Disorder Penetration Rates
by Gender, Age, and Race/Ethnicity
(Medi-Cal Enrollees Source: Kings View Penetration Report FY2017/18)

	Nevada County Average Number of Enrollees FY 2017/18		Number of Medi-Cal Substance Use Participants Served FY 2017/18		SUD Medi-Cal Penetration Rate FY 2017/18
Age Group					
Children (0 – 17)	6,487	27.4%	17	3.5%	17 / 6,487 = 0.3%
Transition Age Youth (17 – 24)	2,088	8.8%	63	12.8%	63 / 2,088 = 3.0%
Adults (25 – 64)	13,165	55.6%	407	82.7%	407 / 13,165 = 3.1%
Older Adults (65+)	1,939	8.2%	5	1.0%	5 / 1,939 = 0.3%
Total	**23,679**	**100.0%**	**492**	**100.0%**	**492 / 23,679 = 2.1%**
Race/Ethnicity					
Black/ African American	138	0.6%	3	0.6%	3 / 138 = 2.2%
American Indian/ Alaskan Native	181	0.8%	17	3.5%	17 / 181 = 9.4%
Asian/ Pacific Islander	270	1.1%	6	1.2%	6 / 270 = 2.2%
White/ Caucasian	18,093	76.4%	418	85.0%	418 / 18,093 = 2.3%
Hispanic	2,671	11.3%	42	8.5%	42 / 2,671 = 1.6%
Other/ Unknown	2,326	9.8%	6	1.2%	6 / 2,326 = 0.3%
Total	**23,679**	**100.0%**	**492**	**100.0%**	**492 / 23,679 = 2.1%**
Gender					
Male	11,451	48.4%	296	60.2%	296 / 11,451 = 2.6%
Female	12,228	51.6%	195	39.6%	195 / 12,228 = 1.6%
Other/ Unknown	-	0.0%	1	0.2%	-
Total	**23,679**	**100.0%**	**492**	**100.0%**	**492 / 23,679 = 2.1%**

12. Analysis of disparities in Drug Medi-Cal participants

The penetration rate for persons with Medi-Cal is similar to the penetration rates among all participants. TAY and adults have similar penetration rates. The penetration rate for Race/Ethnicity is difficult to analyze for the diverse communities because of the small numbers in each racial group. The higher penetration rate for males (2.6%) compared to females (1.6%) is consistent across the state. The majority of SUD clients have Medi-Cal (80.5%).

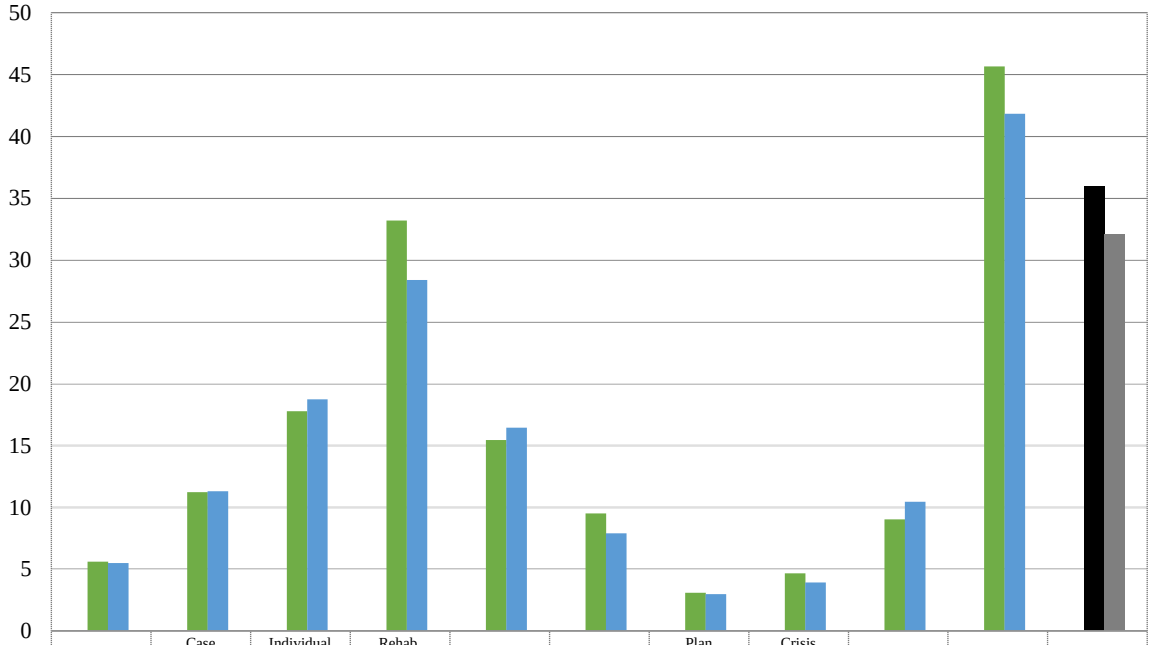
B. Utilization of Mental Health and Substance Use Disorder Services

Figure 10 shows the total number of hours, by type of mental health service, participants, and hours per participant for FY 2016/17 and FY 2017/18. This data shows that the 2,029 mental health participants received 65,055 hours of services in FY 2017/18, which calculates into 32.1 hours per participant. This data also shows the number of participants and average hours for each type of service. Participants can receive more than one type of service. Not all participants received all services. The number of participants varies by type of service.

This data shows that each participant averaged 32.1 hours of services in a year. This is nearly 3 hours per month for 12 months, which clearly shows the intensity of services for participants.

In FY 2017/18, participants who received an assessment averaged 5.5 hours; case management averaged 11.3 hours; individual therapy: 18.7 hours; rehabilitation: 28.4 hours; ICC/IHBS: 16.5 hours; collateral: 7.9 hours; plan development: 3.0 hours; crisis intervention: 3.9 hours; medication management: 10.5 hours; and group: 41.8 hours. This data shows that over 50% of all clients received a crisis intervention service. This may be an opportunity to look more closely at the types of crisis services, and if they are opportunities to provide additional services to reduce the need for crisis intervention.

Figure 10
Nevada County Mental Health Services
Total Mental Health Hours, Participants, and Hours per Participant
per Year, by Service Type
All Mental Health Participants
FY 2016/17 to FY 2017/18

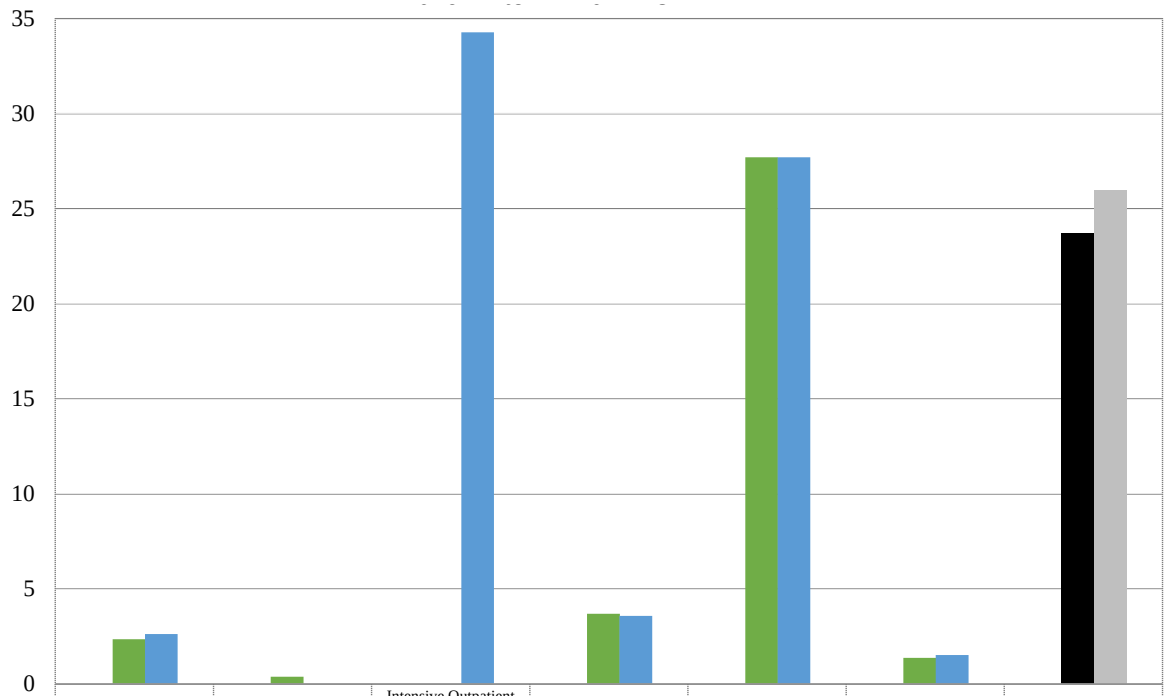


	Assessment	Case Management	Individual Therapy	Rehab. Individual	ICC/ IHBS	Collateral	Plan Development	Crisis Intervention	Medication	Group	Total FY
# Hours FY 2016-17	4,264	12,384	11,972	14,111	448	5,079	2,408	4,314	7,303	10,232	72,513
# Participants FY 2016-17	761	1,102	673	425	29	534	776	925	809	224	2,019
Avg Hrs/Part FY 2016-17	5.6	11.2	17.8	33.2	15.4	9.5	3.1	4.7	9.0	45.7	35.9
# Hours FY 2017-18	3,779	12,429	11,280	9,799	1,481	3,496	1,894	4,049	7,642	9,206	65,055
# Participants FY 2017-18	687	1,100	602	345	90	442	635	1,030	731	220	2,029
Avg Hrs/Part FY 2017-18	5.5	11.3	18.7	28.4	16.5	7.9	3.0	3.9	10.5	41.8	32.1

Figure 11 shows the total number of hours, by type of Substance Use Disorder treatment service, participants, and hours per participant for FY 2016/17 and FY 2017/18. This data shows that the 611 substance use treatment participants received 15,850 hours of services in FY 2017/18, which calculates into 25.9 hours per participant. This data also shows the number of participants and average hours for each type of service. Participants can receive more than one type of service. Not all participants received all services. The number of participants varies by type of service.

In FY 2017/18, participants who received an assessment averaged 2.6 hours; case management: 0.0 hours; intensive outpatient: 34.3 hours; individual: 3.6 hours; group: 27.7 hours; and crisis intervention: 1.5 hours. Most participants received assessment, individual, and group services.

Figure 11
Nevada County Substance Use Disorder Services
Total Substance Use Hours, Participants, and Hours per Participant per Year, by Service Type
All Substance Use Participants
FY 2016/17 to FY 2017/18



	Assessment	Case Management	Intensive Outpatient Treatment	Individual	Group	Crisis Intervention	Total FY
# Hours FY 2016-17	736	3	-	1,398	10,527	54	12,717
# Participants FY 2016-17	312	7	0	378	380	39	537
Avg Hrs/Part FY 2015-16	2.4	0.4	0.0	3.7	27.7	1.4	23.7
# Hours FY 2017-18	918	-	1,371	1,487	12,023	52	15,850
# Participants FY 2017-18	349	0	40	415	434	34	611
Avg Hrs/Part FY 2017-18	2.6	0.0	34.3	3.6	27.7	1.5	25.9

C. An analysis of the population assessment and utilization data, and conclusions drawn

This data shows that there is a slight (0.5%) increase in the number of persons receiving mental health services across the two-year period and a decrease in the average number of hours per person. For mental health services, the total number of hours of services decreased from 72,513 hours to 65,055 hours, and the average hours per participant decreased from 35.9 hours per participant to 32.1 hours per participant. However, compared to data in other counties on the average hours per participant, Nevada County participants still receive a high number of hours per participant per year. However, the high proportion of the participants receiving a crisis service (50.8%) is high. Further analysis of this data by age, race/ethnicity, and gender will provide additional information on who is receiving crisis services.

For SUD services, there is a 13.7% increase in the number of persons receiving services and a slight increase in the average number of hours per person., from 23.7 hours per person to 25.9 hours per person.

III. MEETING CULTURAL AND LINGUISTIC PROFICIENTY 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

We strive to incorporate discussions of delivering culturally-relevant services into our monthly staff meetings and weekly team meetings, as well as during clinical and staff supervision. We take advantage of any regional and/or state training offered on promoting and delivering culturally-relevant services. We treat each participant as an individual, with many different needs and cultures. In addition to delivering services in the person's preferred language and utilizing bicultural staff whenever possible, we also understand that age, health, gender, community, and lifestyle have an important role in meeting the individual needs of each participant. It is also important to note that these needs may change over time, and staff must be sensitive to different needs as they may change.

Our biggest challenge is in hiring bilingual, bicultural staff to provide services to our Hispanic communities. We currently have five (5) staff persons who speak Spanish, and one (1) speaks Russian. In addition, three (3) of our psychiatrists are bilingual and bicultural. One speaks Chinese, one Vietnamese, and one Thai. Unfortunately, none of our psychiatrists speak Spanish.

In our MSHA Plans, we have repeatedly identified the need to hire additional staff that are bilingual and bicultural throughout our organization. We have been successful in developing a contract with consumers to develop the Spirit Peer Empowerment Center, a consumer run program which offers Peer to Peer Counseling. We have also contracted with local Family Resource Centers who have *Promotora* Programs. The *Promotora* is an individual who is Hispanic, bilingual and bicultural, and is a health educator. The *Promotora* provides outreach and engagement services to the Hispanic community, help improve access to services, and support staff in delivering culturally sensitive services.

We are also looking to find relevant, comprehensive training in delivering culturally and linguistically proficient services to our participant community. Any technical assistance in identifying and delivering training in this region would be very helpful.

In our MHSA CSS Plan, PEI Plan, Innovation Plan, and WET Plan, we have outlined specific outreach and engagement activities to improve access for persons who are Hispanic, LGTBQ, TAY, Older Adults, Homeless, persons with co-occurring disorders, and veterans.

Qualified bilingual staff receive a stipend. In order to receive this differential pay, employees must demonstrate proficiency in the second language that is administered through a test conducted by our Nevada County Human Resources Department. The individual is also required to spend a targeted percentage of their time providing bilingual services to qualify for this stipend. In addition to our five (5) Spanish speaking staff, we also contract with persons who are Hispanic in both Grass Valley and Truckee, to provide services in a person's primary, and preferred, language. Our PEI funding is utilized to contract

with the Truckee Family Resource Center, Hennessy School Family Resource Center, and with the Sierra Family Services in Truckee to expand services to the Hispanic community.

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

NCBH utilizes the Sierra Mental Wellness Group (SMWG) for its crisis line. Individuals who staff this 24/7 Access Line are trained to be familiar with the culturally-proficient services that we offer, and are able to provide interpreter services or link participants to language assistance services as needed.

The Nevada 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 participants of their right to FREE language assistance, including the availability of interpreters. This brochure is provided to participants at intake, and is also available at our clinics and wellness centers throughout the county.

A *Provider List* is available to participants which lists provider names, population specialty (children, adult, veterans, LGBTQ, etc.), services provided, language capability, alternative options, and whether or not the provider is accepting new participants. This list is provided to participants upon intake and is available at our clinics and the wellness center. The Provider List is updated regularly.

In addition, NCBH uses the following informal mechanisms to inform participants and potential participants of culturally proficient services and providers:

- NCBH Website and partner websites
- NCBH Facebook page and partner social media sites
- NCBH informal brochures and rack cards identifying available services and how to access them for targeted groups such as TAY, older adults, and persons who are Hispanic.
- 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

In the past, we have had difficulty in hiring bilingual, bicultural staff, especially licensed clinicians, nurses, and psychiatrists. We have recently been able to hire bilingual staff, and we also have an individual who is bilingual and lives in the Truckee area.

Qualified bilingual staff receive an hourly pay differential, if they meet a targeted percentage of time providing Spanish services. In order to receive this differential pay, employees must demonstrate proficiency in the second language and meet the percent of time in providing

services in Spanish. Currently, the county Department of Human Resources conducts a language and written proficiency exam to qualify the individual as bilingual.

D. Describe the process for reviewing grievances and appeals related to cultural and linguistic proficiency; 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 proficiency. The QIC reviews all issues and determines if the resolution was culturally appropriate. The QIC and CLP Committees work together, as many members are on both committees. The QIC committee meets monthly and the CLP Committee meets bi-monthly resulting in alternating months and therefore can identify additional issues and objectives to help improve services during the coming year.

In addition, NCBH has a policy and form to allow individuals 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

NCBH staff by function:

- Director: Caucasian
- Medical Director: Caucasian
- Behavioral Health Program Manager (3.0 FTE): Caucasian
- Clinical Staff: 31 Caucasian, 2 Hispanic, 1 Asian/Pacific Islander
- Senior Account Clerk: Caucasian
- Administrative Assistant (1.0 FTE): Caucasian
- SUD Program Manager: Caucasian
- MHSA Program Specialist (1.0 FTE): Indian

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

According to the Staff and Volunteer Ethnicity and Cultural Proficiency Survey (N=94), 14 respondents are bilingual. Eight (8) respondents speak Spanish and six (6) respondents are proficient in reading and writing Spanish.

3. Staff and Volunteer Ethnicity and Cultural Proficiency Survey

In an effort to assess the cultural awareness of our workforce, we asked staff to complete the Staff and Volunteer Ethnicity and Cultural Proficiency Survey in November 2018. The complete results are shown in Attachment A.

There were 94 persons who completed the survey. This included staff from both county programs and organizational providers. Of these individuals, 65% were direct service staff and 35% were administration and management staff. Of the survey respondents, 77% were Caucasian, 2% were American Indian or Alaska Native, 4% were Native Hawaiian or Other Pacific Islander, 2% were Asian, 12% were Hispanic, and 3% were more than one race. Fifteen percent (15%) of staff identified as bilingual and 3% act as interpreters as part of their job function. Twenty-seven percent (27%) of staff reported that they are consumers, and 34% are family members of a consumer. Seventy-three percent (73%) of respondents are female. For sexual orientation, 88% are heterosexual, 5% are gay/lesbian, and 7% are bisexual.

The survey response options included Almost Always; Often; Sometimes; and Almost Never.

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

Across all respondents:

- I examine my own cultural background and biases (race, culture, sexual orientation) and how they may influence my behavior toward others (Almost Never=2%).

- I intervene, in an appropriate manner, when I observe other staff exhibit behaviors that appear to be culturally insensitive or reflect prejudice (Almost Never=4%).

- I attempt to learn a few key words in the participant's primary language (Almost Never=5%).

- I have developed skills to utilize an interpreter effectively (Almost Never=35%).

- I utilize different methods of communication to help improve communication with consumers and family members (Almost Never=14%).

- I communicate in a style and reading level that can be easily understood by consumers and family members (Almost Never=1%).

There was also a question about participation in cultural awareness activities over the past six (6) months. The responses will be reviewed by the CLP Committee over the next few months to discuss any signification findings from the responses. One of the key findings that was identified by this survey is the need to provide several trainings that focus on cultural awareness. All staff will be encouraged to complete the survey again to determine if there are changes in responses.

B. Analyze staff disparities and related objectives

NCBH strives to hire staff members who at least reflect the cultural diversity of our county. This goal has been extremely difficult for several reasons. For future positions at NCBH, a priority will be placed on hiring more persons who are Hispanic. NCBH now has five (5) bilingual clinicians.

The diversity of our workforce is not equal to our participant population or our general population. As a result, we will continue to identify opportunities to recruit and retain bilingual, bicultural staff. To achieve this objective, it is our goal to have the department's employee demographics be representative of our participant 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. 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.

NCBH 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 regional and/or state trainings offered on promoting and delivering culturally-relevant services.

We treat each participant 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 participant. As circumstances and needs change over time, staff is sensitive to evaluating and implementing services that best fit the participant at any given time.

NCBH has designated Yvonne Foley-Trumbo as the county's Cultural Proficiency/Ethnic Services Manager. This individual is responsible for promoting mental health services that meet the needs of our diverse population. She promotes the delivery of culturally sensitive services and provides leadership and mentoring to other staff on cultural proficiency related issues. The Cultural Competency/Ethnic Services Manager 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 within the county.

Our Cultural and Linguistic Proficiency Committee is a cross-agency and community committee that has representatives from mental health, alcohol and drug, public health services, and community organizations. Committee members are representative of our county's general population. Membership is comprised of 20 members: seventeen (17) Caucasians, two (2) Hispanics and one (1) Indian; fifteen (15) adults ages 26-59 and five (5) seniors; three (3) persons from the LGBTQ community; and five (5) males and fifteen (15) females.

The members of the CLP Committee represent several organizational providers, community members, and consumers, and staff from Health and Human Services. In addition, there are members serving on both the Mental Health Board and the CLP Committee. Working closely together, the committee will review data, organize culturally relevant activities and trainings that promote healing through engagement of one's cultural background. At the last committee meeting, several items were reviewed and suggestions made to increase services to elders, children under 5 years old, LGBTQ and geographically isolated persons. All minutes of the meetings are shared with NCBH 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 PROFICIENCY (2017/2018)

This section describes cultural proficiency training for staff and contract providers, including training in the use of interpreters, in FY 2017/18.

A. List of Cultural and Linguistic Competence Trainings

Training Event	Description of Training	Number of Attendees	Date
LGBTQIA+ Training	Specific to working with LGBTQIA+ clients	12	7/7/2017
LGBTQ Clients	Specific to working with LGBTQIA+ clients	6	8/10/2017
Advanced Motivational Interviewing: Continuing the Journey	Training staff on advanced Motivational Interviewing techniques	3	9/14/2017
Law & Ethics Training	Training staff on laws and ethics in the field of Behavioral Health	106	9/27/2017
Bridges out of Poverty	Educating staff on relating to individuals in poverty	1	10/12/2017
Providing Safe and Supporting Homes for LGBTQ Youth	Specific to working with LGBTQ youth	1	10/13/2017
Adolescent Substance Use Disorder Treatment Summit	Specific to working with youth with substance use disorder	1	11/8/2017
Zero to Three Annual Training	Specific to working to ensure the well-being of children ages three and under	2	11/28/2017
Transgender Care Training	Specific to working with transgender clients	50	11/30/2017
Motivational Interviewing	Training staff on Motivational Interviewing techniques	3	12/7/2017
Sexual Exploitation	Specific to working with clients who have experienced sexual exploitation	1	1/12/2018
Comorbidity of Personality Disorders, Homelessness, and Substance Abuse	Specific to working with clients with co-occurring diagnoses who are homeless or at-risk of homelessness	2	1/16/2018

Training Event	Description of Training	Number of Attendees	Date
Applied Suicide Intervention Skills Training (ASIST)	Intervention techniques for specific situations where someone is suicidal	1	2/3/2018
ACEs Training	Specific to working with clients with Adverse Childhood Experiences	10	2/272018
WRAP Trainings	Training staff on facilitating effective WRAP plans for clients	21	3/9/2018
Applied Suicide Intervention Skills Training (ASIST)	Intervention techniques for specific situations where someone is suicidal	2	3/20/2018
National Adoption Competency Mental Health Training	Specific to working with children in foster, adoptive or guardianship families	1	4/13/2018
Trauma Informed Care Training	Educating and training staff on Trauma-Informed Care for clients and ACEs	231	4/20/2018
LGBTQ Access	Specific to increasing access to services for LGBTQIA+ clients	1	5/1/2018
ACEs Training	Specific to working with clients with Adverse Childhood Experiences	13	5/4/2018
California Mental Health Advocates for Children & Youth Conference	California Mental Health Advocates for Children & Youth	1	5/15/2018
Substance Abuse Research Consortium: Addiction and Motivational Interviewing Training	Training for staff working with clients with Substance Use Disorders	9	6/6/2018
LGBTQ Clients - Clinical Issues & Strategies for Youth and Adults	Specific to working with LGBTQ youth	3	6/6/2018

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 and linguistic proficiency training and discussions in our weekly staff meetings. NCBH 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.

A training plan is being developed to learn how to navigate the person's culture and broader community and support system. 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 participants as an option for helping manage risk. Staff will be aware that accepting a participant's perspective in healing practices will increase the likelihood the participant will engage in psychiatry.

Future evidence-based, promising and community-defined 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 that 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. This will include training 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 staff have attended.

ATTACHMENT A: ETHNICITY AND CULTURAL COMPETENCE SURVEY RESULTS