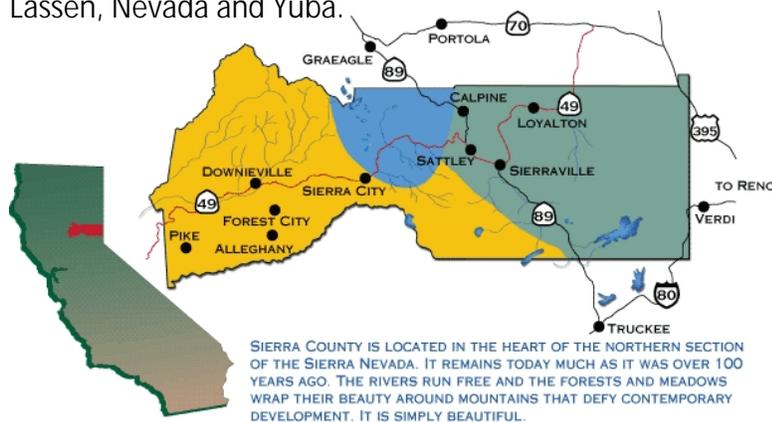


SIERRA COUNTY CULTURAL COMPETENCY PLAN UPDATE

2017-2018

Sierra County is the second least populated county in the State of California. In the summer months, Sierra Valley supports more cattle than the total number of Sierra County residents. Considered a “*Frontier County*”, because of remoteness and population density, Sierra County has no stoplights, fast food restaurants, movie theaters, traditional public transportation systems, hospitals, or shopping centers. Most communities are geographically isolated from services and other communities. The county is bisected by the Sierra Nevada Mountain range, one pass (Yuba Pass, elevation 6,701 ft.) provides access between the east and west side communities. Harsh weather and mountain driving conditions make travel during the winter months treacherous and dangerous.

Sierra County shares a border with the State of Nevada. Neighboring counties are Plumas, Lassen, Nevada and Yuba.



Commitment to Cultural Competence

Goal I: Enhance the community's social and emotional well-being through collaborative partnerships.

Strategy 1: Create partnerships that advance an effective model of integration of mental health, physical health, and substance abuse services to achieve parity in the context of health care reform.

Sierra County is taking steps to integrate the models of mental health, physical health, and substance abuse services. Recently the Mental Health department merged with the Substance Use Disorder's department to form the Behavioral Health Department which reflects current State unification of the two departments into the Department of Health Care Services. In the process of integrating the SUD department, Sierra County Behavioral Health recognizes the need to revise the current mission statement. Additionally, the Mental Health Advisory Board will need to be restructured to encompass the following: Mental Health, Substance Use Disorders, Mental Health Services Act, and Cultural Competency. There is a current proposal to change the name of the board to Behavioral Health Advisory Board. This merger strengthens the services provided by sustaining health equity within Sierra County communities.

With the lack of medical resources in Sierra County, residents fall into the underserved category in regards to physical health. Due to the remote frontier geography of Sierra County, there are no major medical services available. Residents can access two satellite clinics (provided by out of county entities) housed on either side of the county. These clinics offer a basic level of care, on a part-time basis.

As such, Sierra County Behavioral Health is collaborating with Eastern Plumas Health Care on the eastern side of the county to integrate the whole person care model through Behavioral Health. This new collaboration improves access to physical health care for the severe mentally ill population, as well as facilitating bi-lateral referrals for the care of the mild to moderate mentally ill populations. Sierra County Behavioral Health further recognizes the importance of integrating the health care model into wellness and recovery throughout the entire county. Thus, Sierra County Behavioral Health plans to advocate for collaboration with Western Sierra Medical Clinic on the western side of the county, within 18 months. Achieving parity of services for community members throughout the county will be challenging, due to collaborating with two distinct and separate out of county medical facilities tasked with their own regulations and governances.

Strategy 2: Create, support and enhance partnerships with community based organizations in natural settings such as park and recreational facilities to support the social and emotional well-being of communities.

Providing services to Sierra County's small population is challenging due to the intra-connectedness within communities, as well as, the inter-relationships and inter-connectedness which occur throughout the county as a whole. Dual relationships, along with a lack of anonymity, are a distinctive norm community members of Sierra County live and deal with on a

day to day basis. Thus, providing specific programs focusing on an under-represented, minority population inadvertently creates profiling of the population Sierra County Behavioral Health is seeking to serve. For example, a youth seeking services does not feel comfortable receiving services in a group setting because they can be identified, have a current or have had a previous relationship with the other youth receiving services or the facilitator of the service. More likely than not, there are familial ties to the youth and one or more of those individuals involved in receiving or providing the service. Once the service has a 'label' or a specific identified outcome, the youth attending have been profiled. Sierra County's community defined best practices, based on the challenges above; indicate building trust while participating in a universal or selective service strategy resulting in warm referrals is most successful.

As such the Sierra County Wellness Center in collaboration with Sierra County Public Health implemented a new universal "Front Porch" Program. The "Front Porch" program is designed to provide outreach and support to isolated community members. Peer Support staff and Community Outreach Coordinators conduct activities in geographically isolated communities which provides education on different services provided, as well as wellness and recovery (social and emotional well-being of communities).

One such culminating activity provided by the "Front Porch" program, is a weekly community walk. This motivating community walk highlights the benefits of exercise, community socialization, as well as the natural setting of the Alpine valley to support the emotional well being of the participants and community members. When the weather is permitting, this walk was conducted every Friday during the lunch hour on the East side of the county and when feasible on the West side of the County. By promoting this community outreach collaboration, Sierra County Behavioral health is able to provide services to promote health and wellness without further stigmatizing our small population.

Sierra County Behavioral Health will continue to look for community based organizations to further collaborate with to support social and emotional wellbeing within our communities. Over the next three years, the Wellness Center in collaboration with Sierra County Public Health will continue to expand the current Front Porch Program. This expansion will include the development of additional activities to take place in natural and recreational settings.

Goal II: Create and enhance culturally diverse, client and family driven, mental health workforce capable of meeting the needs of our diverse communities.

Strategy 1: Train mental health staff in evidence-based, promising, emerging and community-defined mental health practices.

Currently the Behavioral Health agency offers several different evidence based trainings for the staff. Prevention will continue to offer Mental Health First Aid. Mental Health First Aid is a course designed to help staff learn the risk factors and warning signs for addiction and mental health concerns. This training outlines action plans for someone in either crisis or non-crisis situations.

Additionally, the Workforce Education and Training will provide training in the evidenced based practice of Motivational Interviewing. This training will provide knowledge of the concepts of Motivational Interviewing and how to use MI to create a culturally responsive and trauma-informed approach to care. Additionally, the four key elements of MI (partnership, acceptance, compassion, and evocation), lay the foundation for client driven practice across diverse community populations.

The Sierra County Community Academy will continue to provide evidenced based culturally competent training to staff, professionals, as well as community members. 'Community Academy' activities provide a universal service strategy, reaching community populations, to address Outreach and Engagement objectives. Historically, Community Academies have been successful in Sierra County as a venue to provide one day workshops featuring appropriate and knowledgeable speakers addressing relevant behavioral health topics. A follow-up 'Bridges out of Poverty' workshop will be offered as a result of stakeholder interest in continuing to learn about strategies to improve relationships between different cultures and communities, along with reducing barriers to participating in behavioral health services. Cultural Proficiency will continue to be address through the Community Academy venue. Approximately four Community Academy activities will be offered as identifies through community defined practices.

Strategy 2: Recruit, train, hire and support mental health clients and family members at all levels of the mental health workforce.

In efforts to recruit, train, hire and support mental health clients and family members, Sierra County Behavioral Health with the use of the Mental Health Services Act piloted the Sierra County Wellness Center. The Sierra County Wellness Center is peer run to support wellness and recovery goals for people living with mental illness and their families. The Sierra County Wellness Center's staff is made up of peer with lived, personal experience. Peer Support Specialists are available to provide support, education, advocacy and hope to individuals during their unique wellness and recovery path. Additionally, the Wellness Center provides Whole Person health support through education classes, peer support, life skills, community building, art and other activities which support wellness, recovery and resiliency.

Furthermore, Sierra County Behavioral Health is strongly committed to recruit, train, hire and support mental health clients and family members across all levels of the workforce. Unfortunately, due to the small population, identifying which positions within Behavioral Health would be a violation of HIPAA (Health Insurance Portability and Accountability Act). Identifying which positions were/are former clients or family members of clients will violate confidentiality. Therefore, in efforts to demonstrate Sierra County's efforts to hire clients and

family members, a poll was developed to collect data. As shown in Table One, 12 Behavioral staff members were polled. 8 staff members reported that they were former clients or had a family member who accessed services, while 2 staff members did not. Additionally, two staff members declined to state

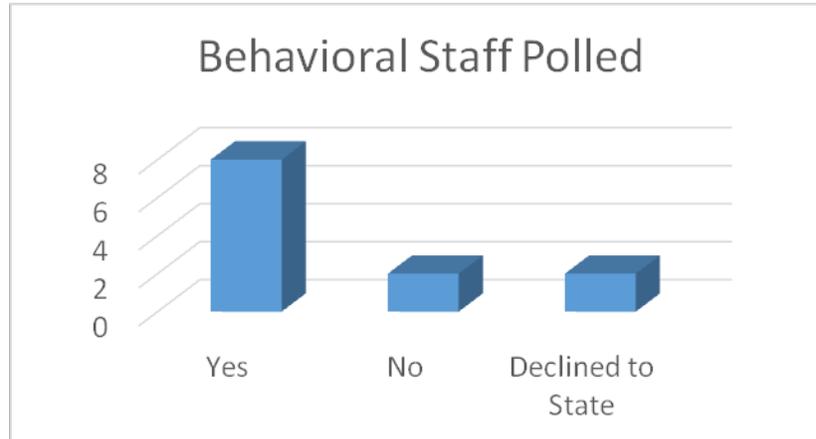


TABLE ONE

Updated Assessment of Service Needs

According to the 2010 Demographic Profile Data from the U.S. Census Bureau, Sierra County’s total population is 3,240 persons, as indicated in Attachment A- Profile of General Population.

Table Two shows Sierra County’s populations divided by race. There are 2,855 persons reported as white only, five African American/Black persons, 41 American Indian/Alaska Native persons, 12 persons reported as Asian only, 269 persons indicated as Hispanic/Latino and 56 persons indicated as some other race. These statistics were located in the 2010 Demographic Profile Data from the U.S. Census Bureau.

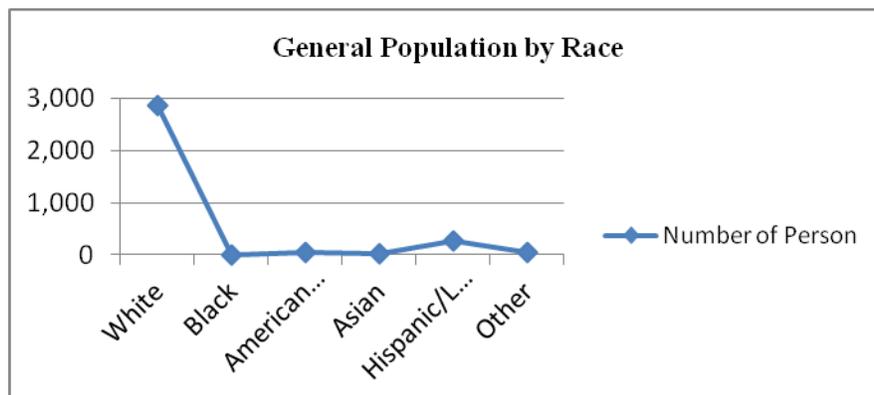


TABLE TWO

The information provided for Sierra County’s 200% poverty population was located in Department of Mental Health’s website: <http://www.dmh.ca.gov/News/Report> . Sierra

County’s client utilization data was compiled by the Department of Mental Health’s Information Technology Web Services (ITWS). The data being used for Sierra County’s 200% poverty population is the 2007 Severe Mental Illness (SMI) Prevalence Rates. The data being used for Sierra County’s client utilization is the fiscal year 2007-2008 Medi-Cal client data. Sierra County gained access to this information in June of 2011.

According to the data that was presented in the 2007 Severe Mental Illness (SMI) Prevalence Rates (Attachment B- Poverty Rates for Sierra County), 83 people were indicated to be persons with mental illness who are below the 200% poverty rate. This data indicates that about 2.5% of Sierra County’s general population fit into this category.

Table three compares Sierra County’s 200% poverty level population with the client utilization rates categorized by race/ethnicity. The second set of bars, located under the Other data, indicates the Hispanic/Latino Data. The set of bars above the White data is Native American/Alaskan Native data.

As shown in Table three, 70 White persons, one Native American/Alaskan Native person, 10 Hispanic/Latino persons, and one person in the Other category are projected to be at 200% poverty level in Sierra County. Sierra County’s client utilization data reports that eight White persons received services, with a difference of 62 White individuals. One Native America/Alaskan Native person received services, which is also the amount determined by the 2007 SMI Prevalence Rate. One person who was categorized as Other received services, which is in alignment with the projected 200% poverty level population estimate. No persons from the Hispanic or Latino population received services and the 200% poverty level indicated that there would be ten persons. This information clearly indicates a need. There were no persons from the African American population that received services no were there any persons/cases from the African American population indicated in the 200% poverty level population.

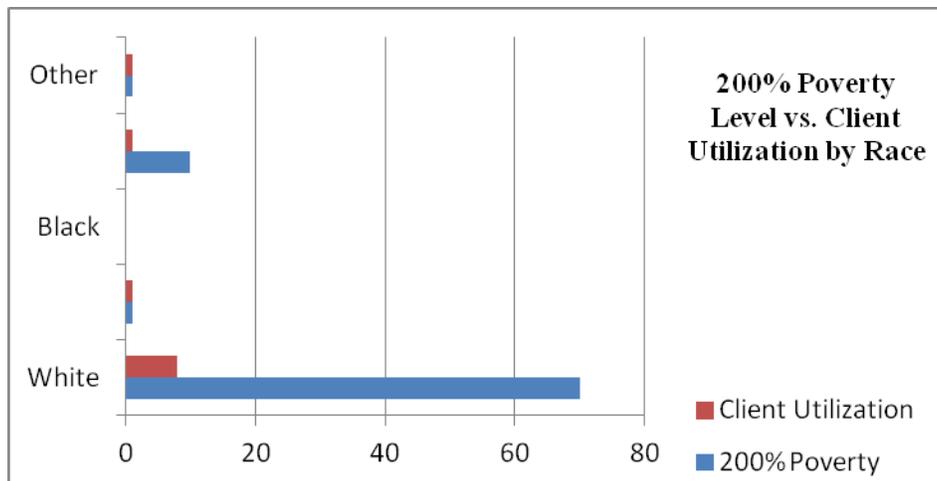


TABLE THREE

Table four compares Sierra County’s 200% poverty level population with the client utilization rates, categorized by age. The specific age brackets are indicated below in Table four, nine age brackets total.

Of the total persons indicated as the 200% poverty level population in Sierra County, 22% of the persons are within the age bracket of 0-17 years old. 73% of the total persons indicated for the 200% poverty level population are in the 18-64 years old age bracket and 0.05% of the persons indicated are 65 years and older. As shown in Table four, the differences listed between the 200% poverty level population data and the client utilization data is quite alarming. The age group that indicated the largest need within the 200% poverty level population was persons between the ages of 25-44. The projected number of the persons in this category for the 200% poverty level was 29 and only five persons in this age bracket received services. The data that presents the most similar information is the age bracket of 18-20 year old. The 200% poverty level population was listed as two and one person in this age bracket received services.

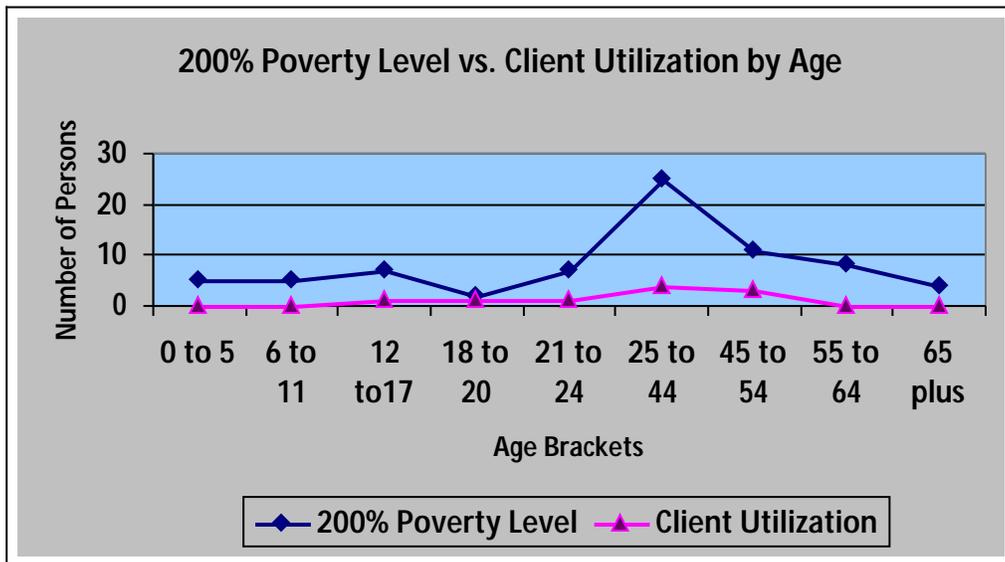


TABLE FOUR

Table five compares Sierra County 200% poverty level population with the client utilization rates, categorized by gender. Sierra County’s general population is 49% female and 51% male. Table five shows that the 200% poverty level population includes 38 males and 46 females. Only one male and nine females were served by Sierra County’s Behavioral Health Systems of Care. This indicates that about only 3% of males are obtaining services within the 200% poverty level population, whereas 20% of females are obtaining services within the 200% poverty level population.

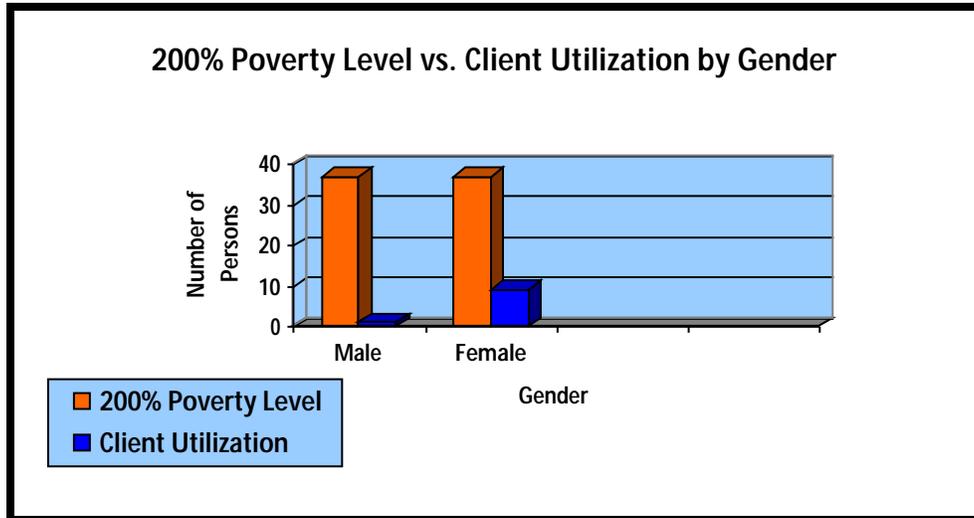


TABLE FIVE

There are three disparities that become visible when comparing Sierra County's 200% poverty level population with the client utilization rates within Sierra County's Behavioral Health System of Care. First, the data indicates that Sierra County Behavioral Health has the potential to be underserving the following race/ethnic groups: the Hispanic/Latino population and the White population. No persons from the Hispanic/Latino population received behavioral health services, although there were 10 persons indicated in the 200% poverty level population. The 200% poverty level indicated that 70 White persons would need services, although only eight persons from this population received services. This identifies a need of 62 people.

The disparity of serving the Hispanic/Latino population will be discussed in terms of possible reasons and potential solutions. The lack of linguistic capacity and cultural proficiency in the Sierra County Behavioral Health System of Care could be one of the leading causes for this noted disparity. The cultural and community cohesiveness in the mentioned population group may be reasoning for this disparity. Lack of community understanding and trust in the county's behavioral health services may be another reason for this disparity. Also, the lack of intentional outreach and engagement that occurs between Sierra County Behavioral Health and the noted population could be reasoning for this disparity.

One potential solution to decrease and/or eliminate this noted disparity would be to continuously train and educate current Behavioral Health staff on cultural proficiency, specifically for Hispanic/Latino populations. Coordination with a cultural broker, within these cultures, to help build trust and conduct outreach would prove to be beneficial in decreasing or eliminating this disparity. Another potential solution to decrease/eliminate this disparity would include translation of all forms, posters, educational material into primary languages other than English.

The disparity of serving the White population, within the 200% poverty level, will be discussed in terms of possible reasons and potential solutions. Lack of community understanding and trust in the county's Behavioral Health services may be a main reason for this disparity. The

lack of intentional outreach and engagement that occurs between Sierra County Behavioral Health and the 200% poverty level population could also be reasoning for this disparity. The lack of cultural proficiency in Sierra County Behavioral Health could be another reason that persons in the 200% poverty level population fail to ask and receive services.

Potential solutions to decrease and/or eliminate this noted disparity will be discussed at the end of this section, as it pertains to decreasing and/or eliminating any disparity within the 200% poverty level population.

Secondly, the data indicates that Sierra County Behavioral Health has the potential to be underserving adults in regards to behavioral health services within the 200% poverty level population. The 200% poverty level population indicates that 29 persons within this age bracket would need services; yet, only five persons received services. According to the 2007 SMI Prevalence Rate, 18 persons within the ages of 34-44 in Sierra County would need services. There were no individuals within this specific age bracket that obtained services, per the client utilization data. This comparison of numbers indicates that there is a large need for services that are not being provided effectively.

Stigma of being served by the Behavioral Health Department may be one reason for this disparity. The lack of community understanding and trust in the county's behavioral health services could be another reason for this disparity. The overall lack of outreach and engagement with adults in Sierra County could be yet another reason for this disparity.

One potential solution to decrease and/or eliminate this noted disparity would be to continue intentional outreach and education of services to the adult population within Sierra County. Coordination with a trusted broker who could assist Sierra County Behavioral Health in establishing a trusting relationship and engaging adults could also be a potential solution to decreasing and/or eliminating this disparity.

Lastly, the data indicates that Sierra County Behavioral Health has the potential to be underserving, or inappropriately serving, the entire population within the county, regardless of gender. Table Five shows that the 200% poverty level population includes 38 males and 46 females, with only 3% and 20%, respectively, obtaining services within the 200% poverty level population. These specific statistics indicate that there is a need, regardless of gender, within Sierra County for services that are not being provided.

There may be varying reasons for this indicated disparity, but the stigma of receiving services, lack of understanding and trust in the behavioral health system and lack of outreach, education and engagement, most likely are high contributing factors to this noted disparity.

One potential solution to decrease and/or eliminate this noted disparity would be to work towards decreasing the established stigma attached to receiving services with Sierra County Behavioral Health Systems of Care. Creating and implementing an anti-stigma campaign would be one option towards decreasing the stigma based around services. Conducting intentional outreach to the entire population in Sierra County would be another potential strategy to decrease and/or eliminate the stated disparity. Another potential solution would be to conduct

research on alternative methods of providing services, outside of the typical clinical appointments, to determine if any of the alternatives could be implemented within Sierra County.

Although the task of analyzing the data to locate specific disparities was completed for this section, a large disparity was overall realized. This specific information, as presented, indicates that there could potentially be an immensely large need for services, within the 200% poverty level population, that are not being appropriately provided by Sierra County's Behavioral Health.

One potential solution to decrease and/or eliminate the 200% poverty level population disparity would be to create a plan to continually educate the community members on the purpose and role of Sierra County Behavioral Health. Ensuring that the community members, persons served, and persons who would need services fully understand and are knowledgeable about the systems of care would lead the way to gaining trust and improving the image of Sierra County Behavioral Health System. An anti-stigma campaign directed at behavioral health services would be beneficial for all members of the county, as well. Intentional outreach to the 200% poverty level population found in this analysis would also be required measure for decreasing and/or eliminating the disparity. Continued education and training for the Behavioral Health staff of cultural competency and proficiency, regarding poverty and the surrounding elements, would be beneficial to ensure that employees understand and recognize the cultural aspects for treatment. In-depth training of Motivational Interviewing would offer Sierra County's Behavioral Health staff many skills and techniques to develop that could enhance services provided to the 200% poverty level population.

In analyzing the above data for Sierra County's 200% poverty level population and the client utilization rates, several limitations were noted. The first limitation presented was that the data in use was compiled in 2007 and 2007-2008. This information is the most current information that is available for counties to access in regards to 200% poverty level population and client utilization rates. Although this is the most current data available, this data could still be greatly inaccurate due to the length between the actual data collection, current trends, and changes for the year of 2017.

Another limitation with the 2007 SMI Prevalence Rates data is that the data was not broken down by language use. The previous Medi-Cal eligibility data was broken down by language use, which allowed for further analysis of the data.

Lastly, it is important to remain cautious when utilizing small sample sizes and rates calculated for small populations, as these rates may tend to be unreliable and could change drastically between years. Small county rates that are determined by formulas may not provide an appropriate representation or statistically sound information. Although the 2007 SMI Prevalence Rates provided Sierra County an idea of the 200% poverty level rates present within the county, the information obtained from this report should be viewed as simply estimates due to Sierra County's small population. This limitation could potentially skew the data presented.

Provision of Culturally and Linguistically appropriate services. Identification of disparities and assessment of needs and assets. Implementation of strategies to reduce identified disparities.

Sierra County Behavioral Health embraces a strong commitment to cultural competence, this includes executing more effective data collecting tools to track and identify the groups served. Sierra County has contracted with the Kings View Corporation for electronic health records (EHR) implementation. With EHR Sierra County Behavioral Health is able to streamline culturally and linguistically appropriate services. Additionally, Sierra County is able to collect data on the groups it serves.

The electronic health records allow Sierra County Behavioral Health to track and record data across several demographic planes. Language, ethnicity, gender, and age demographics can be straightforwardly identified thus further delineating the different cultures within our population. An important to note at this time, Sierra County Behavioral Health staff have found that at times, the data collected from the EHR has been skewed. But Sierra County has not identified precisely how the data is being skewed.

Furthermore, Sierra County contracts outside agencies such as the Family Resource Center which collects data on groups served. This data is collected per Prevention and Early Intervention regulations, through programs such as Nurturing Parenting. This data includes demographics such as Veteran status, sexual orientation, or identifying gender. Unfortunately, due to our small population and HIPPA laws the data is unreportable. If the data was reported, Sierra County contractors can possibly identify the clients thus breaking confidentiality laws.

Due to the lack of resources within Sierra County, currently the Behavioral Health Advisory Board is also designated as the Cultural Competency Committee. This committee convenes once a month to provide on-going, planning, tracking and on-going assessment of the cultural competency needs of the county. With a lack of ethnic diversity within the county, distinct cultures of lower socio-economic status and isolated communities have been identified. Sierra County in accordance with the Cultural Competency Committee is currently implementing strategies to target these populations to reduce disparities and provide community driven care.

Partner with the community to design, implement and evaluate policies, practices and services to ensure cultural and linguistic appropriateness.

In the past, Sierra County's Behavioral Health Advisory Board (BHAB) consisted of 11 members. Due to the small population in Sierra County, it was difficult to consistently hold 11 active members on this board. According to Welfare and Institutions Code 5604. (a). "each community mental health service shall have a mental health board consisting of 10 to 15 members, depending on the preference of the county, appointed by a governing body, except that boards in counties with a population of less than 80,000 may have a minimum of five members." On June 7th, 2011, this code was brought before Sierra County's Board of Supervisors for resolution and Sierra County adopted having five persons be the required number of members in Sierra County BHAB.

The BHAB has five members currently, as outlined in _____ . One person on this board is a representative from the Board of Supervisors, two are family members, one is a community member, and one is a former consumer of Sierra County's Behavioral Health services. These Board members identify with different populations. Castilian, Hispanic, and Caucasian are the ethnic cultures identified within the board members.

All information, including scheduled meetings and agendas regarding the BHAB, will be advertised at various locations frequented by populations. Sierra County Behavioral Health continues to encourage people to attend the scheduled meetings, regardless of membership. Community attendance is encouraged to allow individuals the opportunity to see how meetings are conducted and empower people to participate in each meeting.

Sierra County BHAB is aware that there is a need that must be addressed. Currently, all BHAB are being held on the East side of the county on Loyalton, California. This eliminated the ability to work with the community living on the West side of Sierra County. Thus the BHAB will address this issue by alternating meetings between both sides of the county or by utilizing tele-conferencing equipment when the weather is not permissive.

Educate and train governance, leadership and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.

Sierra County embraces a strong commitment to cultural competence. Thus it ensures that staff and other service providers are given access to culturally appropriate trainings beginning at hire throughout employment at the agency. Sierra County is further committed to cultural competence within the community, by offering programming and training to the residents of the county aptly named the Community Academy.

Community Academy activities strive to educate and build trust with other community based-organizations to help reduce barriers associated with receiving behavioral health services. As such, a universal service strategy is used reaching community populations, to address Outreach and Engagement objectives. Cultural Proficiency will continue to be addressed through the Community Academies.

Historically, Community Academies have been successful in Sierra County as a venue to provide one day workshops featuring appropriate and knowledgeable speakers addressing relevant behavioral health topics. Community Academy topics can be determined through the Community Planning Process. A follow-up 'Bridges out of Poverty' workshop will be offered as a result of stakeholder interest in continuing to learn about strategies to improve relationships between different cultures and communities, along with reducing barriers to participating in behavioral health services. Approximately four Community Academy Activities will be offered.

Additionally, the Workforce Education and Training will provide training in the evidenced based practice of Motivational Interviewing. This training will provide knowledge of the concepts of Motivational Interviewing and how to use MI to create a culturally responsive and trauma-informed approach to care. Moreover, the four key elements of MI (partnership, acceptance, compassion, and evocation), lay the foundation for client driven practice across diverse community populations.

County Mental Health System County's Commitment to Growing a Multicultural Workforce: Hiring and Retaining Culturally and Linguistically Competent Staff

Below (Tables 1 and 2) is an 'at a glance' general ethnic assessment of all Sierra County Health and Human Services workforce. Sierra County Health and Human Services which includes Behavioral Health is predominantly Caucasian. Hispanic/Latinos are underrepresented in our services delivery system as are other race/ethnicity groups. A comparison of staffing and the population reflects a disparity between the Hispanic/Latino population (8.3% of Sierra County's total population) and Sierra County Health and Human Services provider settings.

Table 1 – Ethnic Identification of Sierra County Health and Human Services (SCHHS) Workforce

Sierra County Health & Human Services workforce (2015).	Caucasian	Hispanic /Latino	African American	Asian	American	Other	Total	%
SCHHS								
Admin/Management	3	0	0	0	0	0	3	7.14 %
Direct Services	23	0	0	0	0	0	23	45.76 %
Support Services	13	0	0	0	0	0	13	30.96 %
Interpreters (contracted)	1	1	0	0	0	0	2	4.76 %
Consumers	1	0	0	0	0	0	1	2.38 %
Totals	41	1	0	0	0	0	42	----- --
Percentages	97.59 %	2.41 %	0	0	0	0	100 %	100 %

Table 2 – Ethnic Identification of Contract Agencies Workforce

Sierra County Health & Human Services contract agencies workforce (2015)	Caucasian	Hispanic/Latino	African American	Asian	American Indian	Other	Total	%
Contract Agencies								
Admin/Management	1	0	0	0	0	0	1	33.33 %
Direct Services	1	0	0	0	0	0	1	33.33 %
Support Services	0	0	0	0	0	0	0	
Interpreters	0	0	0	0	0	0	0	
Consumers	1	0	0	0	0	0	1	33.33 %
Totals	3	0	0	0	0	0	3	----- -
Percentages	100 %	0	0	0	0	0	100 %	100%

Table 3 – Comparison of ethnicity between SCHHS staff, client population receiving Specialty Mental Health Services, estimated Medi-Cal Beneficiary population, Households Below 200% population to the General Population.

	Caucasian	Hispanic/Latino	African American	Asian	American Indian	Other	Total	% of Population
Overall Staff	43	1	0	0	0	0	44	-----
Direct Service Staff	26	1	0	0	0	0	27	-----
Client Population receiving Specialty Mental Health Services†	52	2	1	0	0	0	55	1.70%
Medi-Cal Beneficiary Population**	57	17	8	0	7	15	97	2.99%
Households Below 200% Poverty*** Population	673	115	4	1	21	238	837	25.83 %

General Population ^{††††}	2808	269	6	12	44	101	3240	-----
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† Derived from 2013 client utilization

†† 2008 State Medi-Cal Information

††† California Mental Health Prevalence Estimates (2009),

†††† Derived from 2010 U.S. Census Bureau American Fact Finder

In analyzing the WET Plan assessment data with the general population a disparity that comes to light is the fact that Sierra County Health and Human Services employees predominantly Caucasian employees. This creates a disparity with the Hispanic/Latino population which comprises 8.3% of Sierra County’s total population. Historically, Sierra County Health and Human Services (HHS) has not received Hispanic/Latino applicants. Sierra County Health and Human Services and the Behavioral Health Department has experienced almost complete administrative and licensed staff turnover during the past 5 years. These positions are hard to fill and maintain in such a rural and geographically isolated area.

A target population that is not identified with an ethnic group is the Low Socio Economic Status population. In looking at the chart above, 26.57% of the general population lives in households below the 200% poverty level. Therefore, in striving to be culturally aware, the agency needs to be mindful of the culture associated with poverty and uninsured community members.

The objective to improve penetration rates and eliminate disparities will be two pronged, centering more on the Low Socio Economic Status population with the knowledge that Sierra County Health and Human Services needs to continually move forward in recruiting and employing a more culturally diverse staff to lessen the disparity between Sierra County’s workforce and the Hispanic/Latino community.

Goals and strategies are identified below.

Objective	Goal	Strategies
Improve Penetration rates and eliminate disparities associated	1) Increase cultural awareness of Sierra County Health and	1) Provide “Bridges Out of Poverty” training by September 30, 2016.

<p>with the Low Socio Economic Status population.</p>	<p>Human Services of this target population.</p>	<ol style="list-style-type: none"> 2) Provide “Cultural Proficiency: A Framework for Effective Family Strengthening Practice” training by September 30, 2016. 3) Provide training in understanding Medi-Cal, Medicaid, and Managed Care programs so that appropriate outreach and engagement can be accomplished to community members. Training to be conducted annually at All Staff Meetings.
	<ol style="list-style-type: none"> 2) Provide outreach and engagement activities/services throughout Sierra County Communities to provide community members with an understanding of services provided through Sierra County Health and Human Services. 	<ol style="list-style-type: none"> 1) Distribute informational pamphlets addressing services provided and who can receive services at community events. 2) Identify and build relationships with key community leaders within the Low Socio Economic Status population. 3) Educate key community leaders regarding services provided and who can receive services. Key community leaders can then educate and build trust within the Low SES population to help break down barriers and stigma associated with Sierra County Health and Human Services. 4) Hold focus groups with

		identified Key Community Leaders to learn further strategies of engagement with the Low SES population.
Improve penetration rates and disparity between Sierra County's workforce and the Hispanic/Latino population.	1) Sierra County Health and Human Services will employ at least one Hispanic/Latino employee by January 2018.	<p>1) Employment opportunities within Health and Human Services will be advertised in both Spanish and English by January 30, 2016.</p> <p>2) Employment applications will indicate Spanish speaking bi-lingual applicants are preferred by January 30, 2016.</p>

From an ethnic standpoint there has been no change in Sierra County Health and Human Services workforce. Thus far targets still need to be reached. One of the difficulties Sierra County Health and Human services has experienced is the turnover of both administrative staff and staff associated with Behavioral Health during the past 5 years. There have also been times when key positions have not been filled for extended periods of time. It is hoped that current staffing will be maintained for more than a two year period as this staff is committed to implementing culturally aware practices.

The current staff at Sierra County Health and Human Services is quite diverse within some of the cultures identified during the 2013 Cultural Competency Review: 1) income level, 2) geographic community, 3) church affiliation, and 4) industry affiliation.

Northern California Frontier County demographics lend these counties to geographic isolation and being predominantly populated by Caucasians. Sierra County is a Frontier County and as such has a limited pool of people to employ from. Cultural diversity and disparity in Sierra County is not based on ethnicity. Rather, it is based on such factors as what income level one is at, what community one lives in, what church one attends, whether one is associated with the ranching or timber industry or is a government employee.

Perspective employees, especially licensed ones, often need to be willing to relocate to the

area or be willing to commute for a minimum of 45 minutes. Historically, employees new to the County have found it difficult to assimilate into the unique frontier culture of Sierra County.

Hard to fill positions identified in the WET planning and implementation efforts are still identified as hard to fill. Filling these positions with an employee of a specific ethnic culture continues to prove difficult.

County Mental Health System Language Capacity

Currently, there are no threshold languages in the county of Sierra. But Sierra County Behavioral Health has been working diligently to develop the 24/7 telephone line that will meet the culturally linguistic needs of clients. The 24/7 telephone line has successfully gone live on December 11th, 2017. Once the 24/7 phone line is operational for a length of time, Sierra County Behavioral Health should be able to track a variety of data. This data should include how many non-English speaking calls were placed, as well the number of crisis calls.

Additionally, Sierra County Behavioral Health contracts with Telelanguage.com to provide professional services in language support. Interpreters are on-call 24/7 providing language support in over 300 different languages. Telelanguage.com requires all interpreters to complete the Telelanguage Interpreter Certification Program (TICP) that targets industries such as Behavioral Health. Additionally, the TICP course covers ethics, interpreter roles, basic skills (from pre-session to post-session), positioning and terminology, modes of interpreting, steps for sight translation, cultural mediation, and other vital skills. Currently, the industry standard is a 30-hour training course for certification. TICP utilizes a 120-hour training course, coupled with a 370-page training manual, for a highly comprehensive learning experience – exceeding industry standards.

In June of 2017, Sierra County Behavioral Health contracted with a Spanish speaking on site interpreter for interpretation services. This collaboration with the Interpreter provides a continuum of care for Sierra County residents and is available upon client request. Additionally, the Interpreter is asked to attend any and all cultural competency training the agency provides.

County Mental Health System Adaptation of Services

Sierra County Wellness Center, located in Loyalton, is wellness-focused and provides integrated services that are supportive, alternative and unique to support community members on their recovery path. The Wellness Center strives to be culturally competent, member-driven, and wellness-focused. Additionally, the Wellness Center provides services which are racially, ethnically, culturally, and linguistically specific to Sierra County. Peer Support Specialist staff is made up of peers with lived, personal experience. Peer Support Specialists are available to provide support, education, advocacy

and hope to individuals during their unique wellness and recovery path. The Veterans' Peer Support Specialist is also housed at this site. Peer support staff provide services via the phone, home visits, and on site. Downieville does not currently have a Wellness Center, however a Peer Support Specialist is available at the satellite Health and Human Services building located in Downieville. The same services can be provided at this site through collaboration with the Sierra County Wellness Center. It is Sierra County Behavioral Health's goal to find an appropriate setting to house and facilitate a Wellness Center in Downieville. In general, the Wellness Center provides opportunities to find ways to increase the persons served ability to live life at its fullest. Services focus on: • Wellness & Recovery Action Plans (WRAP©) • Supportive Conversation • Independent Living Skills • Veterans Peer Support • Connection with Workforce Alliance • Art and Meaningful Activities • Social Activities • Living with challenges of mental illness • Collaboration with other entities to provide identified individualized services not offered through the Wellness Center

Also, The Ways to Wellness program was implemented from a direct result of an identified need to provide services to underserved or unserved community members living at the Senior Apartment Complex in Loyalton. Many of the community members living in the complex do not access services and supports located at Sierra County Behavioral Health in Loyalton. Peer Support Specialists facilitate this program. This program is implemented to provide an environment where community members can learn creative wellness tools through positive activities aiding in reducing depression and loneliness and promote building relationships, supports and positive social activities through arts and crafts. WRAP's ideas are introduced and participation in completing an action plan is encouraged.

Grievance and Appeal Process

Clients who are dissatisfied with their services may file a complaint. Complaints are divided into two categories: informal complaints and formal complaints (grievances). Clients will not be subject to any penalty or discrimination for filing a complaint or grievance and may appeal decisions. Sierra County Systems of Care Complaint process brochures are printed in both English and Spanish and are located in the lobby of the Loyalton, and Downieville Behavioral Health buildings as well as the Loyalton Wellness Center. But it was discovered that the actual Grievance Form located in the lobby's and online is written in only English. Sierra County Behavioral Health will remedy that as part of a performance improvement plan and have Spanish language grievance forms available.

Attachment A – Profile of General

Subject	Number	Percent
65 to 69 years	126	3.9
70 to 74 years	76	2.3
75 to 79 years	70	2.2
80 to 84 years	33	1.0
85 years and over	35	1.1
Median age (years)	50.5	(X)
16 years and over	1,398	43.1
18 years and over	1,360	42.0
21 years and over	1,314	40.6
62 years and over	449	13.9
65 years and over	340	10.5
Female population	1,594	49.2
Under 5 years	78	2.4
5 to 9 years	62	1.9
10 to 14 years	64	2.0
15 to 19 years	79	2.4
20 to 24 years	54	1.7
25 to 29 years	60	1.9
30 to 34 years	59	1.8
35 to 39 years	76	2.3
40 to 44 years	93	2.9
45 to 49 years	131	4.0
50 to 54 years	157	4.8
55 to 59 years	176	5.4
60 to 64 years	169	5.2
65 to 69 years	104	3.2
70 to 74 years	90	2.8
75 to 79 years	69	2.1
80 to 84 years	35	1.1
85 years and over	38	1.2
Median age (years)	51.5	(X)
16 years and over	1,368	42.2
18 years and over	1,328	41.0
21 years and over	1,302	40.2
62 years and over	429	13.2
65 years and over	336	10.4
RACE		
Total population	3,240	100.0
One Race	3,161	97.6
White	3,022	93.3
Black or African American	6	0.2
American Indian and Alaska Native	44	1.4
Asian	12	0.4
Asian Indian	0	0.0
Chinese	2	0.1
Filipino	3	0.1
Japanese	1	0.0
Korean	1	0.0
Vietnamese	2	0.1
Other Asian [1]	3	0.1
Native Hawaiian and Other Pacific Islander	2	0.1
Native Hawaiian	2	0.1
Guamanian or Chamorro	0	0.0
Samoa	0	0.0

Subject	Number	Percent
Other Pacific Islander [2]	0	0.0
Some Other Race	75	2.3
Two or More Races	79	2.4
White; American Indian and Alaska Native [3]	36	1.1
White; Asian [3]	11	0.3
White; Black or African American [3]	8	0.2
White; Some Other Race [3]	11	0.3
Race alone or in combination with one or more other races: [4]		
White	3,097	95.6
Black or African American	17	0.5
American Indian and Alaska Native	86	2.7
Asian	25	0.8
Native Hawaiian and Other Pacific Islander	9	0.3
Some Other Race	90	2.8
HISPANIC OR LATINO		
Total population	3,240	100.0
Hispanic or Latino (of any race)	269	8.3
Mexican	216	6.7
Puerto Rican	3	0.1
Cuban	5	0.2
Other Hispanic or Latino [5]	45	1.4
Not Hispanic or Latino	2,971	91.7
HISPANIC OR LATINO AND RACE		
Total population	3,240	100.0
Hispanic or Latino	269	8.3
White alone	167	5.2
Black or African American alone	1	0.0
American Indian and Alaska Native alone	3	0.1
Asian alone	0	0.0
Native Hawaiian and Other Pacific Islander alone	0	0.0
Some Other Race alone	74	2.3
Two or More Races	24	0.7
Not Hispanic or Latino	2,971	91.7
White alone	2,855	88.1
Black or African American alone	5	0.2
American Indian and Alaska Native alone	41	1.3
Asian alone	12	0.4
Native Hawaiian and Other Pacific Islander alone	2	0.1
Some Other Race alone	1	0.0
Two or More Races	55	1.7
RELATIONSHIP		
Total population	3,240	100.0
In households	3,207	99.0
Householder	1,482	45.7
Spouse [6]	750	23.1
Child	688	21.2
Own child under 18 years	493	15.2
Other relatives	107	3.3
Under 18 years	40	1.2
65 years and over	20	0.6
Nonrelatives	180	5.6
Under 18 years	19	0.6
65 years and over	16	0.5
Unmarried partner	112	3.5
In group quarters	33	1.0

Subject	Number	Percent
Institutionalized population	33	1.0
Male	13	0.4
Female	20	0.6
Noninstitutionalized population	0	0.0
Male	0	0.0
Female	0	0.0
HOUSEHOLDS BY TYPE		
Total households	1,482	100.0
Family households (families) [7]	926	62.5
With own children under 18 years	279	18.8
Husband-wife family	750	50.6
With own children under 18 years	187	12.6
Male householder, no wife present	70	4.7
With own children under 18 years	37	2.5
Female householder, no husband present	106	7.2
With own children under 18 years	55	3.7
Nonfamily households [7]	556	37.5
Householder living alone	463	31.2
Male	239	16.1
65 years and over	83	5.6
Female	224	15.1
65 years and over	113	7.6
Households with individuals under 18 years	307	20.7
Households with individuals 65 years and over	486	32.8
Average household size	2.16	(X)
Average family size [7]	2.67	(X)
HOUSING OCCUPANCY		
Total housing units	2,328	100.0
Occupied housing units	1,482	63.7
Vacant housing units	846	36.3
For rent	50	2.1
Rented, not occupied	2	0.1
For sale only	33	1.4
Sold, not occupied	4	0.2
For seasonal, recreational, or occasional use	648	27.8
All other vacants	109	4.7
Homeowner vacancy rate (percent) [8]	3.0	(X)
Rental vacancy rate (percent) [9]	10.7	(X)
HOUSING TENURE		
Occupied housing units	1,482	100.0
Owner-occupied housing units	1,065	71.9
Population in owner-occupied housing units	2,349	(X)
Average household size of owner-occupied units	2.21	(X)
Renter-occupied housing units	417	28.1
Population in renter-occupied housing units	858	(X)
Average household size of renter-occupied units	2.06	(X)

X Not applicable.

[1] Other Asian alone, or two or more Asian categories.

[2] Other Pacific Islander alone, or two or more Native Hawaiian and Other Pacific Islander categories.

[3] One of the four most commonly reported multiple-race combinations nationwide in Census 2000.

[4] In combination with one or more of the other races listed. The six numbers may add to more than the total population, and the six

percentages may add to more than 100 percent because individuals may report more than one race.

[5] This category is composed of people whose origins are from the Dominican Republic, Spain, and Spanish-speaking Central or South American countries. It also includes general origin responses such as "Latino" or "Hispanic."

[6] "Spouse" represents spouse of the householder. It does not reflect all spouses in a household. Responses of "same-sex spouse" were edited during processing to "unmarried partner."

[7] "Family households" consist of a householder and one or more other people related to the householder by birth, marriage, or adoption. They do not include same-sex married couples even if the marriage was performed in a state issuing marriage certificates for same-sex couples. Same-sex couple households are included in the family households category if there is at least one additional person related to the householder by birth or adoption. Same-sex couple households with no relatives of the householder present are tabulated in nonfamily households. "Nonfamily households" consist of people living alone and households which do not have any members related to the householder.

[8] The homeowner vacancy rate is the proportion of the homeowner inventory that is vacant "for sale." It is computed by dividing the total number of vacant units "for sale only" by the sum of owner-occupied units, vacant units that are "for sale only," and vacant units that have been sold but not yet occupied; and then multiplying by 100.

[9] The rental vacancy rate is the proportion of the rental inventory that is vacant "for rent." It is computed by dividing the total number of vacant units "for rent" by the sum of the renter-occupied units, vacant units that are "for rent," and vacant units that have been rented but not yet occupied; and then multiplying by 100.

Source: U.S. Census Bureau, 2010 Census.

CPES Estimates of Need for Mental Health Services For California, Sierra County (091) Chron MH imp7 D120-Agesq (w1xmhm2asq_3) for 2007									
	Total Population (HH.,Inst.& Group)			Household Population			Households <200% poverty		
Total Pop	Cases	Pop	Percent	Cases	Pop	Percent	Cases	Pop	Percent
All ages	170	3328	5.10	163	3287	4.95	83	901	9.24
Youth age 0-17									
Youth	Cases	Pop	Percent	Cases	Pop	Percent	Cases	Pop	Percent
Youth total	44	588	7.44	44	587	7.43	18	206	8.72
Age	Cases	Pop	Percent	Cases	Pop	Percent	Cases	Pop	Percent
00-05	11	159	7.22	11	159	7.22	5	53	8.50
06-11	14	178	7.67	14	178	7.67	5	62	8.62
12-17	19	251	7.42	19	251	7.40	8	91	8.93
Gender	Cases	Pop	Percent	Cases	Pop	Percent	Cases	Pop	Percent
Male	23	308	7.46	23	308	7.45	11	120	8.80
Female	21	280	7.42	21	280	7.41	7	86	8.62
Ethnicity	Cases	Pop	Percent	Cases	Pop	Percent	Cases	Pop	Percent
1.White-NH	33	451	7.35	33	451	7.35	13	149	8.86
2.African Am-NH	0	3	8.48	0	3	8.33	0	2	9.47
3.Asian-NH	0	1	7.15	0	1	7.15	0	0	8.96
4.Pacific I-NH	0	1	7.54	0	1	7.44	0	0	8.94
5.Native-NH	1	9	7.53	1	9	7.52	0	4	8.13
6.Other-NH	0	0	0.00	0	0	0.00	0	0	0.00
7.Multi-NH	2	19	8.26	2	18	8.17	0	5	8.36
8.Hispanic	8	105	7.65	8	105	7.63	4	45	8.35
Poverty level	Cases	Pop	Percent	Cases	Pop	Percent	Cases	Pop	Percent
1.Below 100%	7	75	10.00	7	75	10.00	7	75	10.00
2.100%-199%	11	131	8.00	11	131	8.00	11	131	8.00
3.200%-299%	8	117	7.00	8	117	7.00	0	0	0.00
4.300%+ pov	13	223	6.00	13	223	6.00	0	0	0.00
5.Undefined	4	41	10.08	4	41	10.00	0	0	0.00
Residence	Cases	Pop	Percent	Cases	Pop	Percent	Cases	Pop	Percent
Household	44	587	7.43	44	587	7.43	18	206	8.72
Institution	0	0	20.00	0	0	0.00	0	0	0.00
Group	0	0	10.00	0	0	0.00	0	0	0.00
Adults age 18 and older									
Adult total	Cases	Pop	Percent	Cases	Pop	Percent	Cases	Pop	Percent
Adult total	126	2740	4.60	119	2700	4.41	65	695	9.39
Age	Cases	Pop	Percent	Cases	Pop	Percent	Cases	Pop	Percent
18-20	5	135	3.58	3	114	2.42	2	45	4.25
21-24	11	186	6.08	11	183	5.86	8	83	9.13

25-34	22	369	5.98	22	368	5.96	11	103	11.16
35-44	29	341	8.43	28	339	8.29	18	116	15.54
45-54	31	581	5.37	31	581	5.36	14	111	12.87
55-64	16	547	3.02	16	547	3.01	8	110	7.25
65+	11	582	1.96	8	568	1.39	4	127	3.16
Gender	Cases	Pop	Percent	Cases	Pop	Percent	Cases	Pop	Percent
Male	54	1365	3.97	51	1342	3.82	27	318	8.42
Female	72	1375	5.23	68	1358	4.99	39	377	10.22
Ethnicity	Cases	Pop	Percent	Cases	Pop	Percent	Cases	Pop	Percent
1.White-NH	111	2415	4.60	105	2383	4.41	57	580	9.80
2.African Am-NH	0	3	2.91	0	3	2.38	0	1	4.04
3.Asian-NH	0	4	2.00	0	4	1.97	0	1	4.19
4.Pacific I-NH	0	2	1.87	0	2	1.82	0	1	3.28
5.Native-NH	3	49	5.23	2	48	4.89	1	17	8.11
6.Other-NH	0	0	0.00	0	0	0.00	0	0	0.00
7.Multi-NH	2	37	5.82	2	37	5.75	1	15	9.36
8.Hispanic	10	229	4.31	9	223	4.21	6	80	6.95
Marital status	Cases	Pop	Percent	Cases	Pop	Percent	Cases	Pop	Percent
Married	50	1661	3.03	49	1655	2.97	18	267	6.89
Sep/Wid/Div	48	580	8.23	45	568	7.83	30	245	12.43
Single	28	499	5.61	26	477	5.35	16	183	8.99
Education	Cases	Pop	Percent	Cases	Pop	Percent	Cases	Pop	Percent
Grades 00-11	25	448	5.47	23	441	5.12	15	165	8.94
HS graduate	91	1868	4.88	86	1837	4.70	47	479	9.84
College grad	10	424	2.43	10	423	2.39	3	51	6.68
Poverty level	Cases	Pop	Percent	Cases	Pop	Percent	Cases	Pop	Percent
1.Below 100%	35	287	12.27	35	286	12.28	35	286	12.28
2.100%-199%	30	409	7.37	30	408	7.37	30	408	7.37
3.200%-299%	19	468	4.10	19	468	4.10	0	0	0.00
4.300%+ pov	35	1537	2.25	35	1537	2.25	0	0	0.00
5.Undefined	7	39	17.46	0	0	5.00	0	0	0.00
Residence	Cases	Pop	Percent	Cases	Pop	Percent	Cases	Pop	Percent
Household	119	2700	4.41	119	2700	4.41	65	695	9.39
Institution	7	36	18.26	0	0	0.00	0	0	0.00
Group quarters	0	4	7.33	0	0	0.00	0	0	0.00

(*) Youth rates based on Serious Emotional Disturbance.
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