County of Fresno
DEPARTMENT OF BEHAVIORAL HEALTH
Behavioral Health System of Care

Culturally Responsive Plan
Delivered with Humility
FY 2024/25 Update

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OVERVIEW

The Fresno County Department of Behavioral Health (DBH) System of Care (BHSOC) has a long-standing commitment to deliver culturally, ethnically, and linguistically responsive services with humility to individuals accessing and receiving behavioral health services. The BHSOC includes both Department of Behavioral Health staff and contracted organizational and individual providers. The term Behavioral Health (BH) includes both Mental Health and Substance Use Disorder services.

DBH recognizes the importance of developing services that are responsive to the needs of differing cultures, including individuals in recovery; members of Lesbian, Gay, Bisexual, Transgender and Questioning (LGBTQ+) community; veterans; persons living with disabilities (hearing, vision, physical); various age groups (Children: 0-15; Transition Age Youth [TAY]: 16-25; Adults: 26-59; Older Adults: 60+); immigrants and refugees; and persons involved in the justice system.
Developing a culturally and linguistically responsive system requires the commitment and dedication from leadership, staff, organizational providers, and the community to continually strive to learn and adapt from each other and by offering ongoing training, education in implementation of new strategies. Cultural Humility is an approach to service delivery that respects the whole person. This creates a learning environment with an emphasis on a willingness to learn and where the individual served is the expert (Tervalon and Murray-Garcia, 1998).

The current Culturally Responsive Plan (CRP) for Fresno County's BHSOC is delivered with humility and reflects our ongoing commitment to enhancing services to improve access to services, quality care, and positive outcomes. The CRP meets the requirements from the California Department of Health Care Services (DHCS) for both Mental Health and Substance Use Disorder services, and addresses the values outlined in the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (The National CLAS Standards). In addition, BHSOC utilizes DBH's Quadruple Aim to guide the delivery of services: 1) Deliver quality care; 2) Maximize resources while focusing on efficiency; 3) Provide an excellent care experience; and 4) Promote workforce well-being.

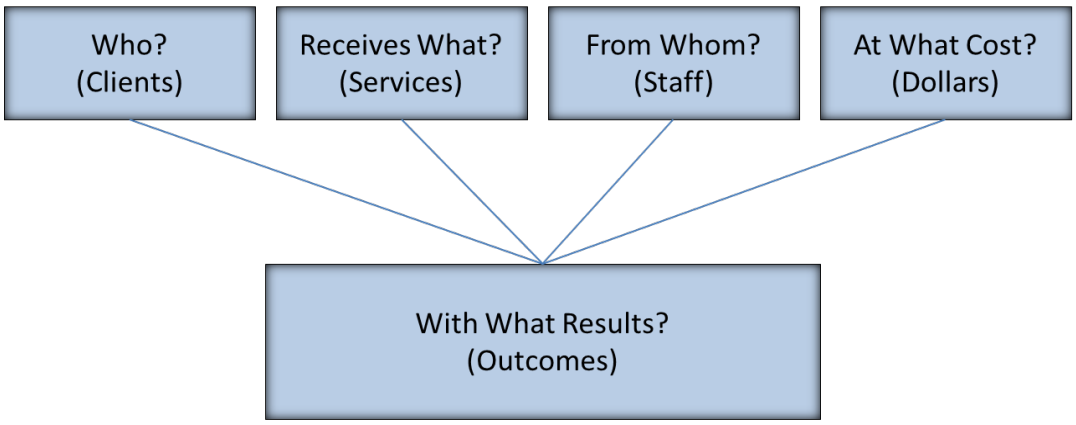
The mission and vision, of the BHSOC drives the commitment to deliver culturally responsive services that promote individualized wellness and recovery to diverse cultures and communities that reflects their health beliefs and practices. The BHSOC's foundation is built on eleven guiding principles of care that are described on the following pages. This vision includes providing effective, equitable, understandable, and respectful services that are responsive to

diverse cultural beliefs, practices, and preferred languages. It is also reflected in our global view, informing materials, and individual treatment plans. Integration of these values creates a safe learning environment for ensuring that we continually enhance our services to be culturally and linguistically relevant for our children, youth, adults, and older adults who receive services, and their families. Staff continually engage in discussions and opportunities to promote the delivery of culturally responsive services.

The FY 2024/25 CRP provides purpose and a blueprint for continually strengthening services across the next several years or until new CRP guidelines are available. The BHSOC has had a comprehensive planning process over the past several years to engage the broad workforce of county staff and organizational providers, as well as community stakeholders, to provide input into the development and ongoing implementation of this CRP. These range from different committee sessions, training/professional development community planning, community needs assessments, surveys and other information gathering opportunities. The goal of these events is to help all stakeholders improve culturally responsive care and identify cultural and linguistic differences and how these individual differences in culture, language, and self-identification impact successful treatment.

BHSOC continues with its commitment to creating a safe learning environment by requiring and offering ongoing behavioral health equity training to the BHSOC workforce which includes all county staff and organizational providers. This emphasis from the BHSOC management clearly illustrates its continuing priority to offer ongoing training and other support to help strengthen services to meet each individual's needs as well as creating a culture of wellness and recovery by integrating families and natural support systems into services.

The CRP is designed to be strategic, working document that provides a blueprint for infusing health equity and inclusion into all components of the BHSOC. The Diversity, Equity, and Inclusion Committee (DEIC) is the identified committee that guides the CRP goals and objectives and continually review and analyze data to better understand our current service delivery system and the impact of the CRP as new strategies are implemented. This includes identifying data needed to document Who Receives What services, from Whom, at What Cost, and with what Results. This paradigm is used throughout the CRP to show *Who* is being served (by demographics), *What* services are being provided (types of services received), by *Whom* (staff and service providers reflect the culture and language of the persons served), at *What Cost*, with what *Outcomes* (are services making a difference in the person's functioning).



The process to update the CRP for FY 2024-2025 provides an opportunity to review past year's data, to have relevant and reliable information to understand our system of care and delivery of services to meet each individual's cultural and/or linguistical needs. Data is currently collected on a number of measures needed to understand the system. As the data is analyzed and reviewed, DBH will ensure the information is as complete and accurate as possible.
DBH has identified opportunities where data collection, type of data, and quality of data can be improved to better inform strategies for culturally and linguistically responsive care, as well being able to assess service outcomes.

The continuous system of collecting data, analyzing data, reviewing data, identifying opportunities to improve data collection, and re-analyzing it to have additional information for strengthening services is the focus of this plan, but also the Planning and Quality Management Division for the County. Updating the systematic process will identify opportunities for improving data collection, data reporting, methods for analyzing the data, selection and use of Evidence-Based Practices, Promising Practices, Community Defined Practices, and information on cost-effectiveness and improved outcomes. This process will include updating the data collection methodology to reflect new data requirements from the state and federal government and improve outcomes reporting.

The BHSOC is committed to continually improving access, quality, and the manner in which services are delivered with cultural responsiveness and humility and demonstrating the importance of culture and language on successful treatment outcomes. The CRP outlines the components of this vision and provides a foundation for continually strengthening the Fresno County BHSOC.

I. COMMITMENT TO CULTURAL AND LINGUISTIC HUMILITY

A. Vision of the BHSOC

Health and well-being for our community.

B. Mission of the BHSOC

DBH, in partnership with our diverse community, is dedicated to providing quality, culturally responsive behavioral health services to promote wellness, recovery, and resiliency for individuals and families in our community.

C. Guiding Principles, Quadruple Aim, and CLAS Standards of BHSOC

A number of different documents have provided guidance in developing the Culturally Responsive Plan (CRP). The BHSOC has identified eleven guiding principles of care delivery. These principles are outlined below. They will also be discussed throughout the CRP, as they are supported throughout this CRP. Similarly, the BHSOC Quadruple Aim of the System of Care and the National CLAS Standards are outlined below.

1. BHSOC Guiding Principles of Care Delivery

Principle 1: Timely Access and Integrated Services
Principle 2: Strengths-based
Principle 3: Person-driven and Family -Driven
Principle 4: Inclusive of Natural Supports
Principle 5: Clinical Significance and Evidence-Based Practices (EBP)
Principle 6: Culturally Responsive
Principle 7: Trauma-Informed and Trauma-responsive
Principle 8: Co-occurring Capable
Principle 9: Stages of Change, Motivation, and Harm Reduction
Principle 10: Continuous Quality Improvement and Outcomes Driven
Principle 11: Health and Wellness Promotion, Illness and Harm Prevention, and Stigma Reduction

2. Quadruple Aim of the BHSOC

a) Deliver quality care
b) Maximize resources while focusing on efficiency
c) Provide an excellent care experience
d) Promote workforce well-being

3. National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (The National CLAS Standards)

The National CLAS Standards are intended to advance health equity, improve quality, and help eliminate health care disparities by establishing a blueprint for health and health care organizations to:

a) Principal Standard

1) Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.

b) Governance, Leadership, and Workforce

2) Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources.
3) Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service area.
4) Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.

c) Communication and Language Assistance

5) Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.
6) Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.
7) Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.
8) Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.

d) Engagement, Continuous Improvement, and Accountability

9) Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization's planning and operations.
10) Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities.

11) Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.
12) Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.
13) Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.
14) Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints.
15) Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public.

4. Cultural Competence Plan Requirements (CCPRs), which includes the following criteria:

a) **Criterion I:** Commitment to Cultural Competence
b) **Criterion II:** Updated Assessment of Service Needs
c) **Criterion III:** Strategies and Efforts for Reducing Racial, Ethnic, Cultural, and Linguistic Mental Health Disparities
d) **Criterion IV:** Individual/Family Member/Community Committee: Hiring more persons with lived experience into BHSOC positions
e) **Criterion V:** Culturally Competent Training Activities
f) **Criterion VI:** County's Commitment to Growing a Multicultural Workforce: Hiring and Retaining Culturally and Linguistically Competent Staff
g) **Criterion VII:** Language Capacity
h) **Criterion VIII:** Adaptation of Services

D. Goals and Objectives of the BHSOC

The Fresno County Department of Behavioral Health and its contracted organizational and individual providers form the Fresno County Behavioral Health System of Care (BHSOC), which delivers Behavioral Health (mental health and substance use) services in Fresno County. The BHSOC is committed to continuous improvement of services to meet the needs of culturally and linguistically diverse communities who are seeking, accessing and receiving services. A number of objectives have been developed through stakeholder process, with input from various committees, needs assessments and stakeholder activities. The following goals and objectives below provide the framework for this CRP and will continue to be developed as these goals are expanded, additional data is reviewed, training is delivered, and activities are implemented.

- **1: To provide improved and timely access to culturally and linguistically appropriate, integrated, behavioral health services for persons from various race/ethnicity groups; across all ages; veterans and their families; individuals who are Lesbian, Gay, Bisexual, Transgender, and Questioning Plus (LGBTQ+); persons living with disabilities (hearing, vision, physical); justice-involved individuals and their families; immigrants and refugees; and other diverse cultures.**

  - **Objective 1a**: BHSOC will increase the number of eligible persons served by the Behavioral Health teams. This increase will include, but not be limited to, persons from various race and ethnicity cultures; persons who are monolingual Spanish and Hmong; all age groups; veterans; LGBTQ+; and families.
    - *DBH continues to review the data related to penetration rates, community needs assessments, annual surveys, assessing those data sets and opportunities for improving data collection to better inform efforts, identify gaps in the system and update strategies.*

  - **Objective 1b**: Whenever feasible, BHSOC will seek to hire diverse/bilingual/LGBTQ+ staff to provide services in the preferred language of individuals served across the behavioral health system of care to provide services and improve access to individuals and their family members.
    - *DBH hosted several youth focused activities with an emphasis on representation and career pathways for possible bicultural and bilingual youth.*
    - *The Department's HR team continues to work with the County's main HR to be able to gather more demographic data points for additional information, including possibility of demographics on applicants, not just applicants who are referred to the department. This can help assess if the recruitments are reaching and being responded to by a broader, diverse applicant pool.*

  - **Objective 1c**: BHSOC will hire, when possible, individuals with lived experience, individuals receiving behavioral health services, and their family members, who may be bilingual and bicultural, to help address barriers for serving culturally diverse populations.
    - *DBH reviewed its Peer Positions, as well as all providers with peer positions and other county peer positions in the region; and found that DBH wages were some*

of the highest in the area. However, there is still a high vacancy in DBH peer positions. With the creation of certified peers in California, DBH has been reexamining its peer positions for a system of career latter that can allow for various levels, expertise and advancements for individuals in those roles. The BHSOC continues efforts to train and certify peers.

- **Objective 1d**: BHSOC will identify individuals who are monolingual and new to receiving BHSOC services and assign a bilingual and bicultural workforce member to deliver services in the individual's preferred language, whenever possible.
    - *During the previous year, the results of several community needs assessments, identified language access and challenges for different monolingual speakers. In some instances, the challenges were identified with the managed care plans, and in others it was not clear if it was MCP or BHSOC where the challenges were. This highlights a need for continued training, improving language access and capacity.*
    - *DBH is continuously working to identify training and staff qualifications to develop a process for identifying individuals' language preferences. The County is now able to test bilingual personnel for proficiency to support monolingual speakers in several languages with certified bilingual personnel.*
    - *Language barriers continue for indigenous persons from southern Mexico and Central America who do not speak Spanish; working on a multi-county training and support to help increase and improve access for these communities. There are also limited SEI providers who speak languages such as Lao, Khmer, and Mien, which will need to be explored and expanded to meet the needs of these communities.*
    - *Over the past few years, DBH has begun to examine possible emerging languages to help anticipate future needs. At this time, we have been examining opportunities for translation of outreach and educational materials into Punjabi. The challenge has been identifying a translation provider with capacity for translation of behavioral health materials. New connections with a provider who is focused on Punjabi speaking populations (Khalsa Community Center and the Jakara Movement) may allow for plans to have translation and secondary review (in accordance with the County's policy) to help develop those materials.*

- **Objective 1e:** BHSOC will ensure that the access line is linguistically responsive to all persons utilizing these services, and individuals receive services in their preferred language in a timely manner, through the use of bilingual staff, interpreters and/or the language line.
    - *The Access Line is tested regularly. Access Line data is analyzed quarterly and reviewed by the DEIC and QIC.*

- **Objective 1f**: BHSOC will continue to provide informing materials in the county's threshold languages (currently Spanish and Hmong) in all BHSOC clinics, and other locations that offer behavioral health services (e.g., contracted service providers, wellness centers). Other forms, including statewide forms, will be available in other languages, when needed.

The County also has a policy to ensure printed materials are at least a minimum of 16pt font, or available in a digital format that will allow for enlargement to better support those who may have vision impairments.

- **Relevant Standards**
  - CLAS Standards: # 1, 2, 3, 5, 7, 8, 9
  - Guiding Principles: # 1, 2, 3, 4, 6
  - Cultural Competence Plan Requirements (CCPR): # 1, 3, 6, 7

➢ **Goal 2: To create a work environment where cultural humility, dignity, inclusion, and respect are practices, so all BHSOC staff experience equitable opportunities for professional and personal growth.**

- **Objective 2a**: BHSOC continued to offer foundational culturally responsive trainings for BHSOC staff, as outlined by the Policy and Procedure Guidelines (PPGs).
  - *With changed brought about by payment reform and the attention to productivity for providers in the BHSOC, the Department is exploring alternatives to required training hours, which can best support a continuous development in culturally proficient care, as well as all other requirements impacting direct service personnel.*
  - *Throughout the year, DBH has highlighted different cultural events and recognition months for the BHSOC, which include panel discussions and sharing of related resources.*
  - *In the future DBH will have to ensure its recognition and or participation in cultural events aligns with the county's new Administrative Policy Number 81 (which requires those celebrations be approved by the County Board of Supervisors).*
  - *DBH continues to provide annual training using the Health Equity, Diversity, and Inclusion Multi-Cultural model.*
  - *Through the BHSOC's virtual training platform Relias, the County is able to provide 81 different trainings affording over 67 hours of training related to health equity.*

- **Objective 2b**: BHSOC will identify and provide trainings on topics including, but not limited to, CLAS standards, equity; inclusion; diversity; social determinants of behavioral health; health disparities, cultural and community practices; consumer culture; recovery culture; access barriers; implicit bias; historical trauma; veteran and family services; and sustainable partnerships, on a regular basis for BHSOC.
  - *DBH continues to explore developing trainings on the following topics: Microaggressions, Racial Equity Impact Survey, Clinical Cultural Responsiveness, Social Determinants of Health (SDOH), etc.*
  - *A BIPOC LGBTQ training was finalized and implemented in the past year. The County is working to secure continuing education units (CEUs) for the course so when accessed on the Relias (on-demand) platform participants can earn CEUs.*
  - *The County is working to secure a training that will help it meet training requirements of Senate Bill 923 and Behavioral Health Information Notice 25-019.*

- **Objective 2c**: BHSOC will provide interpreter and language line training to all direct service providers and staff who regularly communicate with individuals receiving services. Training will address the process for effectively using an interpreter, as well as using the language line, to support individuals receiving services in their preferred language.
    - *DBH has updated the PPGs and developed new guidelines related to Cultural Competence training, language access, interpretation services, etc. DBH has a master agreement with several organizational providers to translate documents, so that translations are conducted by a professional third party and reviewed by "native speakers" who may be BH staff or other community providers. Behavioral Health Interpreter Training (BHIT) was offered to providers who deliver services in languages other than English.*

- **Objective 2d**: BHSOC has supported the development of a Language Services Subcommittee which supports BHSOC bilingual staff to meet regularly to create an opportunity to share ideas on how to interpret complex medical terms and meet the needs of individuals and families receiving services. This subcommittee has supported the ongoing development of a list of commonly used Behavioral Health terms to support the use of consistent translation of terms. This strategy will continue to help promote a common language across bilingual staff and providers and create consistency in language for individuals receiving services and English-speaking treatment staff. BHSOC posted these documents on the DBH website (www.dbhequity) under DBH Language Guides for easy access to updated documents.

- **Objective 2e**: BHSOC has attempted to develop a recruitment practice, in collaboration with HR, to hire individuals and family members to help increase the workforce and expand the number of persons who are reflective of the local community, especially bilingual/bicultural individuals, and help address barriers to accessing services for culturally and linguistically diverse populations. The County and some BHSOC providers have limitations in how they can develop fair practices. DBH had created an inclusion statement which was included with all job announcements; however, those are no longer permitted by the County.

- In the new year, DBH will work with supervisors and managers to identify and develop training to ensure practices of inclusivity, implicit bias, etc. to improve retention within the department and on-going discussions on where opportunities to improve equity can be practiced while promoting psychological safety.

- **Relevant Standards**
    - CLAS Standards: # 1, 2, 3, 4, 5, 6, 7, 9, 13
    - Guiding Principles: # 2, 3, 4, 6
    - Cultural Competence Plan Requirements: # 1, 3, 4, 5, 6, 7

➢ **Goal 3: To deliver innovative, evidence-based, promising and community defined, trauma-informed, strengths-based, wellness and recovery focused behavioral health services in collaboration with other community organizations and co-locate services**

whenever possible, including in diverse community settings (e.g., homes, schools, organizational providers, senior centers, churches, etc.) to promote health and wellness.

- **Objective 3a**: BHSOC will provide training and implementation strategies on identified culturally responsive, evidence-based, promising and community-defined practices for both mental health and substance use disorder services. This training will include, but not limited to, trauma informed Cognitive Behavioral Therapy; Motivational Interviewing; Stages of Change; Harm Reduction; Wellness and Recovery Action Plans (WRAP), and other identified treatment models and tools. Note DBH has three CDEPs programs, Sweet Potato, Hmong Helping Hands, and Atención Y Placticas. Additionally, it has a forensic population focused full-service partnership, and Southeast Asian focused FSP, as well as prevention programs such as Culturally Based Access and Navigation Support (CBANS) and the Holistic Wellness Center to name a few.

- **Objective 3b**: BHSOC will identify BHSOC workforce trained in the identified evidence-based, promising and community-defined practices to deliver strength-based, trauma-informed, wellness and recovery focused services.

  - *During the past year, Fresno County participated in trainings that highlighted its community-defined evidence-based practices (CDEPs). It is one of the only counties to currently fund the CDEPs that emerged from the California Reducing Disparities Project Phase 2. There are three CDEPs operating in Fresno County as part of the BHSOC.*
  - *DBH is working with those three CRDPs and consultant (Third Sector) on sustainability models. DBH and its partners presented at the California Institute for Behavioral Health Solutions' Annual Evidence Based Practice Conference.*
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- **Objective 3c**: BHSOC will support the delivery of person-centered, culturally responsive services which includes family and other natural supports.
    - These have included culturally specific services (such as culturally responsive continuum of care), CDEPs, and other culturally focused services.

- **Objective 3d**: BHSOC will deliver services in the least restrictive environment (e.g., home, schools, organizational providers, senior centers, churches, and other community locations, as appropriate).
    - *Following the COVID-19 pandemic, the BHSOC was to increase access to care using Tele-health, while continuing its work to create opportunities for more community-based services including mobile care delivery. This objective has included the establishment of more continuums of care to better meet the various levels of care needed by individuals who may need a higher level of care, or a step-down to lower levels* of care while maintaining a continuity of care by remaining with the same CBO.

- **Objective 3e**: BHSOC will identify and implement innovative services that utilize cultural leaders, spiritual healers, cultural brokers, and culturally responsive services and practices to create healthy communities that support the delivery of services.

- *For a number of years, DBH has funded programs that work to address community needs through culturally relevant activities. Continuing as in past years, DBH funded the Holistic Wellness Center Program, and provides education, wellness activities, training and referrals to individuals who may not seek out traditional western mental health services. Culturally Based Access and Navigation Services (CBANS) is a program that uses cultural brokers and community health workers, offering aid in Spanish, Hmong, Lao, Khmer, Hindi, and Punjabi, to assist those communities in accessing traditional or non-traditional behavioral health services. DBH has funded specific services in rural communities such as Youth Empowerment Program, a full continuum of care under the Rural Mental Health Services and Living Well Center (serving Southeast Asian communities).*
- *Some of these culturally responsive services may be impacted in the future with the implementation of the Behavioral Health Services Act (BHSA) and changing of funding categories and mandates.*
- *DBH has explored future program options through the African American Community Participatory Action Research Project to explore collaboration with local Black leaders and faith communities to enhance behavioral health literacy.*
    - *During the last year, DBH began work on a research project focused on justice involved youth to better understand prevention and intervention needs from the perspective of those youth to inform future program and service designs, etc.*
    - *DBH has continued as a member of the second phased of the statewide Innovation Plan project around Psychiatric Advance Directives (PADS) with a focus on work with persons served and those with lived experience in piloting and implementing PADs as a consumer empowerment tool.*
- *For the last four years, DBH has utilized Fresno County's MHSA Innovation Plan to fund three local California Reducing Disparities Project (CRDP) Phase II programs, which are community defined and population specific. In the past year the County employed a consultant to assist the CDEPs with suitability strategies for the future with changes to the MHSA with passage of BHSA.*
- *Representation from DBH was part of the statewide taskforce focused on the CRDP Phase 3 (the next round of CDEP development). DBH represented the only county behavioral health perspective and championed expansion of CDEPs to examine SUD care and specialty mental health services and crisis care using CDEPs.*
- *Fresno County DBH's ESM is part of the AB 2473 Advisory Workgroup who is helping develop the parameters for future substance use registrants (on their way to certificated counselors) and is the only County Behavioral Health representative and supporting the workgroup in the area of health equity.*
- *Fresno County is one of just two counties serving on the DHCS Behavioral Health Transformation (BHT) Quality and Equity Advisory Committee, assisting in the development of the BHT goals and the health disparities measures.*

- **Relevant Standards**
    - CLAS Standards: # 1, 4, 6, 8, 13
    - Guiding Principles: # 2, 3, 5, 6, 7, 8

- Cultural Competence Plan Requirements: # 1, 3, 4, 5

➢ **Goal 4: To work collaboratively with diverse community groups and organizations to develop outreach and education activities to help disseminate information about behavioral health services.**

- **Objective 4a**: Identify unserved, underserved, and inappropriately served populations and/or diverse cultures that may experience barriers in accessing behavioral health services (e.g., monolingual Hmong- or Spanish-speaking adults; immigrants and refugees; LGBTQ+; Transition Age Youth (TAY); Older Adults; persons living in rural communities).
  - *DBH continued to utilize its past market research to help assess its efforts for outreach and access, as well as to inform its strategies on how to better meet needs of diverse communities.*
  - *DBH maintains pages on its website that are translated into Spanish through the use of professional translation services, and that is reviewed by native speakers. The page has its own easy to use/identify URL (www.DBHespanol.com) to help improve access to information by Spanish speakers. It also includes audio and video information in Spanish. DBH also has a page in the Hmong language (www.dbhhmoob.com) and is working on improving translation through the use of community members; and audio options are under development as well.*
  - *In the coming year, DBH is seeking to expand some outreach to address the emerging Punjabi speaking community, using information obtained from the recent community needs assessment.*

- **Objective 4b**: BHSOC will continue to make efforts to attend diverse community events each fiscal year that target diverse community outreach activities in a coordinated manner that comply with County Administrative Policy 81. When approved, those efforts may include supporting health literacy and disseminating information related to accessing Behavioral Health services. Some events we have attended and produced in the past include:
  - *Participated in Veteran's Day Parade (November 2024)*
  - *Fresno County participated in the annual Fresno Rainbow Pride Parade and Festival (June 2025)*
  - *Participated in the annual Juneteenth celebration, providing a resource table and highlighting stories in Fresno County's Black/African American community*
  - *The Department hosted numerous virtual panels and discussions in the past year as well. These were all streamed on the Department's social media platforms and are still available for public viewing.*
  - *Pending Approval through Administrative Policy 81, the County will seek to participate in the Veterans Day Parade in 2025.*

- **Objective 4c: In the past** BHSOC has offered prevention and stigma reduction trainings to BHSOC workforce and community organizations [e.g., Suicide Prevention; Mental Health First Aid; WRAP; Crisis Intervention Training (CIT) with Law Enforcement; Applied Suicide Intervention Skills Training (ASIST)]. With the coming changes with the Behavioral Health Services Act, the population prevention and stigma reduction

activities will no longer be performed at the local level, but rather the State for local health jurisdictions (Fresno County Department of Public Health), and thus these efforts will be wrapping up in the near future.

- *DBH has participated in several different webinars as presenters/panelist on community collaboration with community providers, community defined evidence-based practice (CDEPs) and other culturally responsive care efforts.*
- *DBH's staff were involved with MHSA and DEI participated in a yearlong learning project (Interdisciplinary Collaboration and Cultural Transformation Model (ICCTM) including practicum portion which had the staff applying community engagement principles from the training/model.*
- *DBH collaborated in developing the sixth Central California Suicide Prevention Summit, which provided free training and free Continuing Education Credits to licensed professionals in 2024.*
- *Throughout FY 24-25, Fresno County conducted its Mental Health Services Act community planning process, which consisted of 2 different in-person community forums with interpreters.*

- **Relevant Standards**
  - CLAS Standards: # 1, 4, 7, 8
  - Guiding Principles: # 11
  - Cultural Competence Plan Requirements: # 1, 2, 3, 5

➢ **Goal 5: To collect and analyze accurate and reliable demographic, service-level, and outcome data to help understand and evaluate the impact of services on health equity, cost-effectiveness, and outcomes.**

- **Objective 5a**: BHSOC is working to develop strategy for guidance and training on collecting consistent and reliable demographic data on individuals, services delivered, staff areas of specialization, and outcomes.

- **Objective 5b**: BHSOC will utilize data to provide objective and consistent evaluation and feedback to leadership, staff, individuals, and families regarding timely access, individuals served, types of services, and program impact and outcomes to best support and continually strengthen the unique needs of each cultural community.
  DBH has a fulltime epidemiologist who helps support system wide efforts to examine outcomes data and measures, and with the DHC and ESM support data analysis to help assess quality improvement opportunities.
- **Objective 5c**: BHSOC will identify strategies for assessing and measuring improved outcomes as a result of the evidence-based, promising and community-defined practices used to deliver effective services. The newly approved CRDP Evolutions which funds three CRDPs/CDEPs will also be accompanied by an independent third-party evaluator to help evaluate the three community defined practice programs.

- **Objective 5d:** BHSOC will identify instruments that measure individual and family outcomes, to help demonstrate improved outcomes as a result of services received.

- **Objective 5e**: Develop process to train and inform both persons served and BHSOC providers on the need for the data, how the data is used, and how to better collect the data.

- **Relevant Standards**
  - CLAS Standards: # 1, 2, 10, 11, 12, 14, 15
  - Guiding Principles: # 1 through 11
  - Cultural Competence Plan Requirements: # 1, 2, 3, 4, 5, 7, 8

E. Diversity, Equity, and Inclusion Committee

The Diversity, Equity, and Inclusion Committee (DEIC) is the identified committee that guides the CRP goals and objectives and continually reviews and analyzes data to better understand our current service delivery system and the impact of the CRP as new strategies are implemented. The DEIC continues to meet monthly on the first Thursday. Attendees include representatives from DBH Leadership, Technology, Planning and Quality Management, Compliance, Plan Administration, Contracted Providers, Public Health, and local community-based organizations. Results and activities are reported to the QIC on an annual basis. Past accomplishments by the DEIC include developing the official Committee Charter (*See Attachment C)* recommendations for training, updating and developing Policy and Procedure Guide (PPG) for the DEIC membership, Translation Process, and minimum training requirements for DEI. The DEIC is working on a process to measure adherence or cultural responsivity and based on those measures how much training is needed, for less effective care, additional hours are added as part of a PIP, etc.

DBH is including notice of Participation Agreement in new RFPs and language focused on health equity via CLAS standards for Providers to ensure a specific time commitment for DEIC activities.

The DEIC has been implementing an annual cultural humility survey for the past seven years, and has the data to identify trends, opportunities for improvement, and opportunities to develop new tools.

DBH will work in the past year included efforts to formalize employee resource and affinity groups if and where possible. The LGBTQ+ Coalition has provided recommendations to improve and expand behavioral health services for members of this community in Fresno County. In the past the Behavioral Health for Black Lives (BHBL) affinity group was formed to advocate for behavioral health equity for all members of the Black community in Fresno County, including DBH staff and individuals served. Goals of the group have included past recommendations on resources, information, and training to all DBH staff and contract providers; advocating for expanding job opportunities and recruiting activities for aspiring Black Behavioral Health Professionals; providing continued professional development and training to current DBH staff to improve inclusivity ; offering quality, culturally responsive supervision to Black service providers; and recommending activities that promote wellness and reduce stigma. These activities were aimed at helping the system of care obtain training to better serve and support both Black staff and individuals receiving services.

F. Diversity, Equity, and Inclusion Subcommittees

There are three (2) separate DEIC Subcommittees: Language and Access. The DEIC Subcommittees now meet virtually each month. Each subcommittee has an identified Chair, Co-Chair, and Note Taker. Each subcommittee has a set of established goals and activities that correspond with the goals and objectives outlined in the CRP, as outlined below. DBH has a page on its site committed to the DEIC, and it has a second page the DBH equity page where diversity, equity and inclusion information is available.

1. Language

The DEIC Language subcommittee corresponds to CRP Goal 1, to provide improved and timely access to quality culturally- and linguistically-appropriate, integrated, behavioral health services for persons from various race/ethnicity groups; across all ages; veterans and their families; individuals who are Lesbian, Gay, Bisexual, Transgender, and Questioning Plus (LGBTQ+); persons living with disabilities (hearing, vision, physical); persons released from jail and their families; immigrants and refugees; and other diverse cultures. This subcommittee focuses its efforts on improving and expanding linguistically appropriate services for persons served. Objectives include: (1) develop the Language Champion group for Spanish and Hmong languages; (2) review service-level language data trends and identify needs annually; (3) increase bilingual-skills-proficient staffing for interpretation service to better meet the needs of Limited English Proficient (LEP) populations; and (4) identify interpreter trainings and other learning opportunities for monolingual direct-facing and bilingual speaking staff (county and contract providers).

In FY 2024/25, the DEIC Language subcommittee continued to examine the designation and certification of bilingual staff and worked closely with the Human Resources Department to expand the number of paid bilingual positions and develop strategies to help certify bilingual staff in a timely manner. The subcommittee identified an organization, Voiance (now Propio), to certify bilingual staff's skills in Spanish and/or Hmong. In addition, the DEIC Language subcommittee is working to develop an Interpreter Champions group to support bilingual staff to discuss cases, consult with one another, and provide additional training. The subcommittee also identified a Behavioral Health Interpreter Training (BHIT) for interpreters and direct service staff. BHIT is a four-part, fourteen-hour workshop designed to provide instruction on the fundamental principles of interpreting.

The DEI Language Subcommittee also developed a Spanish Language Guide, which is available on the www.dbhequity.com website. This guide provides comprehensive English-to-Spanish translations to use when providing mental health services. This guide shows the English and corresponding Spanish words and phrases, to help communicate with Spanish speakers. It is well organized into different topics from Introductory phrases for counselors to use, through explaining different diagnostic terms (e.g., Depression; Anxiety); Behavioral Health clinical terms; medical terms; and other mental health symptoms and concepts. This provides an excellent guide for creating a common language across interpreters to help 'standardize' terms. This helps both the persons served and family members to have the information translated consistently across interpreters and for behavioral health staff.

2. Access

Similar to the Language subcommittee, the DEIC Access subcommittee corresponds to CRP Goal 1: to provide improved and timely access to culturally- and linguistically-appropriate, integrated, behavioral health services for persons from various race/ethnicity groups; across all ages; veterans and their families; individuals who are Lesbian, Gay, Bisexual, Transgender, and Questioning Plus (LGBTQ+); persons living with disabilities (hearing, vision, physical); justice involved persons and their families; immigrants and refugees; and other diverse cultures. Rather than concentrating efforts on linguistic services, this subcommittee focuses on improving timely access to services for all cultural and racial/ethnic groups, especially for groups who have been identified as underserved by DBH. Objectives include: (1) review service-level data by race/ethnicity, gender, age, language, LGBTQ+, and region; (2) review BH Access Line data by age, race, ethnicity, language, SOGI, region, and use of interpretation services; (3) review data on access to interpretation services by language and program, and compare access to face-to-face versus telehealth; (4) review service level BH data by race, ethnicity, language, gender, and SOGI, and make recommendations to improve access to services for underserved populations; and (5) make recommendations to improve BH data collection.

In FY 2024/25, the DEIC Access subcommittee reviewed service-level data by race/ethnicity, gender, age, language, LGBTQ+, and region to identify strategies to improve engagement with underserved populations in Fresno County. The subcommittee also identified the need to improve data collection, especially for language, gender, and sexual orientation. The subcommittee is also discussing strategies for having the Access Line Provider(s), to consistently collect demographic information (Date of Birth; Race; Ethnicity; Primary/ Preferred Language; Gender; SOGI) and make recommendations to improve access to services for underserved populations. In addition, the Access subcommittee is actively researching the most effective methods for asking demographic questions and continues to work with the Quality Management department to develop strategies to improve data collection and quality.

In the MHSA Innovation Annual Update, DBH identified several human-centered and participatory action needs assessments, focusing on immigrant/refugee, Indigenous, sand other underserved populations. These efforts may inform specific community needs and opportunities to improve and streamline access for populations that have had challenges in accessing care or culturally responsive services.

II. DATA AND ANALYSIS

A. Fresno County Geographic, Demographic, and Socioeconomic Profile

1. Geographical Location and Attributes of the County

Fresno County is a large county (population of 1,017,162) that lies in the Central Valley of California, bordered on the west by the Coast Range and on the east by the Sierra Nevada Mountain Range. The county seat, the City of Fresno, is the fifth largest city in California. Other cities include Clovis, Sanger, Reedley, Selma, Parlier, Kerman, Coalinga, Kingsburg, Mendota, Orange Cove, Firebaugh, Huron, Fowler, and San Joaquin. In addition, there are twenty-eight (28) census-designated places, and seven (7) unincorporated communities.

2. Demographics of the County

Fresno County's population grew by 0.18% (according to world population review). Figure 1 shows age and race/ethnicity, and gender of the general population. For the 1,017,162 residents who live in Fresno County, 22.9% are children ages 0-15; 14.8% are Transition Age Youth (TAY) ages 16-25; 43.9% are adults ages 26-59; and 18.4% are older adults ages 60 years and older. The majority of persons in Fresno County are Hispanic/Latino (53.6%). Persons who are Black represent 4.4% of the population, American Indian/ Alaskan Native represent 0.6%, Asian/Pacific Islander represent 11%, White represent 27%, and Other/Not Reported represent 3.4% of the population. There are an equal proportion of females (50.3%) and males (49.7%) in the county.

Figure 1
Fresno County Residents
By Gender, Age, and Race/Ethnicity
(Population Source: 2020 Census)

	Fresno County Population 2020 Census	
Age Distribution	**Number**	**Percent**
0 - 15 years	231,202	22.9%
16 - 25 years	149,342	14.8%
26 - 59 years	442,520	43.9%
60+ years	185,590	18.4%
Total	**1,008,654**	**100.0%**
Race/Ethnicity Distribution	**Number**	**Percent**
Black	44,295	4.4%
American Indian/ Alaskan Native	6,074	0.6%
Asian/ Other Pacific Islander	110,898	11.0%
Hispanic/ Latino	540,743	53.6%
White	271,889	27.0%
Other/ Not Reported	34,755	3.4%
Total	**1,008,654**	**100.0%**
Gender Distribution	**Number**	**Percent**
Male	501,441	49.7%
Female	507,213	50.3%
Total	**1,008,654**	**100.0%**

It is estimated that approximately 4.5% of the adult population of Fresno County speaks a language other than English at home (2024 American Community Survey). Spanish and Hmong are the threshold languages in Fresno County.

3. Socioeconomic Factors

Healthcare, retail trade, and agriculture are the three largest industries in Fresno County. The unemployment rate in the Fresno County has been decreasing and currently sits at 6.9%; the state unemployment rate was 7.7% in the same period (November 2023 California Employment Development Department). The rates have been decreasing since the pandemic, in Fresno County, and the state of California as a whole.

The median household income in Fresno County is $75,585, which is significantly lower than the statewide amount of $100,149 (2024 American Community Survey). The county has a high percentage of its population living under the poverty level (18.3%), compared to statewide (11.8%).

4. Penetration Rates for Mental Health Services

Figure 2 shows the percentage of the general population who access mental health services. Figure 2 shows the same county general population data shown in Figure 1 and provides information on the number of persons who received mental health services (FY 2024/25). From this data, a penetration rate was calculated, showing the percent of persons in the general population that received mental health services in FY 2024/25. This data is shown by age, race/ethnicity, and gender. primary language was not available for the general population. Note: The general population is used to calculate the penetration rate because the total number of persons in the county with Medi-Cal eligibility/benefits was not available). In addition, the total number of persons served by mental health includes both individuals with Medi-Cal and those who do not have Medi-Cal. So, using the general population is a better representation of access to services.

There were 27,250 people who received one or more mental health services in FY 2024/25. Of these individuals, 30.2% were children ages 0-15; 19.2% were Transition Age Youth (TAY) ages 16-25; 41.6% were adults ages 26-59; and 9.0% were 60 and older. There were 10.2% Black, 0.7% American Indian/Alaskan Native, 4.7% Asian/Pacific Islander, 48.7% Hispanic/Latino, and 18.5% of the individuals who were White. All other race/ethnicity groups represented a small number of individuals. The majority of individuals receiving mental health services have a primary language of English (77.6%), 11.7% have a primary language of Spanish, and .6% have a primary language of Hmong/Lao.

The penetration rate data shows that 2.7% of the Fresno County population received mental health services. Of these individuals, children ages 0-15 had a penetration rate of 3.6%; TAY ages 16-25 had a penetration rate of 3.5%; adults ages 26-59 had a penetration rate of 2.5%; and older adults ages 60 and older had a penetration rate of 1.3%.

For race/ethnicity, persons who are Black had a penetration rate of 6.3%; 3.3% American Indian/Alaskan Native; 1.2% Asian/Pacific Islander; 2.5% Hispanic/Latino; and White had a penetration rate of 1.9%. The other race/ethnicity groups had small numbers of people in the county, so there is a large variability in the data. Data shows that there are 3,201 individuals who reported Spanish as their primary language and 161 who reported Hmong/Lao as their primary language.

Males had a slightly lower mental health penetration rate (2.4%), compared to females (2.5%).

NOTE: *Historical data was collected from Avatar the department's prior Electronic Health Record (EHR). More recent data has been collected from SmartCare the county's current EHR. The data does not include all persons served through the Mental Health Services Act (MHSA) programs, as only some MHSA programs and providers utilize or have access to the EHR. Additionally, the BHSOC moved to a new EHR for the start of FY 24/25. Only recently was a problem with the system identified. For some demographics are not attributed to a single individual but are sometimes credited with an individual per demo (for data like more than one race), thus some of the data/demographic totals may be overrepresented.*

Figure 2
Fresno County Mental Health Penetration Rate
by Gender, Age, Race/Ethnicity, and Language
(Population Source: 2020 Census)

	Fresno County Population 2020 Census		All Mental Health Participants FY 2024-25		Fresno County Population Mental Health Penetration Rate FY 2024-25
Age Distribution	**Number**	**Percent**	**Number**	**Percent**	
0 - 15 years	231,202	22.9%	8,241	30.2%	8,241/231,202 = 3.6%
16 - 25 years	149,342	14.8%	5,229	19.2%	5,229/149,342 = 3.5%
26 - 59 years	442,520	43.9%	11,334	41.6%	11,334/442,520 = 2.6%
60+ years	185,590	18.4%	2,446	9.0%	2,446/185,590 = 1.3%
Total	**1,008,654**	**100.0%**	**27,250**	**100.0%**	**27,250/1,008,654 = 2.7%**
Race/Ethnicity Distribution	**Number**	**Percent**	**Number**	**Percent**	
Black/African American	44,295	4.4%	2,777	10.2%	2,777/44,295 = 6.3%
American Indian/Alaskan Native	6,074	0.6%	202	0.7%	202/6,074 = 3.3%
Asian/Other Pacific Islander	110,898	11.0%	1,281	4.7%	1,281/110,898 = 1.2%
Hispanic/Latino	540,743	53.6%	13,268	48.7%	13,268/540,743 = 2.5%
White	271,889	27.0%	5,047	18.5%	5,047/271,889 = 1.9%
Other/Not Reported	34,755	3.4%	4,675	17.2%	4,675/34,755 = 13.5%
Total	**1,008,654**	**100.0%**	**27,250**	**100.0%**	**27,250/1,008,654 = 2.7%**
Primary Language Distribution	**Number**	**Percent**	**Number**	**Percent**	
English	-	-	21,151	77.6%	-
Spanish	-	-	3,201	11.7%	-
Hmong/Lao	-	-	161	0.6%	-
Other/Not Reported	-	-	2,735	10.0%	-
Total	-	-	**27,248**	**100.0%**	-
Gender Distribution	**Number**	**Percent**	**Number**	**Percent**	
Male	501,441	49.7%	12,065	44.3%	12,065/501,441 = 2.4%
Female	507,213	50.3%	12,452	45.7%	12,452/507,213 = 2.5%
Transgender	-	-	61	0.2%	-
Other/Not Reported	-	-	2,672	9.8%	-
Total	**1,008,654**	**100.00%**	**27,250**	**100.0%**	**27,250/1,008,654 = 2.7%**

5. Analysis of Disparities identified in Mental Health Penetration Rates

The penetration rate data by age shows that there are higher proportions of children and TAY served, compared to adults and older adults. Older adults are the most underserved age group of individuals receiving mental health services. However, many older adults have Medicare insurance and may be accessing mental health services through private providers. When Medicare services are delivered by private providers, the data on service utilization is not reported to DBH.

The penetration rate data by race/ethnicity shows the number of persons served out of the county population for each cultural group. Across all cultures, the penetration rate is 2.7%. This data shows variability across the different cultural groups, but this data is difficult to interpret for the cultural groups with smaller numbers in the population. The penetration rate for persons who are

Hispanic/Latino is 2.5% with 13,268 accessing mental health services out of the total Hispanic/Latino population of 540,743. The penetration rate for persons who are Black is 6.3%, with a smaller number of people served (2,777) and smaller population in the county (44,295). The penetration rate for persons who are White is 1.9%, with 5,047 persons served, out of 271,889 in the population. There were 5,675 out of 34,755 people with an 'Other/Not Reported' for data reported on race/ethnicity, showing a penetration rate of 13.5%. There is a very high rate of Other/Not Reported race/ethnicity for FY 2024/25. This high rate of Other/Not Reported which may reflect the impact of COVID on the system of care. If all services for an individual are delivered through telehealth, demographic information is not consistently collected by service delivery staff. It is also important to note the transition to a new statewide Electronic Health Record and its effect on the continuity of data collection including the acclimation of staff responsible for collection.

This data highlights the need to continue to periodically analyze data to assess access to services for different racial and ethnic groups and identify methods for collecting preferred language, especially for persons who speak Spanish and Hmong, the two threshold languages. Also, the data shows the need to develop methods to accurately collect race and ethnicity, sexual orientation and gender identity (SOGI) and expand the availability of bilingual, bicultural staff to deliver services in the individual's preferred language. This information would be helpful in identifying the need to recruit, hire, and retain more bilingual and bicultural staff to provide direct services and administrative support in each community.

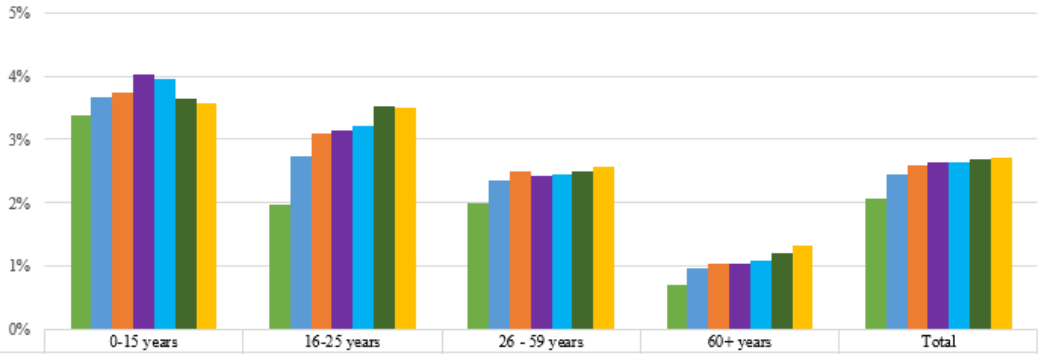
This data provides important information on documenting the ongoing need to attract, employ, and retain bilingual/bicultural staff, improve access, and identify other opportunities to engage culturally diverse communities. The development of additional positions and expanding workforce to address cultural/language needs will be implemented in collaboration with a mental health literacy effort. This approach will help to address the stigma that prevents people from accessing care, even when the staff speaks the language or understands their family's culture. This multi-pronged effort will help to promote access and hiring efforts. While we continue to increase the number of bilingual and bicultural staff across the BHSOC, this data illustrates there is a continued need to refine and enhance data collection to support our goals of improving access and services using accurate and reliable data.

The data on gender distribution shows that there are many challenges in collecting accurate information on Sexual Orientation and Gender Identity (SOGI) data. Out of the 27,250 persons served, only 61 reported Transgender. This area will continue to be a focus for DBH, as well as the DEI Committee, to identify strategies for collecting this important information.

6. Mental Health Penetration Rate Trends for Seven Fiscal Years

Figure 3 shows the penetration rates data for seven (7) years, FY 2018/19 to FY 2024/25, by age. The data shows an increase in the number of individuals served between FY 2018/19 through FY 2024/25 across all age groups. The total number of individuals served increased from 20,918 to 27,250 individuals in this period. The number of individuals served ages 0-15 increased from 7,831 to 8,241, and the number of TAY ages 16-25 increased from 2,956 to 5,229. The number of adult individuals served ages 26-59 increased from 8,822 to 11,334, and the number of older adults ages 60 and older increased from 1,309 to 2,446.

Figure 3
Fresno County Mental Health Services
Mental Health Penetration Rate, by Age
FY 2018-19 to FY 2024-25



	0-15 years	16-25 years	26 - 59 years	60+ years	Total
FY 2018-19 # Participants	7,831	2,956	8,822	1,309	20,918
FY 2018-19 Penetration Rate	3.4%	2.0%	2.0%	0.7%	2.1%
FY 2019-20 # Participants	8,453	4,088	10,434	1,783	24,758
FY 2019-20 Penetration Rate	3.7%	2.7%	2.4%	1.0%	2.5%
FY 2020-21 # Participants	8,632	4,623	11,052	1,932	26,239
FY 2020-21 Penetration Rate	3.7%	3.1%	2.5%	1.0%	2.6%
FY 2021-22 # Participants	9,281	4,679	10,711	1,947	26,618
FY 2021-22 Penetration Rate	4.0%	3.1%	2.4%	1.0%	2.6%
FY 2022-23 # Participants	9,117	4,792	10,791	2,012	26,712
FY 2022-23 Penetration Rate	3.9%	3.2%	2.4%	1.1%	2.6%
FY 2023-24 # Participants	8,442	5,261	11,088	2,246	27,037
FY 2023-24 Penetration Rate	3.7%	3.5%	2.5%	1.2%	2.7%
FY 2024-25 # Participants	8,241	5,229	11,334	2,446	27,250
FY 2024-25 Penetration Rate	3.6%	3.5%	2.6%	1.3%	2.7%
Fresno County Census Population	231,202	149,342	442,520	185,590	1,008,654

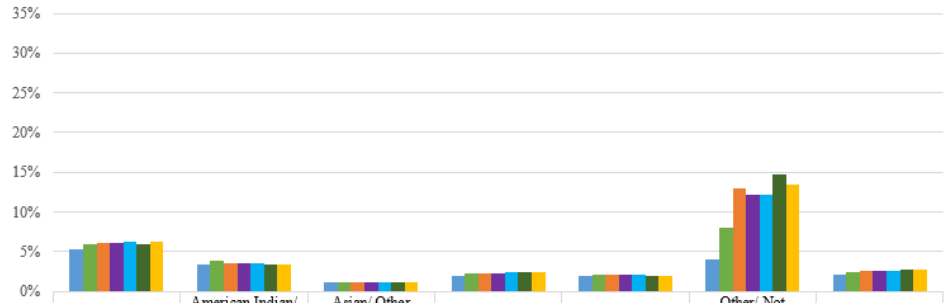
Figure 4 shows the Penetration Rate for the same seven (7) years for race/ethnicity. The total number of persons served each year increased across all race and ethnicity categories, and for the total number of persons served. The number of persons served increased from 20,918 in FY 2018/19 to 27,250 in FY 2024/25. This number is an increase of 6,332 persons served across the seven years.

Overall, the penetration rate shows an increase, 2.1% to 2.7%. Each of the five primary race/ethnicity groups also or an increase in the number of persons served. The number of individuals served who are Black increased slightly (2,310 to 2,777). The number of individuals served who are American Indian/Alaska Native decreased slightly (205 to 202). The number of individuals served who are Asian/Other Pacific Islander increased slightly (1,221 to 1,281).

The number of individuals served who are White decreased slightly across the seven years from 5,238 to 5,047). The number of Hispanic/Latino individuals served showed an increase, from 10,545 to 13,268.

The large number of persons who did not have race/ethnicity reported is also shown in this figure. Across the seven years, there has also been a large increase in the number of individuals served whose race/ethnicity is Not Reported (1,399 to 4,675). This increase was most significant from 2,766 in FY 2019/20 to 4,479 in FY 2020/21. This increase is likely due to COVID-19 and the increase in the use of telehealth. There has been a slight decrease in this category over the last year as the Department continues to address this significant gap in data collection by providing training to staff on our new Electronic Heath Record.

Figure 4
Fresno County Mental Health Services
Mental Health Penetration Rate, by Race/Ethnicity
FY 2018-19 to FY 2024-25



	Black	American Indian/ Alaskan Native	Asian/ Other Pacific Islander	Hispanic/ Latino	White	Other/ Not Reported	Total
FY 2018-19 # Participants	2,310	205	1,221	10,545	5,238	1,399	20,918
FY 2018-19 Penetration Rate	5.2%	3.4%	1.1%	2.0%	1.9%	4.0%	2.1%
FY 2019-20 # Participants	2,640	238	1,269	12,167	5,678	2,766	24,758
FY 2019-20 Penetration Rate	6.0%	3.9%	1.1%	2.3%	2.1%	8.0%	2.5%
FY 2020-21 # Participants	2,680	211	1,178	12,020	5,671	4,479	26,239
FY 2020-21 Penetration Rate	6.1%	3.5%	1.1%	2.2%	2.1%	12.9%	2.6%
FY 2021-22 # Participants	2,722	219	1,224	12,600	5,651	4,202	26,618
FY 2021-22 Penetration Rate	6.1%	3.6%	1.1%	2.3%	2.1%	12.1%	2.6%
FY 2022-23 # Participants	2,775	213	1,243	12,692	5,549	4,240	26,712
FY 2022-23 Penetration Rate	6.3%	3.5%	1.1%	2.3%	2.0%	12.2%	2.6%
FY 2023-24 # Participants	2,647	200	1,237	12,688	5,156	5,109	27,037
FY 2023-24 Penetration Rate	6.0%	3.3%	1.1%	2.3%	1.9%	14.7%	2.7%
FY 2024-25 # Participants	2,777	202	1,281	13,268	5,047	4,675	27,250
FY 2024-25 Penetration Rate	6.3%	3.3%	1.2%	2.5%	1.9%	13.5%	2.7%
Fresno County Census Population	44,295	6,074	110,898	540,743	271,889	34,755	1,008,654

7. Mental Health Medi-Cal Population

In addition to examining the Penetration Rate for access to mental health services in the general population, it is also important to calculate the percent of Medi-Cal mental health service recipients out of total mental health service recipients. Figure 5 shows the comparison of total mental health participants and those who have Medi-Cal benefits. This data is analyzed by age, race/ethnicity, language, and gender.

The first column of numbers in Figure 5 shows the total number of persons served in the mental health system in FY 2024/25. For children, there were 8,442 children served (31.2% of all participants). The middle column shows the number of mental health participants that had Medi-Cal. For children, there were 6,738 children with Medi-Cal (29.5% of Medi-Cal participants). The far-right column shows the percentage of children participants with Medi-Cal (79.8%). Across the ages, 60+ years have the highest proportion of mental health participants on Medi-Cal (95.2%). The smallest proportion is 0-15 years, at 79.8%. Many older adults have Medicare, so access services through private providers.

For Race/ethnicity, Asian/Pacific Islander have the highest proportion on Medi-Cal at 92.4%. Black is 89.9% and American Indian/Alaskan Native is 89%.

Language shows 90.4% of all Hmong/Lao persons served have Medi-Cal while 74.4% of Spanish speakers. Females have a higher proportion on Medi-Cal with 86.9% compared to males at 86.1%.

8. Analysis of Disparities identified in Persons receiving Medi-Cal Services

Figure 5 shows that the majority of individuals served by the mental health system had Medi-Cal benefits. Overall, 80.9% of the persons served had Medi-Cal. Participants ages 0-15 had the lowest proportion of those with Medi-Cal benefits at 73.7%. Regarding race/ethnicity, 70.0% of those with other/not reported had Medi-Cal benefits and those with other/not reported for Primary Language (66.9%) had Medi-Cal. Males had a slightly lower proportion of males with Medi-Cal (81.4%) compared to females (82.1%). We will continue to identify opportunities to improve access and data by going to community forums and conduct needs assessments to identify disparities in services by different populations.

Figure 5
Fresno County Percent of Medi-Cal Mental Health Outpatient Service Recipients out of total Mental Health Service Recipients By Age, Race/Ethnicity, Language, and Gender

	All Mental Health Outpatient Participants FY 2024-25		Medi-Cal Mental Health Outpatient Participants Served FY 2024-25		MH Medi-Cal Participants out of Total MH Participants FY 2024-25
Age Distribution	**Number**	**Percent**	**Number**	**Percent**	
0 - 15 years	8,241	30.2%	6,076	27.6%	6,076/8,241 = 73.7%
16 - 25 years	5,229	19.2%	3,942	17.9%	3,942/5,229 = 75.4%
26 - 59 years	11,334	41.6%	9,959	45.2%	9,959/11,334 = 87.9%
60+ years	2,446	9.0%	2,060	9.3%	2,060/2,446 = 84.2%
Total	**27,250**	**100.0%**	**22,037**	**100.0%**	**22,037/27,250 = 80.9%**
Race/Ethnicity Distribution	**Number**	**Percent**	**Number**	**Percent**	
Black	2,777	10.2%	2,312	10.5%	2,312/2,777 = 83.3%
American Indian/Alaskan Native	202	0.7%	159	0.7%	159/202 = 78.7%
Asian/Other Pacific Islander	1,281	4.7%	1,153	5.2%	1,153/1,281 = 90.0%
Hispanic/Latino	13,268	48.7%	10,953	49.7%	10,953/13,268 = 82.6%
White	5,047	18.5%	4,188	19.0%	4,188/5,047 = 83.0%
Other/Not Reported	4,675	17.2%	3,272	14.8%	3,272/4,675 = 70.0%
Total	**27,250**	**100.0%**	**22,037**	**100.0%**	**22,037/27,250 = 80.9%**
Primary Language Distribution	**Number**	**Percent**	**Number**	**Percent**	
English	21,151	77.6%	17,563	79.7%	17,563/21,151 = 83.0%
Spanish	3,201	11.7%	2,488	11.3%	2,488/3,201 = 77.7%
Hmong/Lao	161	0.6%	156	0.7%	156/161 = 96.9%
Other/Not Reported	2,735	10.0%	1,830	8.3%	1,830/2,735 = 66.9%
Total	**27,248**	**100.0%**	**22,037**	**100.0%**	**22,037/27,248 = 80.9%**
Gender Distribution	**Number**	**Percent**	**Number**	**Percent**	
Male	12,065	44.3%	9,819	44.6%	9,819/12,065 = 81.4%
Female	12,452	45.7%	10,225	46.4%	10,225/12,452 = 82.1%
Transgender	61	0.2%	52	0.2%	52/61 = 85.2%
Other/Not Reported	2,672	9.8%	1,941	8.8%	1,941/2,672 = 72.6%
Total	**27,250**	**100.0%**	**22,037**	**100.0%**	**22,037/27,250 = 80.9%**

9. Penetration Rates for Substance Use Disorder Services

Figure 6 shows the number of persons in the county *general* population (2020 Census) and the number of persons who received substance use disorder (SUD) services in FY 2024/25. From this data, a penetration rate was calculated, showing the percent of persons in the *general* population that received SUD services during this time period. This data is shown by age, race/ethnicity, and gender. Primary Language was not available for the general population. Note: The general population is used to calculate the penetration rate because the total number of persons in the county with Medi-Cal eligibility/benefits was not available. In addition, the total number of persons served by SUD services includes both individuals with Medi-Cal and those who do not have Medi-Cal. So, using the general population is a better representation of access to services.

Of the 1,008,654 residents who live in Fresno County, 30.6% are less than 21 years old; 28.6% are ages 21-39; 22.5% are adults ages 40-59; and 18.4% are older adults ages 60 years and older. The majority of persons in Fresno County identify as Hispanic/Latino (53.6%) and White (27%). There are an equal number of individuals who identify as male (49.7%) and female (50.3%) in the county.

As expected, the proportion of persons receiving SUD services shows a different proportion of individuals by age. There were 6,250 individuals who received one or more SUD services in FY 2024/25. Of these individuals, 50.7% were less than 21 years old; 28.7% were ages 21-39; 18.2% were adults ages 40-59; and 2.4% were ages 60 and older.

Of the individuals who received SUD services, 48.7% identified as Hispanic/Latino and 11.6% identified as White. All other race/ethnicity groups represented a small number of individuals. Most individual's primary language was English (74.3%), 8.3% reported a primary language of Spanish, and no individuals reported a primary language of Hmong/Lao. More individuals receiving SUD services identified as male (51.5%) as compared to female (36.6%) or Transgender (0.2%).

The penetration rate data shows that 0.6% of the Fresno County population received SUD treatment services. Of these individuals, participants less than 21 years old had a penetration rate of 0.9%, ages 21-39 had a penetration rate of 0.6%, adults ages 40-59 had a penetration rate of 0.5%, and older adults ages 60 and older had a penetration rate of 0.1%.

For race/ethnicity, persons who identified as Black had a penetration rate of 1.0% and persons who identified as Hispanic/Latino had a penetration rate of 0.5%. The other race/ethnicity groups had small numbers of people in the county, so there is a large variability in the data. Males had a higher penetration rate (0.6%) compared to females (0.4%).

Figure 6
Fresno County Substance Use Disorder Outpatient Penetration Rate
By Gender, Age, Race/Ethnicity, and Language
(Population Source: 2020 Census)

	Fresno County Population 2020 Census		All Substance Use Outpatient Participants FY 2024-25		Fresno County Population Substance Use Penetration Rate FY 2024-25
Age Distribution	**Number**	**Percent**	**Number**	**Percent**	
0 - 21 years	308,241	30.6%	3,167	50.7%	3,167/308,241 = 1.0%
21 - 39 years	288,313	28.6%	1,795	28.7%	1,795/288,313 = 0.6%
40 - 59 years	226,510	22.5%	1,135	18.2%	1,135/226,510 = 0.5%
60+ years	185,590	18.4%	153	2.4%	153/185,590 = 0.1%
Total	**1,008,654**	**100.0%**	**6,250**	**100.0%**	**6,250/1,008,654 = 0.6%**
Race/Ethnicity Distribution	**Number**	**Percent**	**Number**	**Percent**	
Black	44,295	4.4%	515	8.2%	515/44,295 = 1.2%
American Indian/Alaskan Native	6,074	0.6%	45	0.7%	45/6,074 = 0.7%
Asian/Other Pacific Islander	110,898	11.0%	96	1.5%	96/110,898 = 0.1%
Hispanic/Latino	540,743	53.6%	3,042	48.7%	3,042/540,743 = 0.6%
White	271,889	27.0%	728	11.6%	728/271,889 = 0.3%
Other/Not Reported	34,755	3.4%	1,824	29.2%	1,824/34,755 = 5.2%
Total	**1,008,654**	**100.0%**	**6,250**	**100.0%**	**6,250/1,008,654 = 0.6%**
Primary Language Distribution	**Number**	**Percent**	**Number**	**Percent**	
English	-	-	4,642	74.3%	-
Spanish	-	-	518	8.3%	-
Hmong/Lao	-	-	0	0.0%	-
Other/Not Reported	-	-	1,090	17.4%	-
Total	-	-	**6,250**	**100.0%**	-
Gender Distribution	**Number**	**Percent**	**Number**	**Percent**	
Male	501,441	49.7%	3,216	51.5%	3,216/501,441 = 0.6%
Female	507,213	50.3%	2,290	36.6%	2,290/507,213 = 0.5%
Transgender	-	-	11	0.2%	-
Other/Not Reported	-	-	733	11.7%	-
Total	**1,008,654**	**100.00%**	**6,250**	**100.0%**	**6,250/1,008,654 = 0.6%**

10. Analysis of Disparities identified in SUD Services

Figure 6 data also shows that the majority of SUD outpatient services individuals served are adults 0-21 years (50.7% compared to 30.6% of the population). Individuals served who identified as Hispanic/Latino represent 48.7% of the individuals served compared to 53.6% of the population.

Individuals served who identified as Black had a higher proportion of individuals served (8.2% compared to 4.4% of the population), as did American Indian/Alaskan Native (.7% compared to 0.6% of the population). There was a higher proportion of individuals served who identified as male (51.5%) than female (36.6%). This data illustrates the need to provide culturally responsive/appropriate services to individuals receiving SUD services.

B. Utilization of Behavioral Health Services

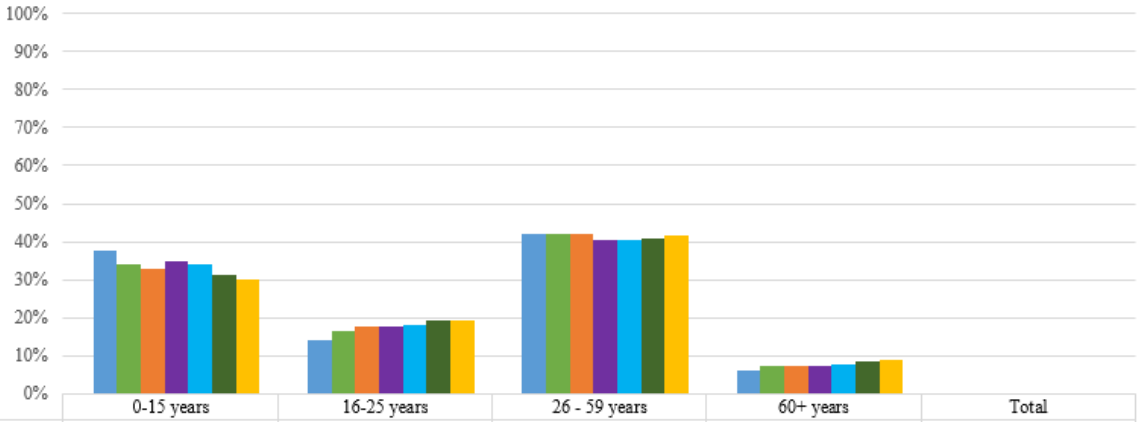
1. Mental Health Outpatient Services by Demographics

Figure 7 shows the number and percent of individuals who received mental health outpatient services by age group for seven (7) years, FY 2018/19 to FY 2024/25. This data is calculated from EHR data. This data does not include persons served through programs funded solely through the Mental Health Services Act (MHSA) and/or from organizational providers who do not report data to the EHR. This data shows an unduplicated count of individuals served in each of the seven (7) fiscal years, by age group. Each fiscal year represents services delivered from July 1 through June 30.

Of the 27,250 people served in FY 2024/25:

- 30.2% were Children ages 0-15;
- 19.2% were TAY, ages 16-25;
- 41.6% were Adults ages 26-59; and
- 9.0% were Older Adults, ages 60+.

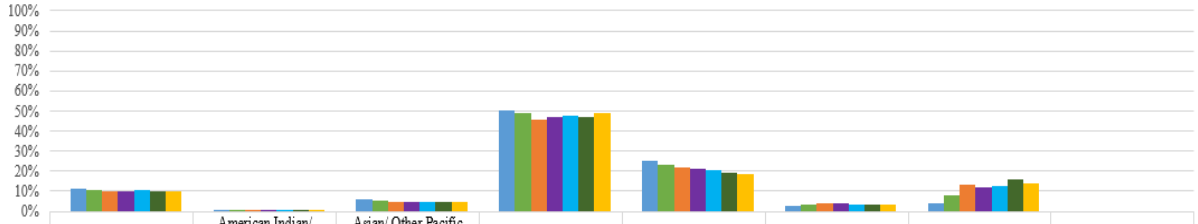
Figure 7
Fresno County Mental Health Outpatient Services
Number and Percent of Individuals Served, by Age
FY 2018-19 to FY 2024-25



	0-15 years	16-25 years	26 - 59 years	60+ years	Total
# Individuals FY 2018-19	7,831	2,956	8,822	1,309	20,918
% Individuals FY 2018-19	37.4%	14.1%	42.2%	6.3%	100.0%
# Individuals FY 2019-20	8,453	4,088	10,434	1,783	24,758
% Individuals FY 2019-20	34.1%	16.5%	42.1%	7.2%	100.0%
# Individuals FY 2020-21	8,632	4,623	11,052	1,932	26,239
% Individuals FY 2020-21	32.9%	17.6%	42.1%	7.4%	100.0%
# Individuals FY 2021-22	9,281	4,679	10,711	1,947	26,618
% Individuals FY 2021-22	34.9%	17.6%	40.2%	7.3%	100.0%
# Individuals FY 2022-23	9,117	4,792	10,791	2,012	26,712
% Individuals FY 2022-23	34.1%	17.9%	40.4%	7.5%	100.0%
# Individuals FY 2023-24	8,442	5,261	11,088	2,246	27,037
% Individuals FY 2023-24	31.2%	19.5%	41.0%	8.3%	100.0%
# Individuals FY 2024-25	8,241	5,229	11,334	2,446	27,250
% Individuals FY 2024-25	30.2%	19.2%	41.6%	9.0%	100.0%

Figure 8 shows the number and percent of individuals who received one or more mental health outpatient services from FY 2018/19 to FY 2024/25, by race/ethnicity. This data is collected from the EHR. This data shows that in FY 2024/25, of the 27,250 individuals receiving mental health services, 18.5% are White, 48.7% are Hispanic/Latino, 0.7% are American Indian/Alaskan Native, 4.7% are Asian/Other Pacific Islander, 10.2% are Black, and 3.3% Other. There were 3,770 (13.8%) that did not report race/ethnicity.

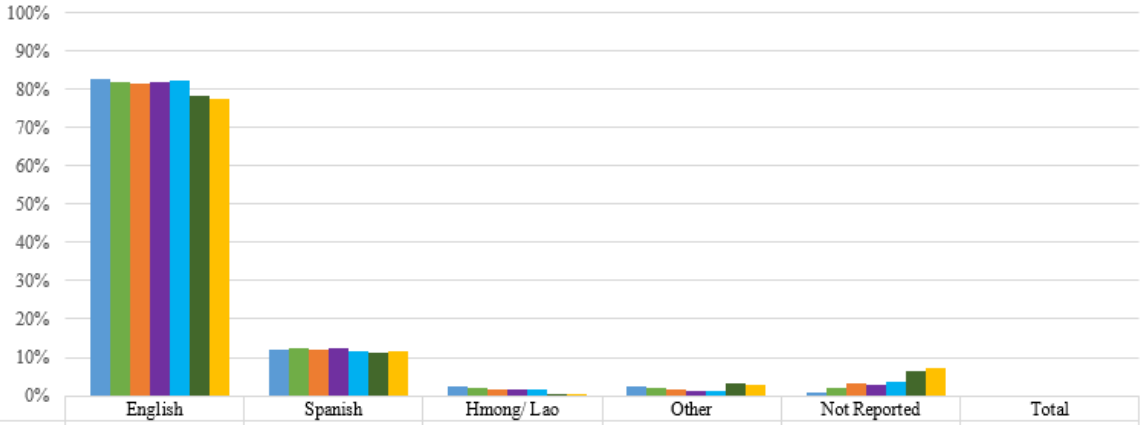
Figure 8
Fresno County Mental Health Outpatient Services
Number and Percent of Individuals Served, by Race/Ethnicity
FY 2018-19 to FY 2024-25



	Black	American Indian/ Alaskan Native	Asian/ Other Pacific Islander	Hispanic/ Latino	White	Other	Not Reported	Total
# Individuals FY 2018-19	2,310	205	1,221	10,545	5,238	589	810	20,918
% Individuals FY 2018-19	11.0%	1.0%	5.8%	50.4%	25.0%	2.8%	3.9%	100.0%
# Individuals FY 2019-20	2,640	238	1,269	12,167	5,678	772	1,994	24,758
% Individuals FY 2019-20	10.7%	1.0%	5.1%	49.1%	22.9%	3.1%	8.1%	100.0%
# Individuals FY 2020-21	2,680	211	1,178	12,020	5,671	1,050	3,429	26,239
% Individuals FY 2020-21	10.2%	0.8%	4.5%	45.8%	21.6%	4.0%	13.1%	100.0%
# Individuals FY 2021-22	2,722	219	1,224	12,600	5,651	1,021	3,181	26,618
% Individuals FY 2021-22	10.2%	0.8%	4.6%	47.3%	21.2%	3.8%	12.0%	100.0%
# Individuals FY 2022-23	2,775	213	1,243	12,692	5,549	916	3,324	26,712
% Individuals FY 2022-23	10.4%	0.8%	4.7%	47.5%	20.8%	3.4%	12.4%	100.0%
# Individuals FY 2023-24	2,647	200	1,237	12,688	5,156	882	4,227	27,037
% Individuals FY 2023-24	9.8%	0.7%	4.6%	46.9%	19.1%	3.3%	15.6%	100.0%
# Individuals FY 2024-25	2,777	202	1,281	13,268	5,047	904	3,770	27,250
% Individuals FY 2024-25	10.2%	0.7%	4.7%	48.7%	18.5%	3.3%	13.8%	100.0%

Figure 9 shows the number and percent of individuals who received one or more mental health outpatient services for seven (7) years (FY 2018/19 to FY 2024/25) by primary language. This data shows that in FY 2024/25, 77.6% of individuals served reported English, 11.7% reported Spanish, .6% reported Hmong/Laotian (note that these are grouped but we understand these are two different distinct language, but most common languages spoken by our API population), and 2.7% reported Other Languages. There were 2,013 that did not report a primary language (7.4%).

Figure 9
Fresno County Mental Health Outpatient Services
Number and Percent of Individuals Served, by Primary Language
FY 2018-19 to FY 2024-25

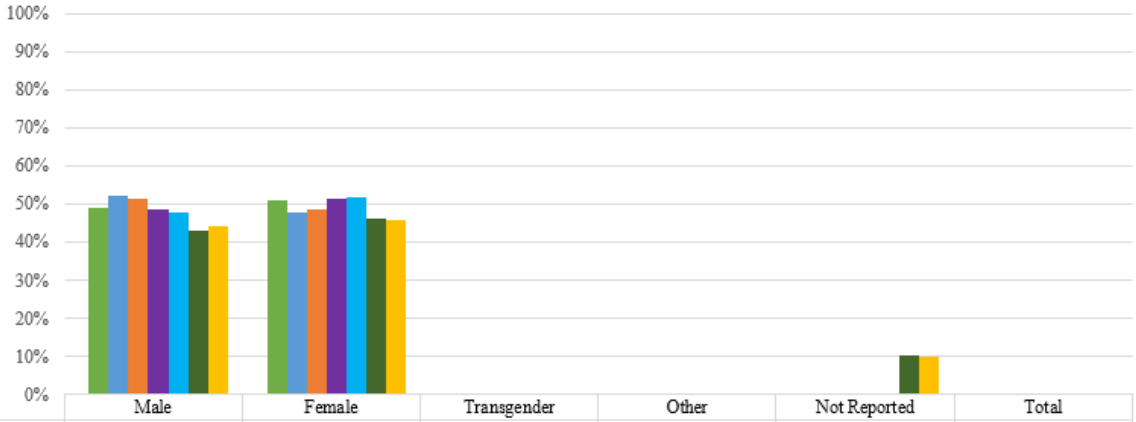


	English	Spanish	Hmong/ Lao	Other	Not Reported	Total
# Individuals FY 2018-19	17,253	2,512	501	470	182	20,918
% Individuals FY 2018-19	82.5%	12.0%	2.4%	2.2%	0.9%	100.0%
# Individuals FY 2019-20	20,244	3,054	479	473	508	24,758
% Individuals FY 2019-20	81.8%	12.3%	1.9%	1.9%	2.1%	100.0%
# Individuals FY 2020-21	21,398	3,107	438	416	880	26,239
% Individuals FY 2020-21	81.6%	11.8%	1.7%	1.6%	3.4%	100.0%
# Individuals FY 2021-22	21,780	3,301	436	369	732	26,618
% Individuals FY 2021-22	81.8%	12.4%	1.6%	1.4%	2.8%	100.0%
# Individuals FY 2022-23	21,920	3,078	442	349	923	26,712
% Individuals FY 2022-23	82.1%	11.5%	1.7%	1.3%	3.5%	100.0%
# Individuals FY 2023-24	21,322	3,046	125	830	1,714	27,307
% Individuals FY 2023-24	78.1%	11.2%	0.5%	3.0%	6.3%	100.0%
# Individuals FY 2024-25	21,151	3,201	161	724	2,013	27,250
% Individuals FY 2024-25	77.6%	11.7%	0.6%	2.7%	7.4%	100.0%

This data identifies the need to train staff on collecting data on Primary Language. It would also be helpful to collect information on Preferred Language to help identify the need for trained interpreters to deliver services in the person's preferred language.

Figure 10 shows the number and percent of individuals who received one or more mental health outpatient services for seven (7) years, FY 2018/19 to FY 2024/25, by gender. This data shows that in FY 2024/25, 44.3% were males and 45.7% were female. There were 61 individuals that were transgender (0.2%); twenty (34) reported "Other;" and 2,638 did not report gender.

Figure 10
Fresno County Mental Health Outpatient Services
Number and Percent of Individuals Served, by Gender
FY 2018-19 to FY 2024-25



	Male	Female	Transgender	Other	Not Reported	Total
# Individuals FY 2018-19	10,256	10,659			3	20,918
% Individuals FY 2018-19	49.0%	51.0%	0.0%	0.0%	0.0%	100.0%
# Individuals FY 2019-20	12,896	11,852	5		5	24,758
% Individuals FY 2019-20	52.1%	47.9%	0.0%	0.0%	0.0%	100.0%
# Individuals FY 2020-21	13,434	12,780	17	4	4	26,239
% Individuals FY 2020-21	51.2%	48.7%	0.1%	0.0%	0.0%	100.0%
# Individuals FY 2021-22	12,957	13,623	33	2	3	26,618
% Individuals FY 2021-22	48.7%	51.2%	0.1%	0.0%	0.0%	100.0%
# Individuals FY 2022-23	12,782	13,839	72	5	14	26,712
% Individuals FY 2022-23	47.9%	51.8%	0.3%	0.0%	0.1%	100.0%
# Individuals FY 2023-24	11,617	12,517	59	20	2,824	27,037
% Individuals FY 2023-24	43.0%	46.3%	0.2%	0.1%	10.4%	100.0%
# Individuals FY 2024-25	12,065	12,452	61	34	2,638	27,250
% Individuals FY 2024-25	44.3%	45.7%	0.2%	0.1%	9.7%	100.0%

This data illustrates the need to train staff on how to collect sensitive information and report on individuals identifying as transgender or other identities on the gender spectrum. This cultural group has experienced a high rate of bullying, and many have experienced trauma and/or suicidal behavior. As a result, having accurate and timely data on the persons served will help the CRP identify opportunities to expand or adapt services to this vulnerable population. These individuals, and their families, could benefit from receiving welcoming and accessible mental health services. It also makes clear the need to ensure that SOGI data is collected for each person served.

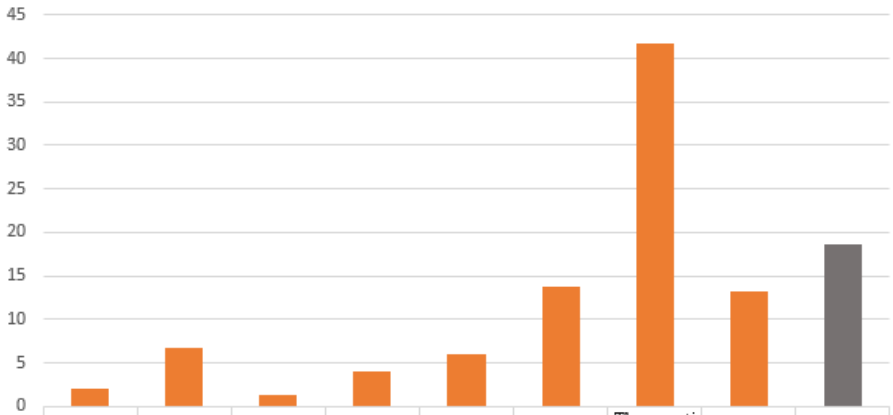
2. Utilization of Mental Health Outpatient Services

Figure 11 shows the total number of hours per year, individuals served, and hours per individual, by type of mental health service for FY 2024/25.This EHR data shows that the 27,250 individuals served in FY 2024/25 received a total of 505,344 hours of mental health outpatient services in the year. This calculates into an average of 18.54 hours per individual per year. This data also shows the number of individuals and average hours for each type of service. Individuals can receive more than one type of service. The number of individuals varies by type of service.

In FY 2024/25, individuals who received an assessment averaged 2.11 hours of assessment in the year; care coordination averaged 6.65 hours; rehabilitation averaged 13.71hours; crisis services averaged 1.31 hours; medication support averaged 3.99 hours; and outpatient therapy averaged 13.28 hours.

Over 50% of all persons served received an assessment and case coordination. Nearly 50% received outpatient therapy and medication services was around 44%. It is also important to review the number of persons served that received each type of service.
With future efforts to have more complete demographic data available, DBH hopes to identify any possible disparities.

Figure 11
Fresno County Mental Health Outpatient Services
Total Mental Health Hours, Persons Served, and Hours Per Person Served, by Service Type
FY 2024-25



	Assessment	Care Coordination	Crisis Services	Medication Support	Peer Support	Rehabilitation	Therapeutic Behavioral Services	Therapy	Total
# Hours FY 2024-25	29,821	117,998	5,243	47,722	9,108	106,839	15,916	172,696	505,344
# Individuals FY 2024-25	14,123	17,754	4,009	11,970	1,518	7,793	382	13,005	27,250
Avg. Hours per Person Served FY 2024-25	2.11	6.65	1.31	3.99	6.00	13.71	41.66	13.28	18.54

3. Analysis of the Mental Health Data

The DEIC will review the Mental Health population data and develop recommendations in the next six (6) months. This review will allow the DEIC to better understand the service utilization data and make recommendations for enhancing services. Additional programmatic data will be used and support efforts around reducing health disparities as part of future BHT goals and reporting.

4. SUD Outpatient Services by Demographics

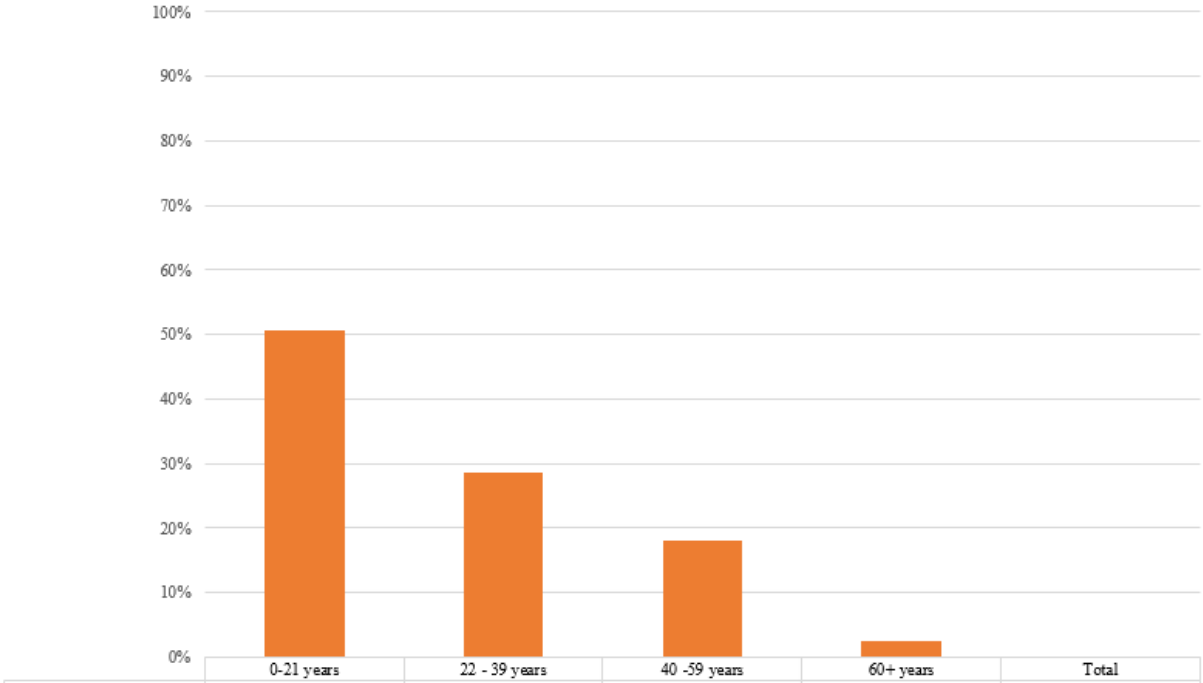
Figures 12 through 17 show SUD outpatient service utilization data by demographics for FY 2024/25. The implementation of this complex system transformed the service delivery system, which in turn changed the data collection processes in the county's Electronic Health Record (EHR). As a result, the timeliness and quality of the data is being refined. The data for the SUD outpatient services is shown only for one year: FY 2024/25. The Drug Medi-Cal Organized Delivery System (DMC-ODS) system was implemented beginning in January 2020, for a partial year through June 30, 2020. The data below shows a full 12 months of data for FY 2024/25 for SUD services delivered between July 1, 2024 and June 30, 2025.

Figure 12 shows the number and percent of individuals who received SUD outpatient services by age group for FY 2024/25. This EHR data shows an unduplicated count of individuals served by age group. Each individual received one or more SUD services in FY 2024/25.

Of the 6,250 (unduplicated) people receiving SUD outpatient services in FY 2024/25:

- 50.7% were less than 21 years
- 28.7% were ages 21-39
- 18.2% were ages 40-59
- 2.4% were ages 60+

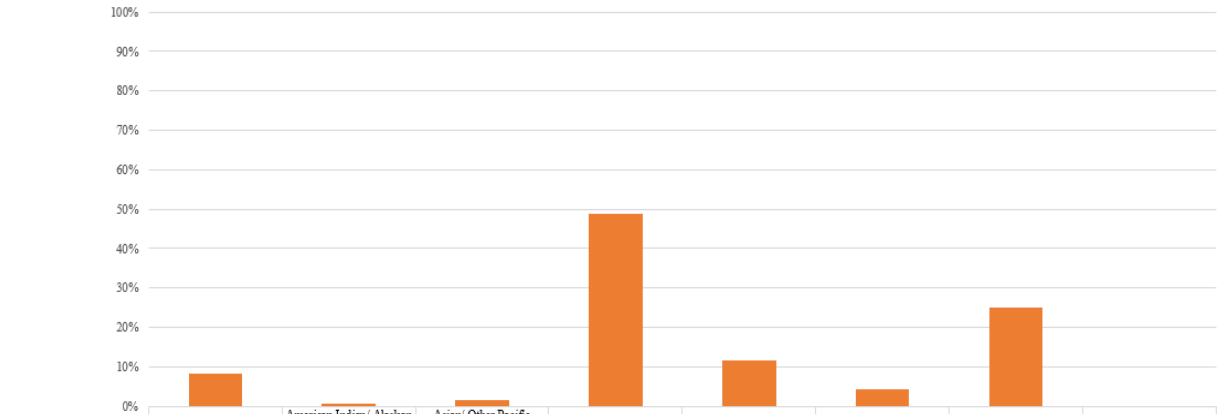
Figure 12
Fresno County Substance Use Disorder Outpatient Services
Number and Percent of Individuals Served, by Age
FY 2024-25



	0-21 years	22 - 39 years	40 -59 years	60+ years	Total
# Individuals FY 2024-25	3,167	1,795	1,135	153	6,250
% Individuals FY 2024-25	50.7%	28.7%	18.2%	2.4%	100.0%

Figure 13 shows the number and percentage of individuals who received one or more SUD outpatient service in FY 2024/25, by race/ethnicity. This data shows that of the 6,250 individuals receiving SUD services, 8.2% are Black, .7% are American Indian/Alaskan Native, 1.5% are Asian/Other Pacific Islander, 48.7% are Hispanic/Latino, 11.6% are White, 4.3% Other, and 24.9% (1,557) were not reported. DBH is engaging in efforts to address data collection and improving quality of data with the goal to reduce high numbers of unreported data and help provide a clearer picture to inform strategies.

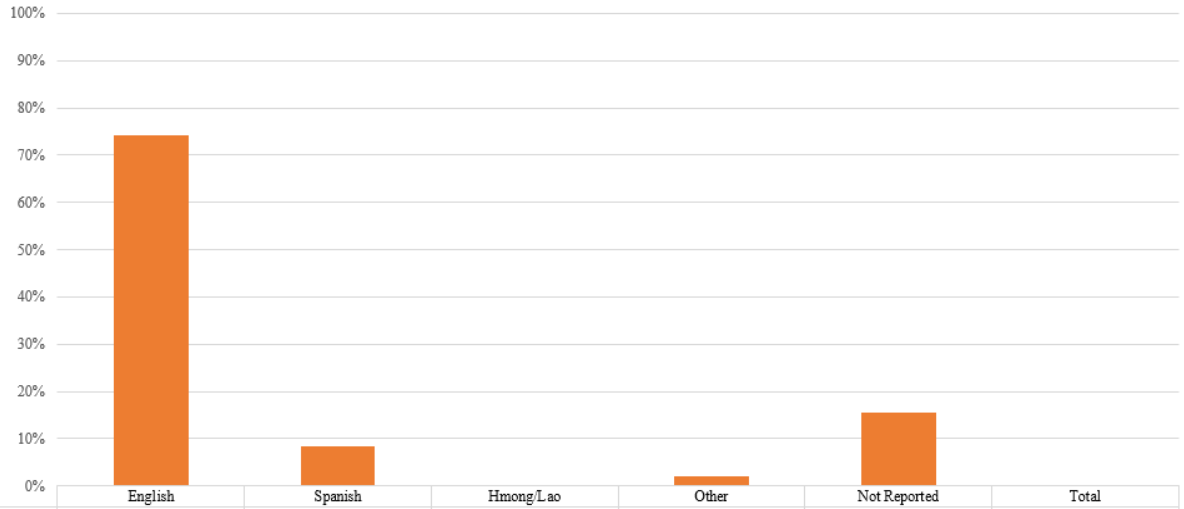
Figure 13
Fresno County Substance Use Disorder Outpatient Services
Number and Percent of Individuals Served, by Race/Ethnicity
FY 2024-25



	Black/ African American	American Indian/ Alaskan Native	Asian/ Other Pacific Islander	Hispanic/ Latino	White	Other	Not Reported	Total
# Individuals FY 2024-25	515	45	96	3,042	728	267	1,557	6,250
% Individuals FY 2024-25	8.2%	0.7%	1.5%	48.7%	11.6%	4.3%	24.9%	100.0%

Figure 14 shows the number and percent of individuals who received one or more SUD outpatient service in FY 2024/25, by primary language. This data shows that 74.3% of individuals served speak English, 8.3% speak Spanish, 0 % speak Hmong or Lao, 1.9% reported that they speak a different language, and 15.5% were not reported. With the transition to BHSA, an integrated plan and implementation of BHT goals, DBH seeks to have improved data collection that can reduce unknown or not reported data.

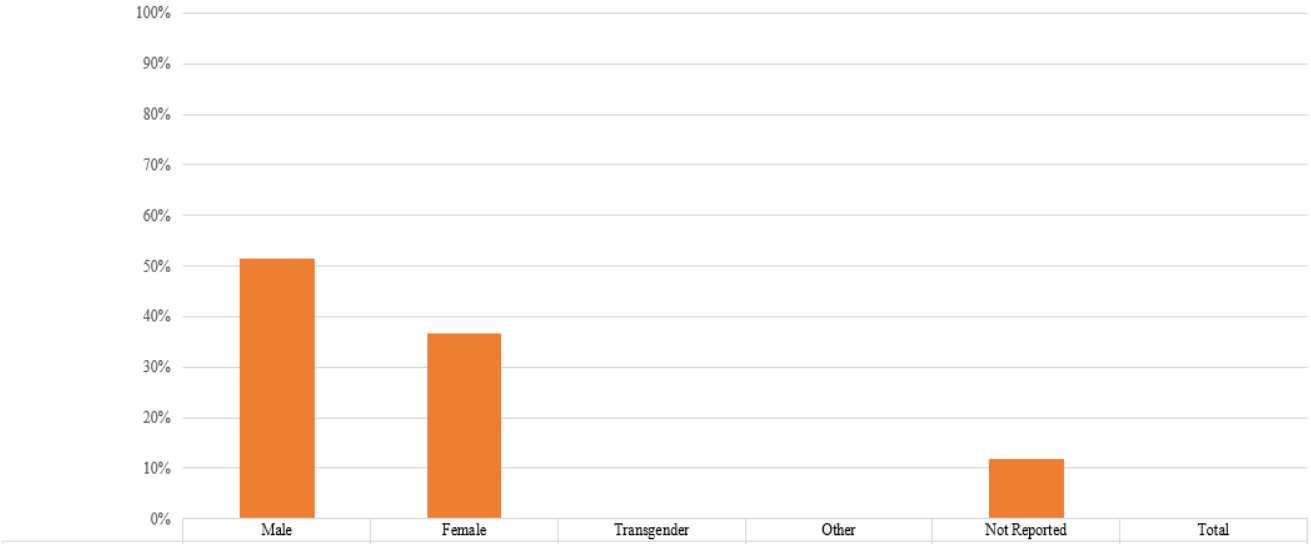
Figure 14
Fresno County Substance Use Disorder Outpatient Services
Number and Percent of Individuals Served, by Primary Language
FY 2024-25



	English	Spanish	Hmong/Lao	Other	Not Reported	Total
# Individuals FY 2024-25	4,642	518	-	121	969	6,250
% Individuals FY 2024-25	74.3%	8.3%	0.0%	1.9%	15.5%	100.0%

Figure 15 shows the number and percent of individuals who received one or more SUD outpatient services in FY 2024/25, by gender. This data shows that for the 6,250 individuals served, 51.5% were male, 36.6% were female, and 0.2% were Transgender. Efforts to improve data collection should reduce the number of "unreported" and/or clarify if the data is unreported, or if the person served opted to "decline to state".

Figure 15
Fresno County Substance Use Disorder Outpatient Services
Number and Percent of Individuals Served, by Gender
FY 2024-25



	Male	Female	Transgender	Other	Not Reported	Total
# Individuals FY 2024-25	3,216	2,290	11	-	733	6,250
% Individuals FY 2023-24	51.5%	36.6%	0.2%	0.0%	11.7%	100.0%

Figure 16 shows the number and percent of individuals who received one or more SUD outpatient service in FY 2024/25 by sexual orientation. This data shows that 2,628 individuals (42%) reported they identified as Heterosexual/Straight; 39 individuals (.6%) identified as Gay or Lesbian; 93 individuals identify as Bisexual (1.5%); 1 individual (0.1%) identified as Transgender; 13 individuals (0.2%) identified as Unsure/Questioning; and 4 individuals (.1%) declined to state. There were 3,472 individuals (55.6%) did not report sexual identity.
The development of this report highlights the significant number of missing data under the category of "not reported" for sexual orientation gender identity (SOGI) data. Efforts will continue so to understand if the not-reported option is being used for those who decline to state, rather than information that has not been asked/collected and develop strategies to improve the data collection so there is less "not-reported" or to know it was not reported as a choice of the person served.

Figure 16
Fresno County Substance Use Disorder Outpatient Services
Number and Percent of Individuals Served, by Sexual Orientation
FY 2024-25

	Heterosexual/ Straight	Gay/ Lesbian	Bisexual	Transgender	Unsure/ Questioning	Declined to State	Not Reported	Total
# Individuals FY 2024-25	2,628	39	93	1	13	4	3,472	6,250
% Individuals FY 2024-25	42.0%	0.6%	1.5%	0.0%	0.2%	0.1%	55.6%	100.0%

5. Utilization of SUD Outpatient Services

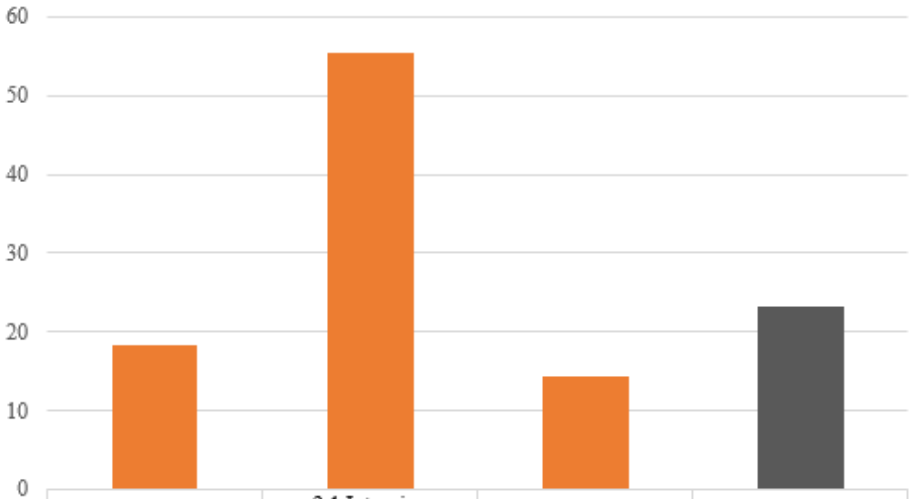
Figure 17 shows the total number of individuals that received SUD outpatient services, the total hours of outpatient services delivered by type of SUD outpatient service for FY 2024/25, and the average hours of outpatient services per individual.

This graph shows data from FY 2024/25. There were 5,869 individuals that received a total of 107,597 hours of SUD outpatient services. This data calculates into an average of 18.3 hours per individual for the fiscal year.

This data also shows the number of individuals, total hours, and average hours per person, for Individual Outpatient. There were 504 individuals that received a total of 27,897 hours of SUD Intensive Outpatient services averaging out to 55.4 hours per individual.

In addition, the data shows that 604 individuals were provide Recovery Services for a total of 8,722 and averaged out to 14.4 hours per person.

Figure 17
Fresno County Substance Use Disorder Outpatient Services
Total Hours, Individuals Served, And Average Hours Per Individual Served, by Level of Care
FY 2024-25



	1.0 Outpatient	2.1 Intensive Outpatient	Recovery Services	Total
# Hours FY 2024-25	107,597	27,897	8,722	144,216
# Individuals FY 2024-25	5,869	504	604	6,250
Avg. Hours per Person Served FY 2024-25	18.3	55.4	14.4	23.1

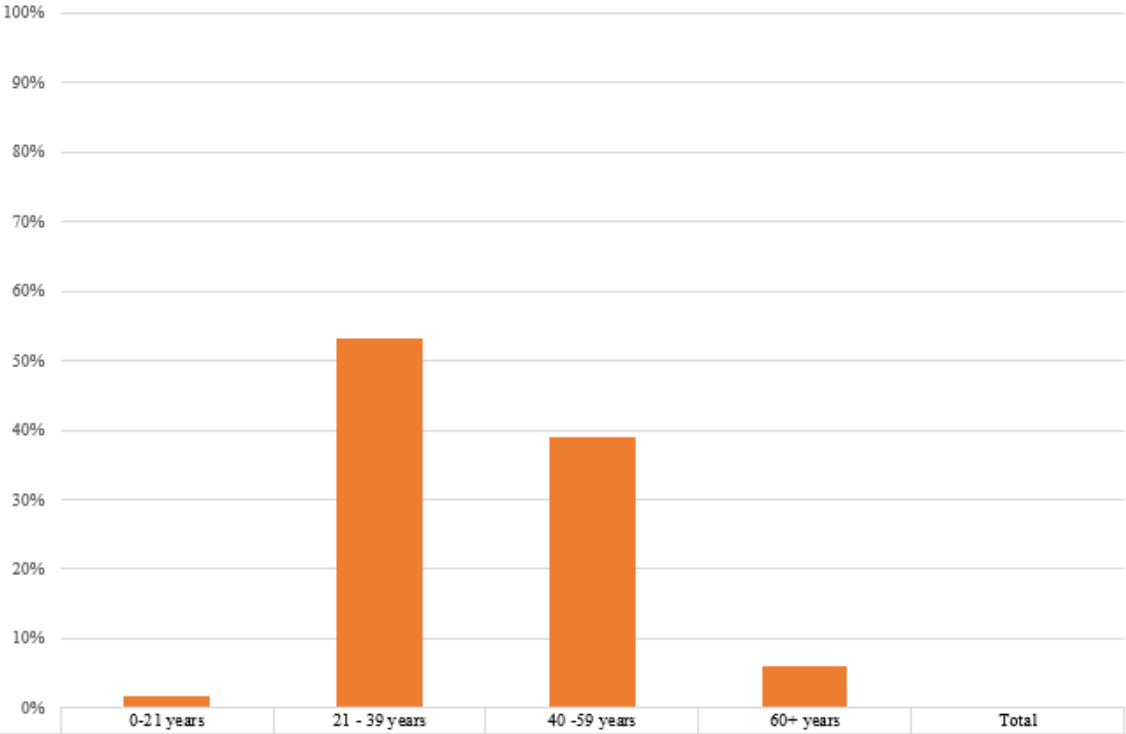
6. SUD Residential Treatment Services by Demographics

Figure 18 shows the number and percent of individuals who received substance use disorder residential treatment services by age group for FY 2024/25.

Of the 1,877 (unduplicated) people that received residential treatment in FY 2024/25:

- 1.8% were ages youth ages <21 years (N=33)
- 53.1% were ages 21-39 (N=997)
- 39.1% were ages 40-59 (N=734), and
- 6.0% were ages 60+ (N=113).

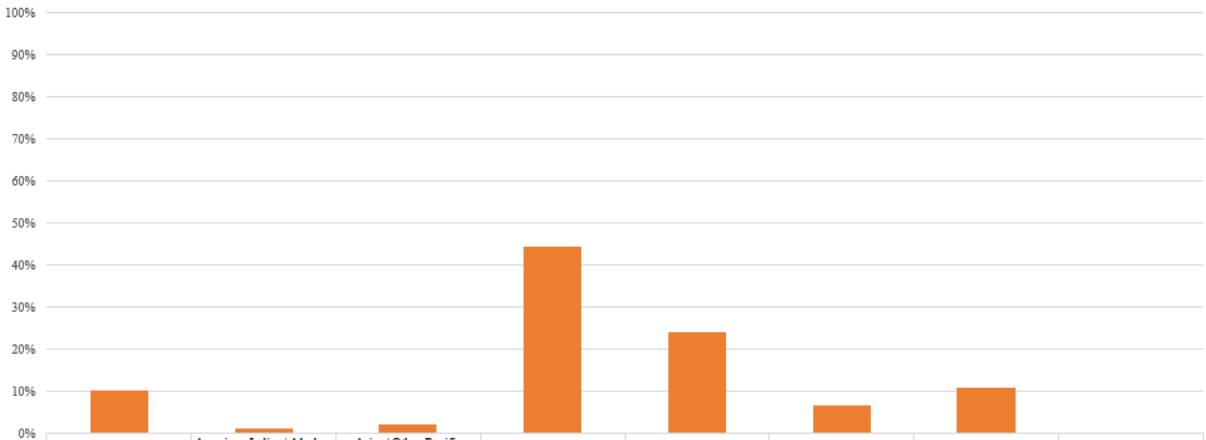
Figure 18
Fresno County Substance Use Disorder Residential Treatment
Number and Percent of Individuals Served, by Age
FY 2024-25



	0-21 years	21 - 39 years	40 -59 years	60+ years	Total
# Individuals FY 2024-25	33	997	734	113	1,877
% Individuals FY 2024-25	1.8%	53.1%	39.1%	6.0%	100.0%

Figure 19 shows the number and percent of individuals who received SUD residential treatment services by race/ethnicity for FY 2024/25. This data shows that for FY 2024/25, of the 1,877 individuals receiving SUD residential treatment services, 10.4% are Black; 1.2% are American Indian/Alaskan Native; 2.2% are Asian/Other Pacific Islander; 44.4% are Hispanic/Latino; 24.2% are White; 6.6% Other; and 11.0% (207) were not reported. An area of focus in the coming year will be to work to educate and support SUD providers in improving data collections, as the number of unreported demographic data is often high.

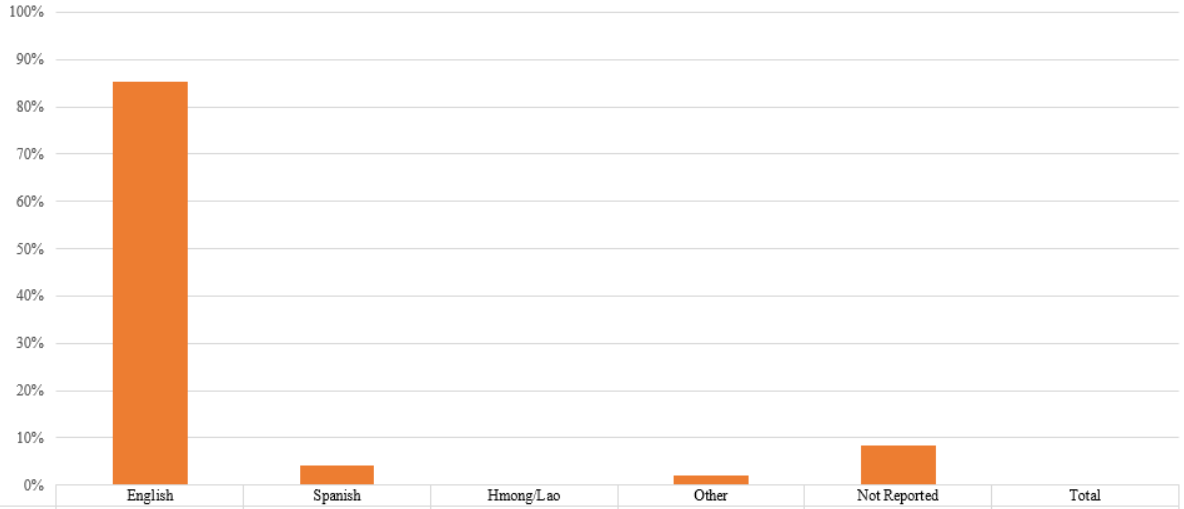
Figure 19
Fresno County Substance Use Disorder Residential Treatment
Number and Percent of Individuals Served, by Race/Ethnicity
FY 2024-25



	Black/ African American	American Indian/ Alaskan Native	Asian/ Other Pacific Islander	Hispanic/ Latino	White	Other	Not Reported	Total
# Individuals FY 2024-25	195	22	42	834	454	123	207	1,877
% Individuals FY 2024-25	10.4%	1.2%	2.2%	44.4%	24.2%	6.6%	11.0%	100.0%

Figure 20 shows the number and percent of individuals who received SUD residential treatment service by primary language for FY 2024/25. This data shows that 85.4% of individuals served speak English; 4.2% speak Spanish, 2.1% reported that they speak a different language; and 8.3% were not reported. There are efforts to engage with other community partners in the Punjabi speaking and south Asian communities as those may become "emerging" languages and some input from the community is an increasing need for SUD related services.

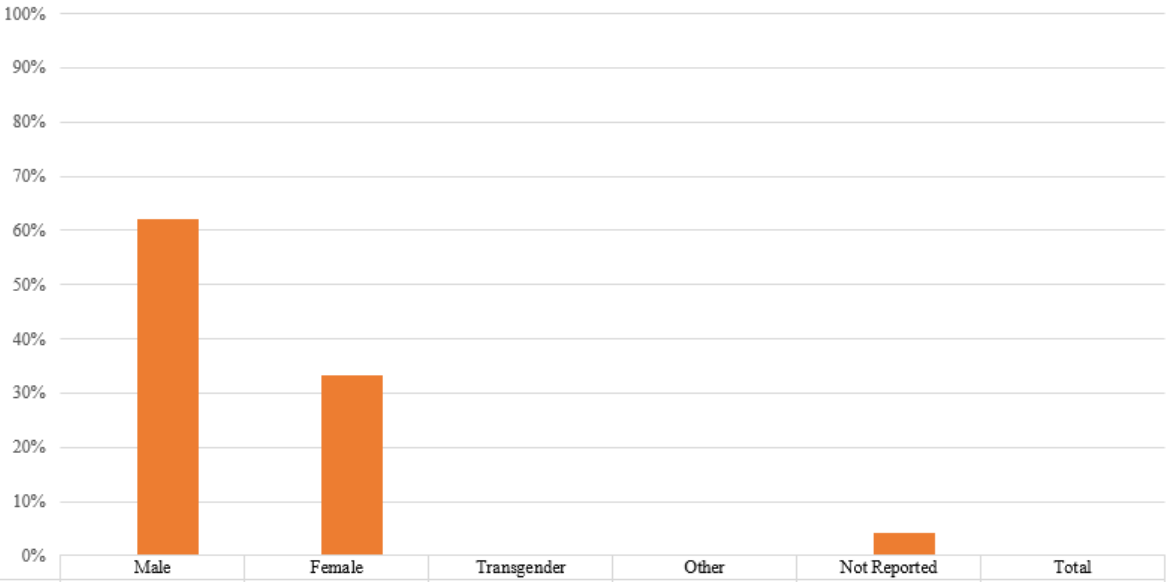
Figure 20
Fresno County Substance Use Disorder Residential Treatment
Number and Percent of Individuals Served, by Primary Language
FY 2024-25



	English	Spanish	Hmong/Lao	Other	Not Reported	Total
# Individuals FY 2024-25	1,603	79	-	39	156	1,877
% Individuals FY 2024-25	85.4%	4.2%	0.0%	2.1%	8.3%	100.0%

Figure 21 shows the number and percent of individuals who received SUD residential treatment services by gender for FY 2024/25. This data shows that for the 1,877 individuals served in FY 2024/25, 62.1% were males and 33.4% were females. There were three (3) people who identified as transgender (0.2%) and 81 were not reported (4.3%).

Figure 21
Fresno County Substance Use Disorder Residential Treatment
Number and Percent of Individuals Served, by Gender
FY 2024-25



	Male	Female	Transgender	Other	Not Reported	Total
# Individuals FY 2024-25	1,165	627	3	1	81	1,877
% Individuals FY 2024-25	62.1%	33.4%	0.2%	0.1%	4.3%	100.0%

Figure 22 shows the number and percentage of individuals who received SUD residential treatment services by sexual orientation for FY 2024/25. This data shows that 59% of individuals served identified as Heterosexual/ Straight; 2% identified as Gay or Lesbian; 1.3% identified as Bisexual; none identified as Transgender; 0.1% identified as Unsure/Questioning; .1% declined to state; and 37.5% not reported. The data is highlighting the gaps in data with the unreported which does skew the data and thus a need to continue to work on developing strategies to improve data collection.

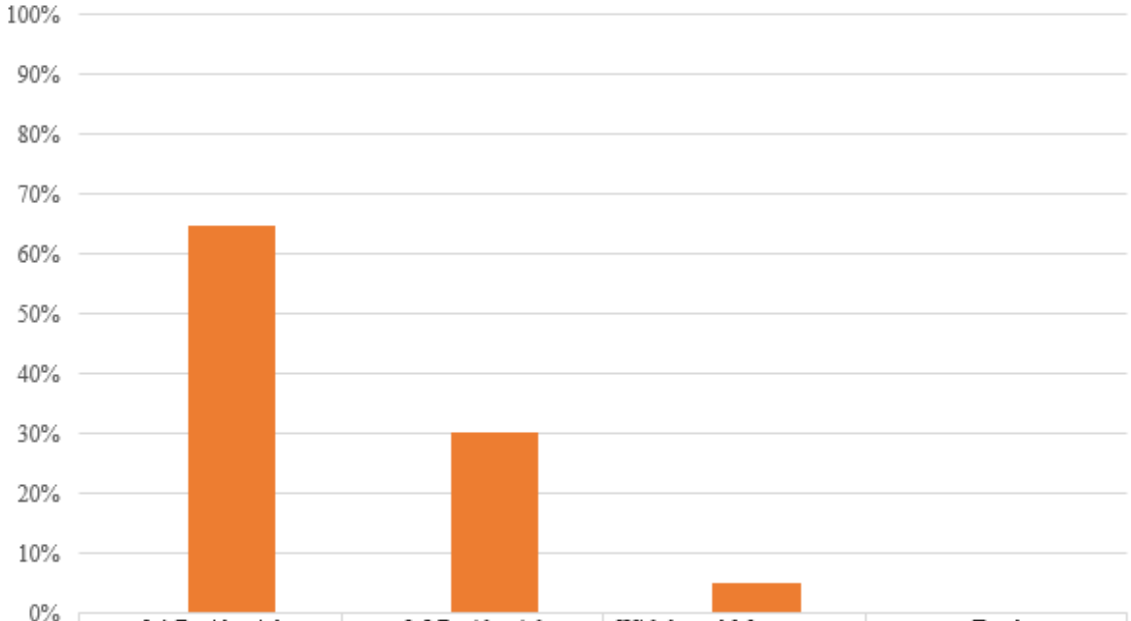
Figure 22
Fresno County Substance Use Disorder Residential Treatment
Number and Percent of Individuals Served, by Sexual Orientation
FY 2024-25

	Heterosexual/ Straight	Gay/ Lesbian	Bisexual	Transgender	Unsure/ Questioning	Declined to State	Not Reported	Total
# Individuals FY 2024-25	1,108	38	24	-	2	2	703	1,877
% Individuals FY 2024-25	59.0%	2.0%	1.3%	0.0%	0.1%	0.1%	37.5%	100.0%

7. Utilization of SUD Residential Treatment Services

Figure 23 shows the number and percent of days that substance use disorder individuals served accessed Level 3.1 residential services, Level 3.5 residential services, and withdrawal management services in FY 2024/25. There were 81,317 total days of services delivered to substance use disorder individuals, with 52,670 days of residential Level 3.1 (64.8%), 24,567 days of Level 3.5 residential services (30.2%), and 4,080 days of withdrawal management (5.0%).

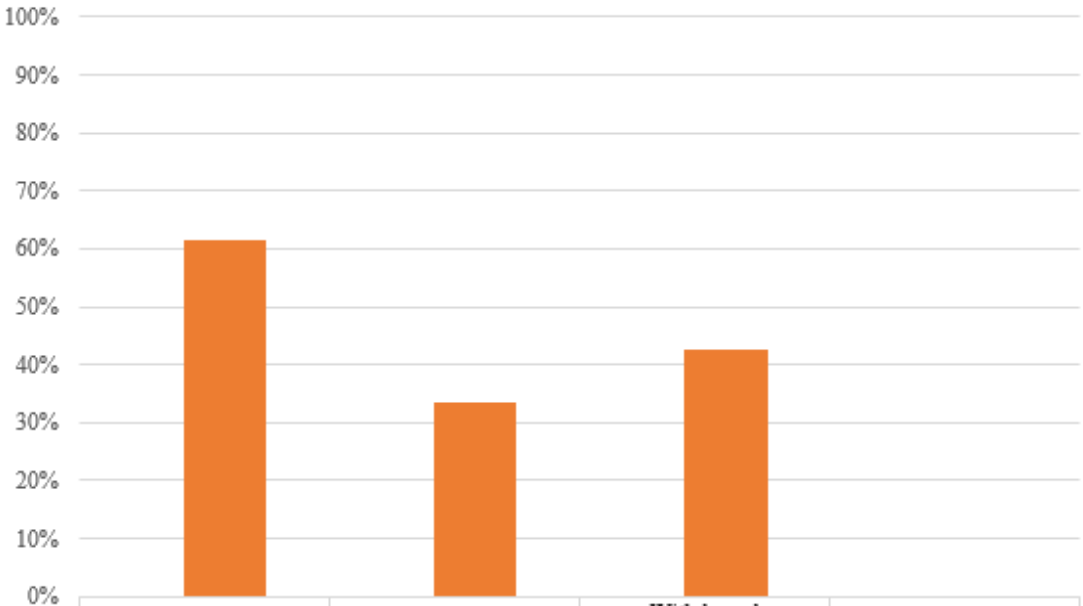
Figure 23
Fresno County Substance Use Disorder Residential Treatment
Number and Percent of Days, by Level of Care
FY 2024-25



	3.1 Residential	3.5 Residential	Withdrawal Management	Total
# Days FY 2024-25	52,670	24,567	4,080	81,317
% Days FY 2024-25	64.8%	30.2%	5.0%	100.0%

Figure 24 shows the number and percent of individuals served who received Level 3.1 residential services, Level 3.5 residential services, and withdrawal management services for FY 2024/25. Data is shown for each individual that received one or more of these services in FY 202425. There were 1,877 unique individuals who receive SUD residential services, with 1,154 individuals who received Level 3.1residential services (61.5%), 629 received Level 3.5 residential services (33.5%), and 802 received withdrawal management services (42.7%).

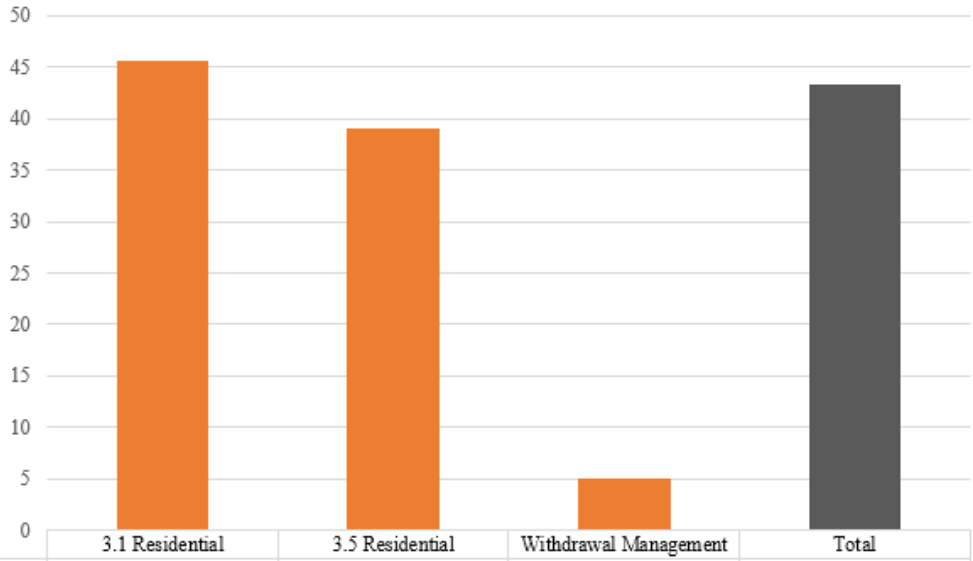
Figure 24
Fresno County Substance Use Disorder Residential Treatment
Number and Percent of Individuals Served, by Level of Care
FY 2024-25



	3.1 Residential	3.5 Residential	Withdrawal Management	Total
# Individuals FY 2024-25	1,154	629	802	1,877
% Individuals FY 2024-25	61.5%	33.5%	42.7%	100.0%

Figure 25 shows the number of residential treatment days, number of individuals served, and average days per individual served in residential treatment services for FY 2024/25. There were 1,877 individuals served. These individuals received a total of 81,317 days of service, which calculates to an average of 43.3 days per individual. There were 1,154 individuals that received 52,670 days of 3.1 residential services (45.6 days per individual); 629 individuals that received 24,567 days of 3.5 residential service (39.1 days per individual); and 802 individuals that received 4,080 days of withdrawal management services (5.1 days per person).

Figure 25
Fresno County Substance Use Disorder Residential Treatment
Number of Days, Individuals Served, And Average Days Per Individual Served, by Level of Care
FY 2024-25



	3.1 Residential	3.5 Residential	Withdrawal Management	Total
# Days FY 2024-25	52,670	24,567	4,080	81,317
# Individuals FY 2024-25	1,154	629	802	1,877
Avg. Days per Person Served FY 2024-25	45.6	39.1	5.1	43.3

8. Analysis of the SUD Data

The DEIC will review the SUD utilization data and develop recommendations in the next six months. This will allow the DEIC to better understand the service utilization data and make recommendations for enhancing services. Also working to understand the reason some demographic data is "not reported" so that strategies can be developed to effectively improve data collection.

III. MEETING CULTURAL AND LINGUISTIC REQUIREMENTS

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

The BHSOC has several culturally specific services in place, as well as programs with a peer driven focus.

- Fresno County has one of the only culturally focused Full-Service Partnership (FSP) programs in the state. The BHSOC has a FSP called *Living Well* which provided those services to a Southeast Asian adult population through the Fresno Center.
- Fresno County DBH's Diversity Services Coordinator (DSC) is spearheading a new statewide African American workgroup through County Behavioral Health Directors Association (CBHDA) to help leverage learning, insights and best practices from around the state to support more responsive and equitable care. The work was presented in the last year to the CBHDA members, Ethnic/equity Services Managers (EMS), and slated to present to leadership of the California Department of Public Health (CDPH) in the coming year.
- The BHSOC also has an FSP program that is specifically for individuals who are actively involved in the justice system. This program is operated by TURN Behavioral Health Systems and focuses on some of the unique needs of justice involved and forensic populations.
- The BHSOC has specific continuum of care for rural communities which are predominantly Latino and a number who are Spanish speaking only. Services are located in many of those communities and are staffed by personnel who reflect the communities being served. Turning Point of Central California provides those rural continuum of care services.
- During the last several years, through the use of its Mental Health Services Act (MHSA) prevention dollars, the Department has funded *Pop Up* for the local LGBTQ+ community. The services have been a part of a suicide prevention effort for LGBTQ+ young people, which seeks to provide safe and affirming space to reduce risk factors for this population.
- Westside Family Preservation Services is the contract operator for Youth Empowerment Program who operates in the western portion of the county and provides youth prevention services to small farming communities who are predominantly Latino. This program thus provides prevention services to Latino youth in rural communities of Huron, San Joaquin, Tranquility, Mendota, and Firebaugh.
- The Innovation Plan CRDP Evolutions fully funds three California Reducing Disparities Project (CRDP)/Community Defined Evidence-Based Practices (CDEP) programs that each have a specific population focus. The Sweet Potato Program serves African American Youth though prevention strategies. The Hmong Helping Hand provides PEI and some clinical services to older adult Hmong and other SEA seniors. The *Plactica Y Plenta* provides PEI services to Latino youth. These three CDEPs were part of the original community defined evidence-based practices developed in the state, and the only existing CDEPs funded by counties at this time.

- Programs such as the Culturally Based Access and Navigation (CBANS) assist with linkages and accessing care, through the use of cultural brokers and community health workers.
- The Holistic Wellness Center provides engagement, stigma reduction, and outreach to underserved communities through non-traditional practices and approaches for mental health and wellness.
- The Lodge and now the Lodge 2.0 is an active INN Plan that seeks to engage unhoused persons with an SMI and/or SUD and who are not in care, but in the pre-contemplation stage of change with participation in care services. The program is peer driven and has seven (7) full-time peers and just two clinicians. The program focuses on exploring how peers may effectively help the target population engage in care through connections that may be formed from lived experience.
- The previous year Department completed three community needs assessments. One with the Fresno Economic Opportunities Commission (EOC) LGBTQ Center focused on LGBTQ transition aged youth, one with the Jakara Movement focused on Punjabi speaking community, and one with the Children's Movement of Fresno examining needs across different communities and regions in the county. Those can be found at www.dbhequity.com . These were intended to support efforts for more targeted population services from prevention to specialty mental health services (prior to changes in funding and priorities of BHSA)
- The Department completed the second of a two-year long phase of a Community Participatory Action Research, for African Americans, in the previous year. The initial phases were focused on mental health literacy. The second phase established an African American Mental Health Advisory Council to help assess, identify, and recommend culturally specific ideas to address local African American mental health needs and produce final recommendations. The last year Department has supported efforts by the project to share and highlight its findings so to increase culturally responsive approaches in behavioral health.
- Black Wellness and Prosperity Center completed a concept paper to conceptualize and propose future MHSA Innovation funded demonstration projects that could leverage the use of doulas to support underserved communities and homes. New changes with Behavioral Health Services Act (BHSA) to Innovation projects for the future have since curtailed viability of such projects for now. In California, Black infants have the highest mortality rates of any groups, and in Fresno County Black infants have the highest rates among all local populations and thus the focus on how whole person wellness approach could have improved rates.
- Since participating in the Interdisciplinary Collaboration and Cultural Transformation Model (ICCTM) team, (a year-long training effort through the MHSOAC and UC Davis), also identified in an evidence-based community practice model for effective stakeholder engagement. This included a variety of non-contracted community-based organizations that provide services to underserved populations. Since completion of the training DBH has sought to apply those lessons in its community planning and stakeholder engagement where and when possible.
- DBH has developed and implemented a training specifically designed for Black Indigenous and other Persons of Color (BIPOC) LGBTQ populations in Fresno County to

improve the quality of care for underserved or inappropriately served populations which is available in the training catalog.

Language access has been a challenge (as reported in some local community needs assessments in recent years). There is an ongoing need to expand the number of bilingual, bicultural staff. Hiring persons who are bilingual and bicultural has always been a challenge, especially licensed clinicians and prescribers. Recent needs assessments demonstrated the language access is not just for care providers but for those supports, schedules, and others in the system of care. The DBH will continue to identify opportunities to expand the workforce to meet the needs of our linguistically diverse communities. The Central Regional Workforce Education and Training (WET) plan partnership has sought to expand efforts to increase bilingual and bicultural persons into the BHSOC.

DBH has a number of peer-driven services through contract providers. These organizations hire persons with lived experience and offer wellness and recovery focused services. Wellness centers also offer services to individuals to support wellness, recovery. The county is invested in the development of the peer workforce based on the value of lived experience in provision of services, with its funding of training to increase the number of peers who are certified. Several models of care call for use of peers in service delivery, i.e. FSPs.

DBH has a full range of services for children, transition age youth, adults, and older adults and continually strive to expand services to reach unserved and underserved individuals in the community. The DBH will continue to explore opportunities to expand services and provide outreach to communities to reduce barriers to services. BHSOC under BHSA will be exploring options for more FSP level services for TAY and older adults.

The DBH will continue to identify and implement goals and strategies for improving services. These may include, but not limited to the following:

- Have services delivered in the individual's preferred language, whenever possible, and identify opportunities to enhance this process by developing best practice protocols.

- Identify opportunities to develop, engage, attract, hire, and retain bilingual, bicultural case managers and rehab specialists, as well as persons with lived experience and family members

- Analyze on and ongoing basis the availability of interpreters across the BHSOC, develop a process for certifying bilingual skills of staff; expand the number of positions / slots that can receive pay for providing interpretation services, and expanding the number of persons who receive bilingual pay

- Develop a skill-based interview to demonstrate bilingual skills

- Continue to identify training opportunities for staff including how to utilize an interpreter and schedule training for all staff

- Develop Policy and Procedure Guidelines for assigning interpreters (e.g., rotation; consistency with individual and family; skills and expertise understanding medical term for psychiatric services; wait time for accessing an interpreter) to ensure quality and continuity of care

- Identify goals for the ratio of bilingual and bicultural staff to individuals served to address equity

- Provide training to staff to deliver innovative, evidence-based, culturally responsive trauma-informed wellness and recovery services in diverse settings

- Continue to support a work environment where cultural humility, dignity, and respect are modeled

B. Mechanisms for informing individuals of culturally responsive services and providers, including culturally specific services and language services; identify issues and methods of mitigation

Individuals who staff the 24/7 Access Line are trained to be familiar with the culturally responsive services that are offered at BHSOC. Access line staff are able to speak Spanish and Hmong and are knowledgeable about using the Language Line to link individuals to language assistance services, as needed.

In addition, the high use 988 Suicide Prevention and Access line for the central region is located in Fresno County and is staffed by responders who reside in the community. The 988 line operated as the Central Valley Suicide Prevention Hotline (CVSPH) also has bilingual and bicultural staff to address linguistic and cultural needs, as well as processes for utilizing language line for languages for which there may not be personnel employed on duty.

In the first 3 quarters of FY 24-25, this service answered calls from 4,683 persons in Fresno County (of which 2,536 were crisis, 2,585 identified a mental health issue, and 1,615 identified suicidal content). This data points to significant increase in utilization over the previous year. Nearly half of the calls are missing demographic information, as the call/encounter does not always provide this information nor it is viable always during crisis calls, etc. to try and gather such demographics.

The Mobile Crisis services which started in January of 2024 are supported by a dispatch team that works within the CVSPH and applies the same approaches. The responding teams in the field have access to language line for interpretation in real time based on the language need.

The BHSOC *Guide to Mental Health Services* brochure is available in our threshold languages: English, Spanish, and Hmong. This guide highlights available services, including culturally specific services. In addition, the brochure informs individuals of their right to free language assistance, including the availability of interpreters. This brochure is provided to individuals at intake, and is also available at county clinics, organizational providers, and wellness centers

throughout the county. The service pages have language on them in Spanish, Hmong and Punjabi of accessing services in their preferred language w/o cost to them. DBH has also set up a page that has been translated into Spanish on its website to make access and information more readily available and has created a specific URL to help accessing the page easier via www.DBHespanol.com and www.DBHespanol.org. The website for the Hmong community has also been created www.DBHhmoob.com and www.DBHhmoob.org

A *Provider Directory* is available to individuals which lists provider names, population specialty (children, adult, veterans, LGBTQ+ when available, etc.), services provided, language capability, and whether or not the provider is accepting new individuals. This Directory is provided to individuals upon intake and is available at our clinics, organizational providers, and wellness centers. The Provider List is updated every other month and posted on the DBH website (www.hopefresnocounty.com).

The BHSOC also provides to DBH managers an updated *Interpreter List*, which provides individuals with the names, hours, and contact information of interpreters available in the county, as well as language and other cultural information (age, gender, sexual orientation). This list is provided to individuals upon intake and is available at county clinics, organizational providers, wellness centers, and on the BHSOC website.

BHSOC uses a New Person Served/Client Intake Log to ensure that when a person is new to receiving BHSOC services and requests specialty behavioral health services, that individual is informed about the availability of free language assistance services. This document is completed by front office staff, added to the individual's Electronic Health Record (EHR), and forwarded to clinical staff for scheduling the intake assessment appointment to ensure an interpreter is available for the appointment.

In the next year when additional data is available for analysis, the various divisions and committees within DBH will review data and identify opportunities for addressing any identified disparities.

C. Process for capturing an individual's need for an interpreter and the methods for meeting that need; identify issues and methods of mitigation

The 24/7 Access Log includes a field to record an individual's need for interpreters. It is our goal to have at least one bilingual staff person for each threshold language (Spanish and Hmong) working at the front office in each of our county outpatient clinics and at organizational providers for each of the threshold languages. These are subject to availability of such persons in the workforce. These individuals are able to communicate with any caller who speaks Spanish or Hmong, or is knowledgeable about using the language line, when needed. The new person is offered an assessment with a Spanish or Hmong speaking clinician, whenever possible. A recent needs assessment focused on Spanish speaking parents that identified the need for more than just the therapist of the prescriber to be bilingual but also those support staff that are available when they call to access, schedule appointments, etc.

The New /Person Served/Client Intake Tracking Sheet allows BHSOC to document when an individual requests an interpreter. This form is forwarded to clinical staff for the intake assessment and included in the individual's EHR. This information is also utilized when individuals are assigned to a service provider, to help determine the need for a bilingual staff to provide ongoing services in the individual's primary language, whenever possible.

Currently, BHSOC has a policy and procedure guideline in place that outlines the requirements and processes for meeting an individual's request for language assistance, including the documentation of providing that service. However, there is a need to update this policy to include the process for capturing when an interpreter is used with the persons served and/or family member during services.

Objective: In FY 24/25, BHSOC began utilizing a process for assessing both county staff, and organization provider's staff bilingual language skills. This process will create the opportunity to analyze staff and provider disparities and identify opportunities for meeting the needs of individuals receiving services, and the needs of their families, when the family is involved in supporting the individual meet their goals.

The Diversity, Equity, and Inclusion Committee (DEIC) is working to identify where data gaps existing in terms of demographics and to then develop a strategy and implement it to improve data collection and quality of data. Focus has been on identifying the gaps, the possible reasons for the gaps and a possible two-pronged approach for improving data collection.

- One, training for providers to understand why the data is important to the work and the need to collect timely and accurate data. Then providing training to support efforts for effective data collections.
- The second, to help persons served understand the purpose of the data collection, how the data will be used, and how the data can help improve care for all. This can be in developing training for BHSOC staff to communicate or some information that can be developed and shared with persons served in our BHSOC.

These are being discussed with the DEIC committee and will remain an on-going goal for this coming year.
Understanding SOGI data, language, and other needs of our diverse population are key for developing policy, programs, strategies, workforce, and other steps to have an accessible, responsive and effective public BHSOC.

D. Process for reviewing grievances related to cultural competency; identify issues and methods of mitigation

The Quality Improvement Committee (QIC) reviews grievances. Each grievance is recorded in a Grievance Log including those related to cultural or linguistic issues. The QIC reviews all issues and determines if the resolution was culturally appropriate. The QIC and DEIC work together to identify additional issues and objectives to help improve services during the coming year. The

QIC and DEIC share data, whenever feasible, to provide a consistent foundation of information across the service system. Under the Department's reorganization that occurred at the start of the FY 24/25 the QI team which oversees the QIC and the equity work lead by the Diversity Services Coordinator and ESM are all part of a new Planning and Quality Management division where there will be more natural synergy in coordinating ways to improve quality and equity.

IV. STAFF AND SERVICE PROVIDER ASSESSMENT

A. Current Staff Composition

1. Ethnicity by Function

The Diversity, Equity, and Inclusion Committee (DEIC) will coordinate with Department of Behavioral Health (DBH) to provide summary data on the number of persons employed by the county, and at organizational providers, on race, ethnicity, and language. Where possible data will show race, ethnicity, and language by region, whether they are a mental health or substance use disorder (SUD) provider and if the provider serves specific age groups. Certain existing county and legal protocols do limit some of the demographics data that can be collected from personnel.

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

The Language Subcommittee has been meeting nearly every month over the past year and has made excellent progress on the key objectives. The subcommittee focuses its efforts on improving and expanding linguistically appropriate services for persons served. In FY 2024/25, the Language subcommittee has continued its work to examine the designation and certification of bilingual staff. DBH has worked closely with the County's Human Resources Department to expand the number of paid bilingual positions and develop strategies to help certify bilingual staff in a timely manner. It will be examining options to ensure some future peer positions are also bilingual allocations as well, as the Department will be seeking to update job descriptions for peer positions.

In addition, the Language Subcommittee members have also recommended that DBH expand the number of employee positions that are certified and authorized to receive the pay differential for interpreting for individuals served and/or family members.

The DEI Language Subcommittee has also recommended starting two Language Champions Committees, to provide support to persons who serve as interpreters. One committee will support Spanish language interpreters, and one will support Hmong and Lao interpreters. Each committee will hold a monthly meeting to provide a forum for people to develop common translations for key words that are frequently used in mental health. The Language Champions Committee will help provide consistency of interpreting across both interpreters and staff who use interpreters.

The DEI Language Subcommittee also developed a Spanish Language Guide, which is available on DBH's website (www.dbhequity.com). This guide provides a comprehensive, well-organized English - Spanish translations to use when providing interpreting mental health services. This guide shows the English and corresponding Spanish words and phrases, to help communicate with Spanish speakers. It is well organized into different topics from Introductory phrases for counselors to use, through explaining different diagnostic terms (e.g., Depression; Anxiety); Behavioral Health clinical terms; medical terms; and other mental health symptoms and

concepts. This provides an excellent guide for creating a common language across interpreters to help 'standardize' terms. This helps both the persons served and family members to have the information translated consistently across interpreters and for behavioral health staff. This guide will also be used as a model for developing a Hmong language guide.
This committee has also helped create standard practices for interpreting and identify training opportunities for both interpreters and staff who use interpreters, to improve the experience for monolingual individuals served. A group for Spanish speakers and a group for Hmong/Lao speakers will be developed in the coming year to support the Language Champions Committee for the two languages that meet the threshold language requirement in Fresno County. In addition, the committee will review service-level language data and identify needs; assess interpretation service capacity and quality; identify interpreter trainings; and review translated materials for accuracy.

3. Staff and Volunteer Cultural Humility Survey

To assess the cultural responsiveness of the workforce, staff and volunteers were asked to complete the Staff and Volunteer Cultural Humility Survey in Spring 2025. The complete results are shown in Attachment E.

This survey has been implemented annually since 2019 in the same period each year, and now has the capacity to provide trends, benchmarks and track efforts.

There were 436 staff who completed the survey (this was an increase over the previous year). Of these individuals, 71% were county staff, 28% were contract provider staff, and 1% were volunteers. Of the staff responding to the survey, 39% were direct service/clinical/case management staff, 27% were administration/clerical staff who do *not* routinely interact with persons served, 16% were administration/clerical staff who *do* routinely interact with persons served, 15% were management staff, 1% were paid peer staff, and 2% were peer support.

The breakdown of staff who completed the survey by department/program is as follows: 15% from Children's Mental Health, 48% from the Adult System of Care,), 20% from Administration, 9% from Finance/Accounting/Business Office, 26% from Information Technology /Quality Improvement, 2% and from Compliance/Medical Records.

Of the 435 survey respondents who reported their race/ethnicity, 48% were Hispanic/Latino, 45% were White, 15% were Asian, 8% were Black, 1% were Native Hawaiian or Other Pacific Islanders, 3% were American Indian or Alaska Native, <1% were Middle Eastern, and <1% identified as 'Other.' Respondents were able to provide multiple answers, therefore totals do not sum to 100%. For the 409 respondents who report their current gender identity, 71% identify as Female, 28% identify as Male, and approximately 1% identify as another gender. For sexual orientation, 91% of staff identified as Heterosexual/Straight, and 9% as LGBTQ+.

Of the 433 survey respondents, 185 (43%) consider themselves bilingual, with 68% of those bilingual staff speaking Spanish, 22% speaking Hmong, 1% speaking Punjabi, and 11% speaking another language. Staff may speak more than one language other than English. Of the 185 bilingual staff, 79 (42.7%) acted as an interpreter as a part of their job function, and 62% of those interpreters responding received bilingual pay (49/79). This 2024 data shows a decrease from

the 2024 survey results, in which 55.9% of bilingual staff acted as an interpreter as a part of their job function. The 62% receiving bilingual pay is an increase over 2024 survey responses. These results highlight an area of improvement, though there is more potential growth for the County to support the importance of the DBH's efforts to hire and train bilingual staff. One of the goals of the DEI Language Committee in the last year has been achieved by implementing a process for certifying bilingual staff so more staff can receive bilingual pay. There are now 72 staff who have been certified bilingual.

Other survey results show that 62% of staff identified as a person with lived Mental Health experience and 72% reported having a family member with lived Mental Health experience; 25% of staff identified as a person with lived substance use disorder experience and 59% reported having a family member with lived substance use disorder experience.

For the following survey items, the response options included Frequently, Occasionally, Rarely or Never, or Did Not Occur to Me.

Upon initial review, there were some interesting results when examining the staff responses to the questions.

A high percentage of staff responded "**Frequently**" to the following questions. This pattern of responses was similar across all respondents: White respondents, Hispanic/Latino respondents, and respondents of another race/ethnicity.

- *I recognize and accept that persons served/clients are the primary decision makers about their treatment, even though they may be different from my own beliefs. (Frequently = 86%)*
- *I recognize that family may be defined differently by different cultures. (Frequently = 81%)*
- *I recognize that gender roles in families may vary across different cultures. (Frequently = 77%)*

Conversely, a high percentage of staff responded "**Rarely or Never**" or "**Did Not Occur to Me**" to the following questions. This pattern of responses was similar across all respondents: White respondents, Hispanic/Latino respondents, and respondents of another race/ethnicity.

- *I intervene, in an appropriate manner, when I observe other staff exhibit behaviors that show cultural insensitivity or prejudice. (Rarely or Never = 17%, Did not Occur to Me = 6%)*
- *I attempt to learn a few key words in the person served/client's primary language (e.g., "Hello, Goodbye, Thank you, etc.). (Rarely or Never = 18%, Did not Occur to Me = 4%)*

Overall, these results indicate that staff recognize the importance of person's served autonomy in decision making, and that family and gender roles may vary across different cultures. However, the results also indicate an opportunity to offer additional staff training regarding how to appropriately intervene if they observe another staff member exhibiting behaviors that show cultural insensitivity or prejudice. DBH recently provided a training on psychological safety in

the workplace for staff to help create more champions to create spaces where staff can raise the issue or awareness. In addition, future training could offer staff an opportunity to learn a few key words in the primary language of the person served.

Survey results were also analyzed across the past four years (2022; 2023; 2024, 2025). In 2022, 432 staff completed the survey; in 2023, 551 staff completed the survey, in 202 and, 382 staff completed the survey and 436 staff completed the survey in 2025. We compared the responses to see how we have improved from 2022 to 2025.
There was a **consistently high** percentage of staff who responded "**Frequently**" or "**Occasionally**" to the following questions from 2022 to 2025:

- *I recognize and accept that clients/ persons served are the primary decision makers about their treatment, even though they may be different from my own beliefs. (Frequently or Occasionally = 95%+ in 2022 through 2025)*
- *I recognize that "family" may be defined differently by different cultures. (Frequently or Occasionally = 97%+ in 2022 and in 2025)*
- *I recognize that gender roles in families may vary across different cultures. (Frequently or Occasionally = 96%+ in 2022 through 2025)*

Staff also reported on their participation in professional development activities during the past six months. The trends in survey responses were similar across all respondents (N=436); White respondents (N=76); Hispanic/Latino respondents (N=208), and respondents of another race/ethnicity (N=112).

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

- *Talked to a colleague about a racial and/or cultural issue (53%).*
- *Reflected on my racial identity and how it affects my work with clients/ persons served (52%).*
- *Read/watched/listened to media about multicultural issues (69%).*
- *Learned something about a racial and/or cultural group other than my own (65%).*

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

- *Sought guidance about a racial and/or cultural issue that arose during therapy/service delivery (19%).*
- *Sought supervision about multicultural issues (17%).*
- *Attended a training on Implicit Bias (24%).*

B. Analyze Staff Disparities and Related Objectives

Survey results may be analyzed and shared with the DEIC to help identify new strategies and goals.

C. Identify Barriers that Impede Progress in Objectives and Methods of Mitigation

Survey results will be analyzed and shared with the DBH and DEIC to identify and discuss barriers and recommend strategies to mitigate any issues.

V. CLIENT (PERSON SERVED) AND FAMILY/CAREGIVER CULTURAL HUMILITY SURVEY

A. Survey Distribution

In an effort to assess the cultural responsiveness of our service delivery, we asked individuals who received behavioral health services through Fresno County DBH to complete the Client (Person Served) Cultural Humility Survey and Family/Caregiver Cultural Humility Survey Spring 2025. In total, 1,855 surveys were completed by individuals served and family member/caregivers (an increase from the previous survey period). The complete results for both surveys are shown in Attachments F and G.
This is a survey that has been used annually since 2019 and provides trends and benchmarks at this time.

B. Client/Person Served Cultural Humility Survey Results

There were 1,592 individuals who completed the Client/Persons Served Cultural Humility Survey. For the 1,532 individuals served who reported their age, 27.6 % were TAY 12 – 25; 52.4% were adults ages 26 – 59, and 19.9% were older adults, ages 60 and over.

Of the 1,498 survey respondents who reported their race/ethnicity, 55.4% reported Hispanic/Latino; 32.3% as White; 9.7% as Black; 18.8% as Asian; 5.3% as American Indian or Alaska Native; 0.9% as Native Hawaiian or Other Pacific Islander; and .7% as 'Other'. Respondents were able to provide multiple answers.

Of the 1,529 individuals reporting primary language, 74.3% reported English; 21.9% reported Spanish; 10.8% as Hmong; 1.1% as Khmer, 0.5% as Punjabi; and 1.0% as 'Other.'

For sexual orientation, 1,387 individuals responded to this question. 87.6% of respondents identified as heterosexual/straight; and 13.2% identified as LGBTQ+. For current gender identity, 55.4% of the 1,495 survey respondents identify as female; 42.1% as male; and 2.8% identify as another gender. 96.1% of respondents reported not being involved with the military; and 40.5% reported that they have a disability.

The survey response options for the following items included Agree, Neither Agree nor Disagree, and Disagree. Upon initial review, there were some interesting results when examining those questions where the responses were lower than expected for "**Agree.**" These questions are listed below.

Across all Respondents:

- *If I want to receive services from a person from my own racial or ethnic group, staff help me connect to those services. (Agree = 76%)*
- *If I want to receive services from a person of my own gender and/or from the LGBTQ+ community, staff help me connect to those services. (Agree = 73%)*

- *The facility has pictures or reading material that show people from my racial or ethnic group. (Agree = 75%)*

C. Family/Caregiver Cultural Humility Survey Results

There were 250 individuals who completed the Family/Caregiver Cultural Humility Survey. For the 245 individuals who reported their family member's age, 36.3% were children ages 0 – 11; 40.4% were TAY ages 12 – 25; 17.5% were adults ages 26 – 59; and 5.7% were older adults, ages 60 and over.

For the 241 individuals who reported their family member's race/ethnicity, 70.5% reported Hispanic/Latino; 34.4% as White; 10.4% as Black; 9.1% as Asian; .8% as American Indian or Alaska Native; and 2.1% of survey respondents reported their race/ethnicity as 'Other.'

For the 241 individuals who reported their family member's primary language, 71.9% reported English; 36.9% reported Spanish; and 1.6% as Hmong.

For sexual orientation, 176 individuals responded to this survey question. 90.3% of respondents identified their family member as heterosexual/straight; and 7.3% as LGBTQ+. For current gender identity, 56.2% of survey respondents indicated that their family member identified as female; 43.8% as male; and 1.7% as transgender. 99.1 respondents reported that their family member had no military involvement; and 24.6% reported that their family member has a disability.

The survey response options for the following items included Agree, Neither Agree nor Disagree, and Disagree. Upon initial review, there were some interesting results when examining those questions where the responses were lower than expected for "**Agree.**" Those will be briefly outlined below.

Across all Respondents:

- *If my family member wants to receive services from a person from their own racial or ethnic group, staff help them connect to those services. (Agree = 89%)*
- *The facility has pictures or reading material that show people from my family member's racial or ethnic group. (Agree = 86%)*

D. Analyze Disparities and Related Objectives

Survey results will be analyzed and shared with the DEIC to help identify new strategies and goals over the coming year (2025).
Having data over a number of years has allows the BHSOC to track changes/improvement in areas of responsiveness and to identify positive trends, allowing providers to acknowledge their efforts are effective or having desired impact.

E. Identify Barriers that Impede Progress in Objectives and Methods of Mitigation

These survey results provide valuable information on staff, family members, and individual's understanding of culture and their experience with mental health services within the system of care. The results also help identify training opportunities to support staff to deliver culturally responsive services. The DEI Committee, and subcommittees have made great strides in creating a system of care that delivers culturally, ethnically, and linguistically responsive services to individuals receiving behavioral health services. This supports services that are sensitive to other cultures, including individuals in recovery; Lesbian, Gay, Bisexual, Transgender and Questioning (LGBTQ+) community; veterans; persons living with disabilities (hearing, vision, physical); various age groups (Children: 0-15; Transition Age Youth [TAY]: 16-25; Adults: 26-59; Older Adults: 60+); immigrants and refugees; and persons involved in the justice system.

DBH is awaiting recommendation from County Behavioral Health Directors Association (CBHDA) on increasing the required annual training for staff and providers from a minimum of "one" training a year to a certain number of hours, with certain hours devoted to core competencies and foundational learning and additional hours to be determined by the program or agency to enhance the skills of the staff for the populations and communities they are serving. Efforts have been made through surveys to help identify averages or ranges from counties. It is the desire of the BHSOC to provide adequate training while balancing the needs for productivity for service providers and minimize the time spent in non-productive (claiming) time.

The development and implementation of a culturally and linguistically responsive system requires the commitment and dedication from leadership, staff, organizational providers, and the community to continually strive to learn from each other and by offering ongoing training and education. All Department staff, including leadership, are required to complete the foundational training *Introduction and Implementation of Cultural Responsiveness*. This training is also offered to contracted staff within the BHSOC. These trainings help to identify and mitigate barriers to ensure a service delivery system that respects the whole person.

VI. TRAINING IN CULTURAL RESPONSIVENESS AND HUMILITY

Behavioral Health System of Care (BHSOC) will continuously offer Core Cultural Competency Trainings for county staff and contracted providers. The expectation is for these trainings to be completed by the target audience within six (6) months of hire date and/or contract execution and repeated every five (5) years. BHSOC had required county staff and contracted direct service providers to complete a minimum of eight (8) hours of additional cultural competency training per fiscal year, this has been placed on hold pending recommendation from CBHDA for consistency from county to county and mitigate the impact of fee-for service model now used vs cost reimbursement model.
In the coming year the BHSOC will implement new mandatory TGI training for all those engaged with the public in accordance with BHIN 25-019.

A. Rationale for the Cultural Competency Trainings

Racial and ethnic disparities in BHSOC services have been nationally recognized and officially documented in landmark reports and publications: The Surgeon General's 2001 Report, IOM 2000, and Stanley Sue's research. The County's service utilization data in the last several years suggested gender, age, and racial/ethnic related disparities. The County's BHSOC workforce assessments show: shortages of psychiatrists with special skills working with children and older adults, none-White individuals in managerial positions requiring licenses and advanced degrees, in direct care providers, especially licensed staff with working with American Indian, Hmong, Cambodian, Laotian, Vietnamese, Hispanic/Latino and other immigrant and refugee groups indigenous communities from Mexico and Central America.

The objectives in training and education of the BHSOC workforce are to develop and maintain a culturally responsive workforce that includes individuals and their family members, to address stigma and reduce discrimination, and ensure individual recovery and resilience. The DEIC will discuss and recommend opportunities for identifying additional trainings.

Some trainings are mandated, such as the TGI (outlines in BHIN 25-019).

B. Training Participation

This section describes cultural responsiveness and humility trainings for staff and providers, including training in the use of interpreters, in FY 2024/25.

C. Core Cultural Competency Trainings in FY 2024/25

Title of Training / Event / Conference	Number of Participants
Your Role in Workplace Diversity (Relias)	124

Title of Training / Event / Conference	Number of Participants
Introduction & Implementation of Cultural Responsiveness (IICR)	461
Behavioral Health Interpreter Training (BHIT) Interpreter Trainings	43
Behavioral Health Interpreter Training (BHIT) Providers Trainings	80

D. Additional Cultural Competency Trainings in FY 2024/25

Title of Training / Event / Conference	Number of Participants
The Latino Commission - Latino Conference - Strengthening the Roots	10
A Multicultural Approach to Recovery-Oriented Practice	74
Addressing Racial Trauma in Behavioral Health	62
Addressing Substance Use in Military and Veteran Populations	1
An Overview of the Social Determinants of Health - Retired 11/2/2024	2
An Understanding of Military Culture for Behavioral Health Paraprofessionals	1
Anti-Asian Hate	1
Behavioral Health for Black Lives - Conversation with Dr. Karen Crozier	1
Implicit Bias in Healthcare	4
Bridging Differences in Cross-cultural Communication	10
Bridging the Diversity Gap	120
Building Shared Understanding across Cultural Divides	15
Care of Sexual and Gender Diverse Populations	22
Caring for LGBTQIA+ Residents in California	2
Cultural Awareness and Humility	105
Cultural Competence - Retired 9/7/2024	3
Cultural Competence and Healthcare	49
Cultural Competence for Supervisors	12
Cultural Considerations Related to Suicide	52
Cultural Diversity and the Older Adult	10
Cultural Humility and Implicit Bias in Behavioral Health	37

Title of Training / Event / Conference	Number of Participants
Cultural, Religious, and Spiritual Considerations at End of Life	5
DEI: Achieving Greater Health Equity in Your Organization	6
DEI: An Introduction to Multicultural Care	46
DEI: Multicultural Care for the Clinician	14
DEI: Multicultural Care for the Organization	6
DEI: Understanding Privilege	1
Discrimination: Its Impact on Healthcare	2
Diversity, Equity, and Inclusion for the Healthcare Employee – Retired 2/2/2025	11
Diversity, Equity, and Inclusion for the Healthcare Worker	7
Economic Stability: Social Determinants of Health	1
Ethical and Legal Issues for Behavioral Health Interpreters	2
How Culture Impacts Communication - Retired 7/6/2024	1
Implicit Bias for the Healthcare Professional	1
Implicit Bias in Healthcare	4
Improving Behavioral Health Equity: Children, Adolescents, and Emerging Adults	10
Improving Behavioral Health Equity: Immigrant and Refugee Populations	11
Improving Behavioral Health Equity: Individuals in Rural or Remote Communities	9
Improving Behavioral Health Equity: Individuals Living in Poverty	7
Improving Behavioral Health Equity: Individuals with Asian American Identities	3
Improving Behavioral Health Equity: Individuals with Black or African American Identities	2
Improving Behavioral Health Equity: Individuals with Hispanic and Latine Identities	3
Improving Behavioral Health Equity: Individuals with Marginalized Ethnic Identities	9
Improving Behavioral Health Equity: Individuals with Physical Disabilities	1
Improving Behavioral Health Equity: Individuals with Tribal, Indigenous, or Native Identities	11
Improving Behavioral Health Equity: People Who Are LGBQ+	1
Improving Behavioral Health Equity: People Who Are Transgender and Nonbinary	10
Improving Behavioral Health Equity: Spiritual and Religious Diversity	11
Improving Behavioral Health Equity: Veterans	9

Title of Training / Event / Conference	Number of Participants
Improving Clinical Competency Through an Understanding of Military Culture	1
Improving Behavioral Health Equity: Women	1
Influence of Culture on Care in Behavioral Health for Paraprofessionals	34
Introduction to Cultural Variations in Behavioral Health for Paraprofessionals	17
Leading an Inclusive Work Environment	5
Medi-Cal Mobile Crisis Training - Collaborative, Culturally Responsive Crisis Safety Planning	4
Medi-Cal Mobile Crisis Training - Introduction to Culturally Responsive Crisis Care for Tribal and Urban Indian People	3
Medi-Cal Mobile Crisis Training - Introduction to Culturally Responsive Crisis Care in Diverse Communities	3
Overcoming Barriers to LGBTQ+ Affirming Behavioral Health Services – Retired 1/4/2025	2
Overcoming Unconscious Bias in the Workplace	2
Overcoming Your Own Unconscious Biases	21
Overview of the Indian Child Welfare Act	2
Podcast: Implicit Bias and Prejudice	1
Preventing Suicide Among Veteran Populations	1
Providing Culturally Competent Care to Children	4
Providing Culturally Competent Care to Older Adults	1
Providing Culturally Competent Care to Special Populations	3
Social and Community Context as Social Determinants of Health	1
Social Determinants of Health: Education Access and Quality – Retired 4/5/2025	2
Social Determinants of Health: Neighborhood and Built Environment	1
Social Determinants of Health: Overview	10
Strategies for Gender-Inclusive Interactions	3
Substance Use Treatment and Relapse Prevention for Marginalized Populations	7
Substance Use Treatment for Women	2
Supporting the Behavioral Health Goals of LGBTQ+ Clients	4
The Black Church & Mental Wellness - A Panel Discussion	1
The Necessity of Black Service Providers - A Panel Discussion	1
The Role of Social Determinants of Health in Today's Healthcare	1

Title of Training / Event / Conference	Number of Participants
Treating Substance Use Disorders in the LGBTQ+ Community	10
Understanding and Minimizing Cultural Bias for Paraprofessionals	17
Veterans and Mental Health Conditions	1
Working More Effectively with LGBTQ+ Children and Youth – Retired 12/7/2024	16
Working with LGBTQ+ Children and Youth	12
Your Role in Workplace Diversity - Retired 7/6/2024	1
Your Role in Workplace Diversity	123
The Latino Commission – Latino Conference – Strengthening the Roots	10
Using Data to Promote Equity in Behavioral Health Organizations	1

VII. ADAPTATION OF SERVICES

BHSOC will utilize the Culturally Responsive Plan (CRP) to continue to expand services to achieve the goals and objectives outlined in this Plan. The DEIC will continue to meet monthly to continually identify opportunities to promote the delivery of culturally responsive services.

Fresno County DBH has subcommittees which provide additional insights. The LGBTQ+ workgroup which has been a sub-committee may be lifted up to a possible affinity or employer resources group with specific projects and tasks to focus on increasing parity and quality of services.
Additionally, there may be future consideration to lift the Behavioral Health for Black Lives advisory group into a possible subcommittee or taking on a more formal role withing the DEI efforts including additional insights, workforce engagement and support efforts for more equitable care.

Fresno County DBH will be exploring options to create possibly employee advisory groups for LGBTQ+ Populations, African American populations, as well as possibility of a Peer group and Veterans groups.
Past efforts to create an employee resource group for API personnel did not generate interest.

A Plan Do Study Act (PDSA) method will be used to continually improve services. A PDSA method is a way to try out an idea on a small scale before implementing it system-wide. The steps of the cycle are: Step 1: Plan – Plan the test or observation, including a plan for collecting data; Step 2: Do – Try out the test on a small scale; Step 3: Study – Set aside a time to analyze the data and study the results; Step 4: Act – Refine the change, based on what was learned from the test.

Appendix A

National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care

The National CLAS Standards are intended to advance health equity, improve quality, and help eliminate health care disparities by establishing a blueprint for health and health care organizations to:

Principal Standard:

1. Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.

Governance, Leadership, and Workforce:

2. Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources.
3. Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service area.
4. Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.

Communication and Language Assistance:

5. Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.
6. Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.
7. Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.
8. Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.

Engagement, Continuous Improvement, and Accountability:

9. Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization's planning and operations.
10. Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities.
11. Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.
12. Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.
13. Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.
14. Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints.
15. Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public.

OMH U.S. Department of Health and Human Services Office of Minority Health

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Appendix B
Cultural Competence Guidance and Resource Crosswalk

CLAS Standard	CCPR Criteria	Framework Guiding Principles
Principle Standard		
1) Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy and other communication needs.	Criterion 3: Strategies and Efforts for Reducing Racial, Ethnic, Cultural, and Linguistic Mental Health Disparities	Provision of Culturally and Linguistically Appropriate Services (18)
Governance, Leadership and Workforce		
2) Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources.	Criterion 1: Commitment to Cultural Competence	Commitment to Cultural Competence and Health Equity (1,2,3,4)
3) Recruit, promote and support a culturally and linguistically diverse governance, leadership and workforce that are responsive to the population in the service area.	Criterion 1: Commitment to Cultural Competence Criterion 6: Commitment to Growing a Multicultural Workforce: Hiring and Retaining Culturally and Linguistically Competent Staff	Workforce Development (16)
4) Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.	Criterion 1: Commitment to Cultural Competence Criterion 5: Culturally Competent Training Activities	Workforce Development (16)
Communication and Language Assistance		
5) Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.	Criterion 7: Language Capacity	Provision of Culturally and Linguistically Appropriate Services (18)

CLAS Standard	CCPR Criteria	Framework Guiding Principles
6) Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.	Criterion 7: Language Capacity	Provision of Culturally and Linguistically Appropriate Services (18)
7) Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.	Criterion 6: Commitment to Growing a Multicultural Workforce: Hiring and Retaining Culturally and Linguistically Competent Staff	Workforce Development (16)
8) Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.	Criterion 7: Language Capacity	Provision of Culturally and Linguistically Appropriate Services (18)
Engagement, Continuous Improvement and Accountability		
9) Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organizations' planning and operations.	Criterion 1: Commitment to Cultural Competence	Commitment to Cultural Competence and Health Equity (5)
10) Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into assessment measurement and continuous quality improvement activities.	Criterion 3: Strategies and Efforts for Reducing Racial, Ethnic, Cultural, and Linguistic Mental Health Disparities	Identification of Disparities and Assessment of Needs and Assets (7) Implementation of Strategies to Reduce Identified Disparities (11)
11) Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.	Criterion 2: Updated Assessment of Service Needs	Identification of Disparities and Assessment of Needs and Assets (6,7)

CLAS Standard	CCPR Criteria	Framework Guiding Principles
12) Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.	Criterion 8: Adaptation of Services	Identification of Disparities and Assessment of Needs and Assets (8)
13) Partner with the community to design, implement and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.	Criterion 4: Person Served-Client/Family Member/Community Committee: Integration of the Committee Within the County Mental Health System	Community Driven Care (13,14,15) Provision of Culturally and Linguistically Appropriate Services (21,22)
14) Create conflict- and grievance-resolution processes that are culturally and linguistically appropriate to identify, prevent and resolve conflicts or complaints.	Criterion 3: Strategies and Efforts for Reducing Racial, Ethnic, Cultural, and Linguistic Mental Health Disparities	Community Driven Care (13)
15) Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public.	Criterion 1: Commitment to Cultural Competence	Implementation of Strategies to Reduce Identified Disparities (10,11)

Appendix C

Fresno County Department of Behavioral Health

Cultural Humility Committee (CHC) Charter

Mission Statement:
The Fresno County Department of Behavioral Health's Cultural Humility Committee (CHC) seeks to support the development of a continuous collaborative effort to improve service delivery and strengthen services for underserved, unserved, and inappropriately served diverse populations in Fresno County. The CHC brings together a wide array of community stakeholders to identify, address, and reduce health disparities within the department's services and the overall system of care, as outlined in the annual Fresno County Culturally Responsive Plan (CRP).

Type of Committee: Standing Committee (as mandated)

Membership:

- Chair (ESM)
- Co-Chair (DSC)
- Division Managers
- QI Staff
- Stakeholders
- DBH Director
- DBH Deputy Director
- DBH Medical Staff
- Sub-Committee Personnel
- DBH Contracted Providers
- Staff Development
- Admin-HR
- Compliance
- DBH Clinical Program Staff
- DBH Substance Use Disorder

Chairperson: DBH Ethic Services Manager (ESM)/Division Manager
Co-Chair: DBH Diversity Services Coordinator (DSC)

Duties/Responsibilities of the QIC:
The CHC is responsible for the following:

1. Review and approval of the annual mandated Cultural Competency Plan Requirement (CCPR),
2. Identify opportunites to strengthen access, quality, and cost-effectiveness of services for diverse populations to improve outcomes;
3. Identify and recommend cultural humility trainings and cultural enrichment activities;
4. Develop culturally responsive strategies for improved access to care;
5. Ensure the department and the system of care adhere to Federal Culturally and Linguistically Appropriate Services (CLAS) standards; and
6. Make reccomendations for strategies to improve overall health equity in Fresno County.

Objectives:

1. Assist with the development, review, and approval of the required CCPR/Culturally Responsive Plan and annual updates (California Code of Regulations, Title 9, Section 1810.410).
2. Guide efforts for implementation of the goals of the County's Culturally Responsive Plan (CRP) Delivered With Humility:
    a. Goal 1: To provide timely access to culturally- and linguistically-appropriate, integrated, behavioral health services to improve access for persons from various race/ethnicity groups; across all ages; veterans and their families; individuals who are Lesbian, Gay, Bisexual, Transgender, and Questioning (LGBTQ+); persons released from jail and their families; and other diverse cultures.
    b. Goal 2: To create a work environment where cultural humility, dignity, and respect are modeled, so all BHSOC staff experience equitable opportunities for professional and personal growth.
    c. Goal 3: To deliver innovative, evidence-based, trauma-informed, strengths-based behavioral health services in collaboration with other community organizations and co-locate services whenever possible, including in diverse community settings (e.g., schools, organizational

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providers, senior centers, churches, and other community locations) to promote health and wellness.

d. Goal 4: To develop outreach and education activities focused on disseminating information about behavioral health services for groups and organizations known to serve specific racial and ethnic groups within the community.
e. Goal 5: To collect and produce accurate and reliable demographic, service-level, and outcome data to understand and evaluate the impact of services on health equity, cost-effectiveness, and outcomes

3. Address the implementation and coordination of the Culturally Responsive Plan through work of five standing subcommittees:
    a. Communication
    b. Access
    c. Cultural Enrichment and Training
    d. Governance Policy and Human Resources
    e. Language

    *Other subcommittees and ad-hoc workgroups may be formed as needed.
4. Recommend policies, practices, and protocols to support cultural humility and CLAS standards across the system of care.
5. Provide support for External Quality Review (EQR) and Tri-Annual Medi-Cal reviews of cultural humility efforts from the system of care.

Delegation of Authority:
Provide recommendation of findings, outcomes, reports to the EMS and DSC, DBH Leadership for approval, denial, direction or additional guidance for action.

Frequency: First Thursday of each month.

Time: 10:00 am to 12:00 pm

Place: Heritage Center Training Room/Virtual

Formalities:

- Sign In sheets
- Meeting Agenda
- Meeting Minutes

Appendix D


THE
RAVEN
APPROACH
Department of Behavioral Health
The R.A.V.E.N. Framework provides practical ways to respond to micro-aggressions both in the work place and on-line.
Micro Aggression - a statement, action or incident regarded as indirect, subtle or unintentional discrimination against members of a marginalized group.
REDIRECT
Redirect the interaction to prevent further harm from occuring.
"Can I speak with you over here for a second?"
ASK
Ask probing questions that help the aggressor understand their statements are hurtful & problematic.
"Were you suggesting they shouldn't attend this college because English isnt their native language?"
VALUES CLARIFICATION
Values Clarification - Identifying and clarifying that the organization values are not aligned with their actions.
"In training, we all agreed to contribute towards a safe and wel coming environment. Your statements do not uphold these values."
EMPATHIZE
Empathize with your own thoughts and feelings. Using I statements, explain how you were affected by the aggressors hurtful statements: "I think" "I feel" "I was hurt" "I was disappointed"
"When you said Juan was actually articulate. I felt hurt that your expectation was for him to not be"
NEXT STEPS
Next Steps - Suggesting to the aggressor what they could do to correct their behavior moving forward.
"I think you should be more aware of how your words can effect the people around you. It would be a good Idea to apologize."
R.A.V.E.N. is not a step by step process. It's a general guide to provide us all with some options and actions that we can engage in to respond and (in time) eliminate microaggressions from our workplace. You can use whichever parts of R.A.V.E.N that may work for the current situation. The work with microaggressions are not sought to be a tool to address intentionally discriminative behaviors and/or belief systems towards marginalized groups.
RAVEN Approach is adapted from Dr. J. Luke Wood and Dr. Frank Harris III of San Diego State University.

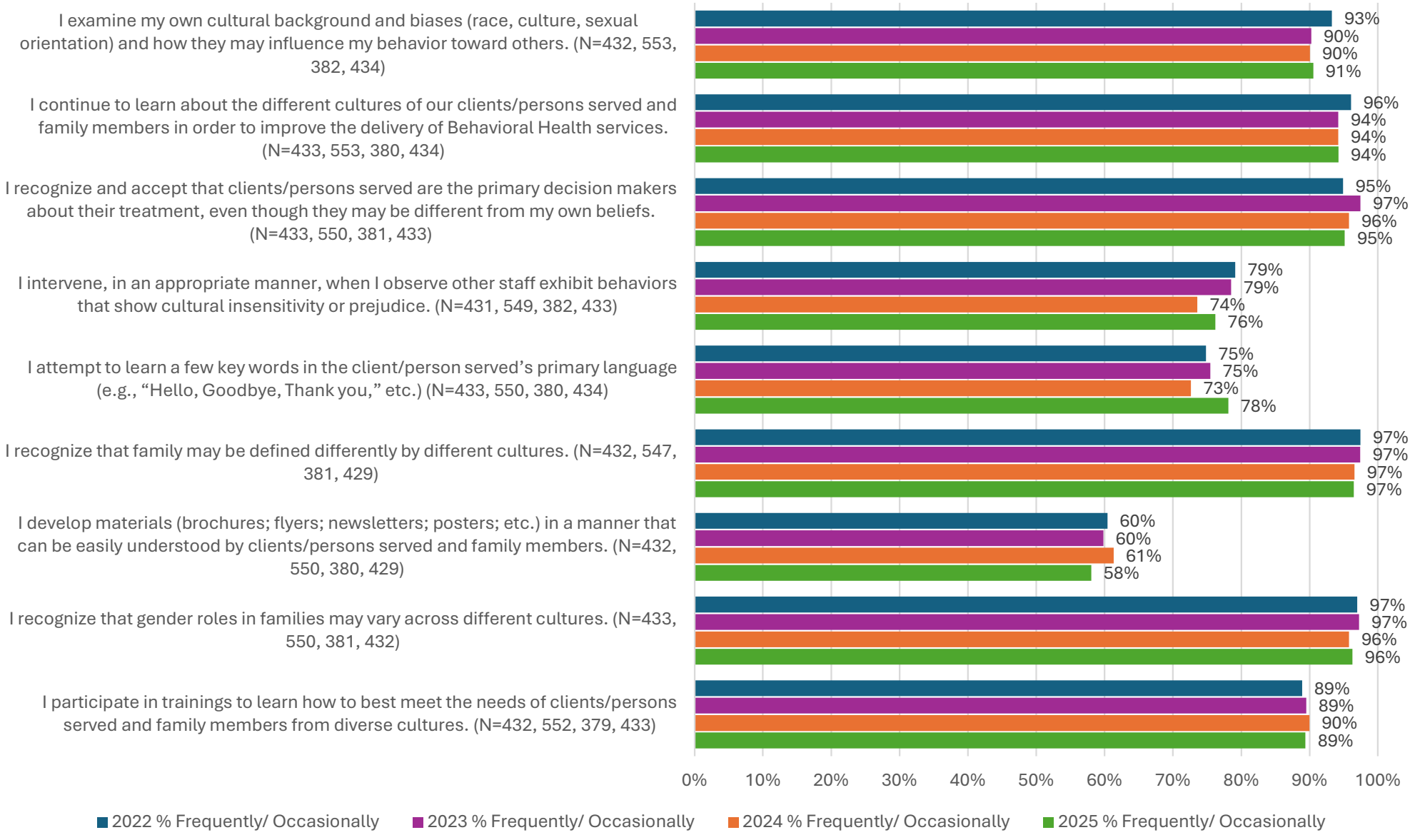
Appendix E: Staff and Volunteer Cultural Humility Survey Results

Fresno County Department of Behavioral Health

Staff Cultural Humility Survey

Comparison: 2022-2025

All Respondents

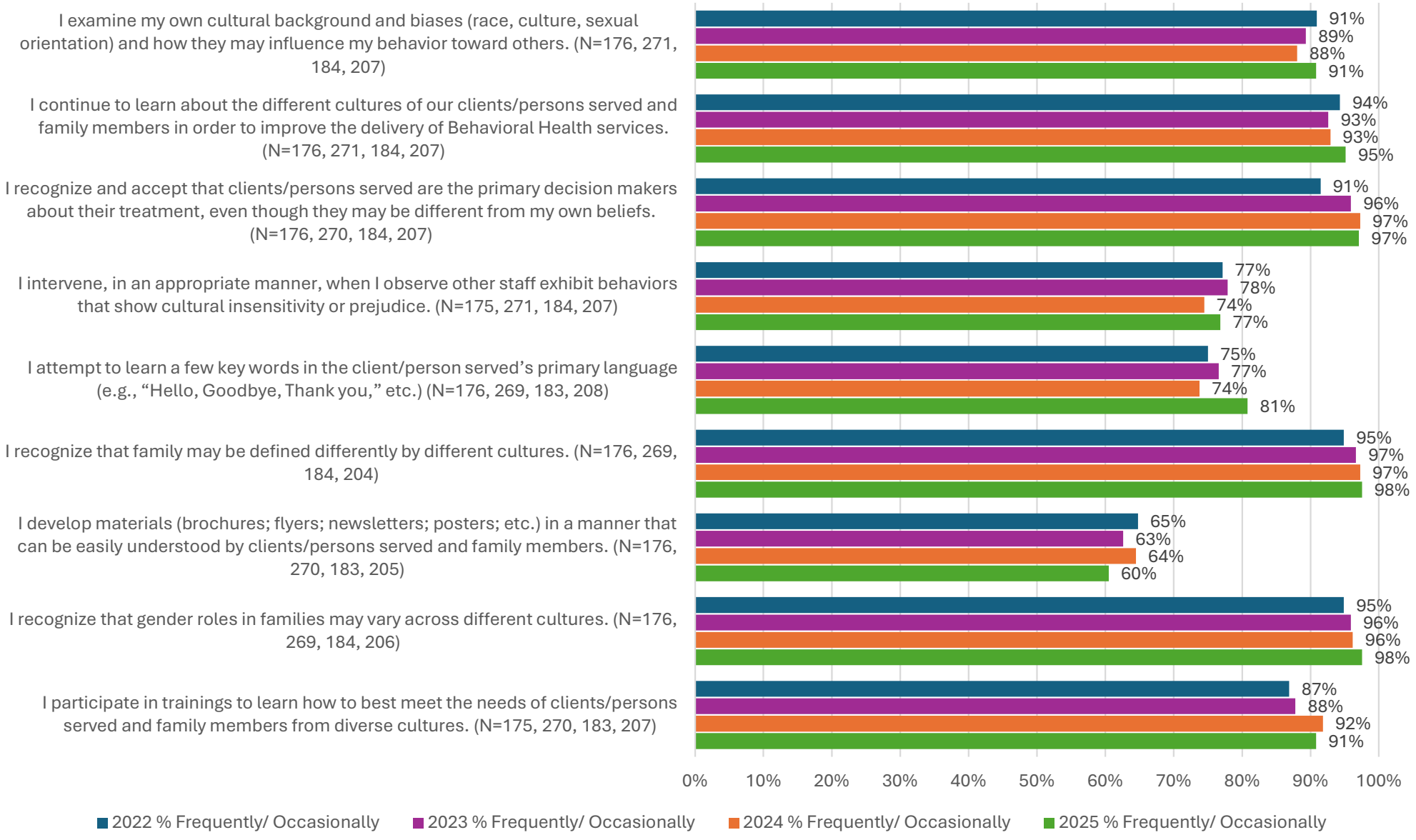


Fresno County Department of Behavioral Health

Staff Cultural Humility Survey

Comparison: 2022-2025

Hispanic/Latino Respondents

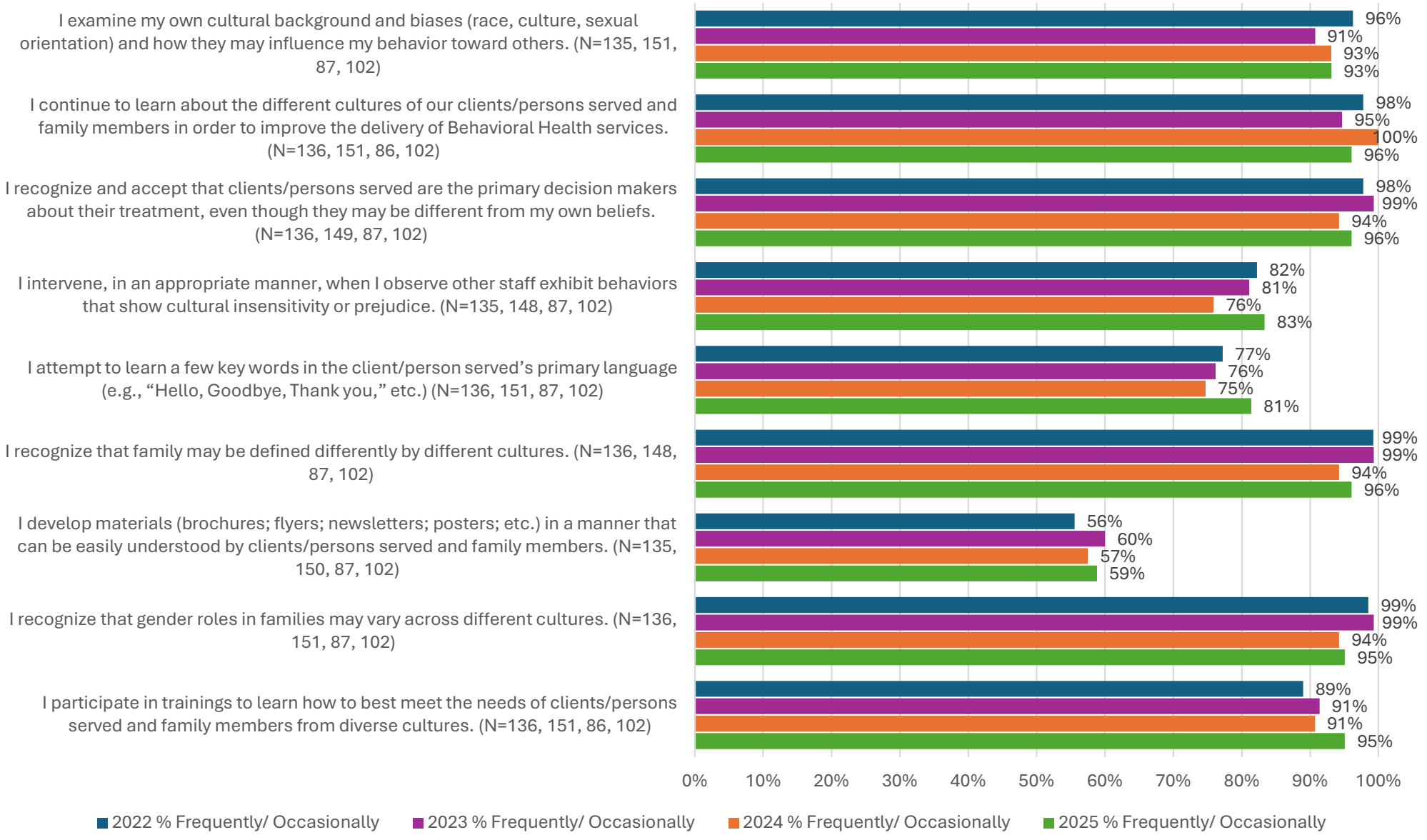


Fresno County Department of Behavioral Health

Staff Cultural Humility Survey

Comparison: 2022-2025

White, Non-Hispanic/Latino Respondents

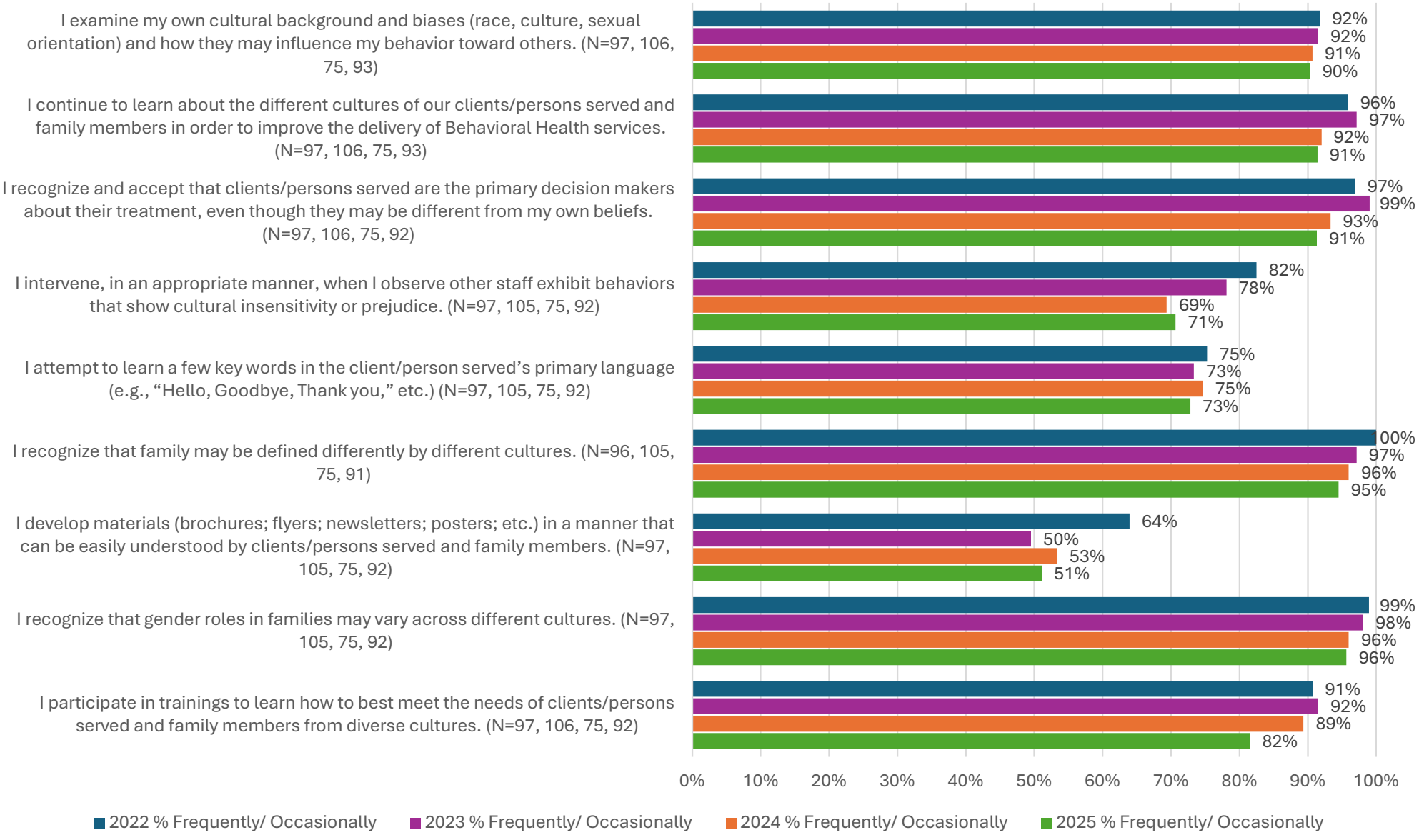


Fresno County Department of Behavioral Health

Staff Cultural Humility Survey

Comparison: 2022-2025

Non-White, Non-Hispanic/Latino Respondents

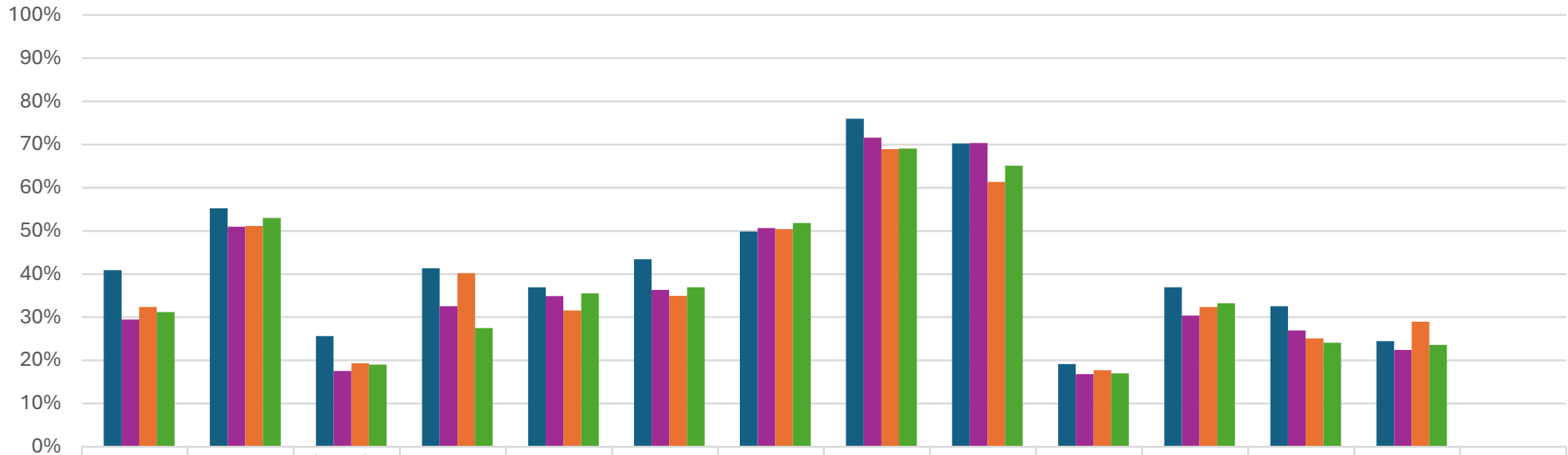


Fresno County Department of Behavioral Health

Staff Cultural Humility Survey

Comparison: 2022-2025

Participation in Professional Development (last 6 months): All Respondents



	I recognized a prejudice I have about certain people.	I talked to a colleague about a racial and/or cultural issue.	I sought guidance about a racial/ cultural issue that arose during therapy/ service delivery.	I attended a multi-cultural training seminar.	I attended a multi-cultural event.	I attended an event in which most of the other people were not my race.	I reflected on my racial identity and how it affects my work with clients/ persons served.	I read/ watched/ listened to media about multi-cultural issues.	I learned something about a racial and/or cultural group other than my own.	I sought consultation or supervision about multi-cultural issues.	I talked to a friend/ associate about how our racial differences affect our relationship.	I challenged a racist remark – my own or someone else's.	I attended a training on Implicit Bias.	Total
2022 # Respondents	177	239	111	179	160	188	216	329	304	83	160	141	106	433
2022 % Respondents	40.9%	55.2%	25.6%	41.3%	37.0%	43.4%	49.9%	76.0%	70.2%	19.2%	37.0%	32.6%	24.5%	100.0%
2023 # Respondents	163	282	97	180	193	201	280	396	389	93	168	149	124	553
2023 % Respondents	29.5%	51.0%	17.5%	32.5%	34.9%	36.3%	50.6%	71.6%	70.3%	16.8%	30.4%	26.9%	22.4%	100.0%
2024 # Respondents	124	196	74	154	121	134	193	264	235	68	124	96	111	383
2024 % Respondents	32.4%	51.2%	19.3%	40.2%	31.6%	35.0%	50.4%	68.9%	61.4%	17.8%	32.4%	25.1%	29.0%	100.0%
2025 # Respondents	136	231	83	120	155	161	226	301	284	74	145	105	103	436
2025 % Respondents	31.2%	53.0%	19.0%	27.5%	35.6%	36.9%	51.8%	69.0%	65.1%	17.0%	33.3%	24.1%	23.6%	100.0%

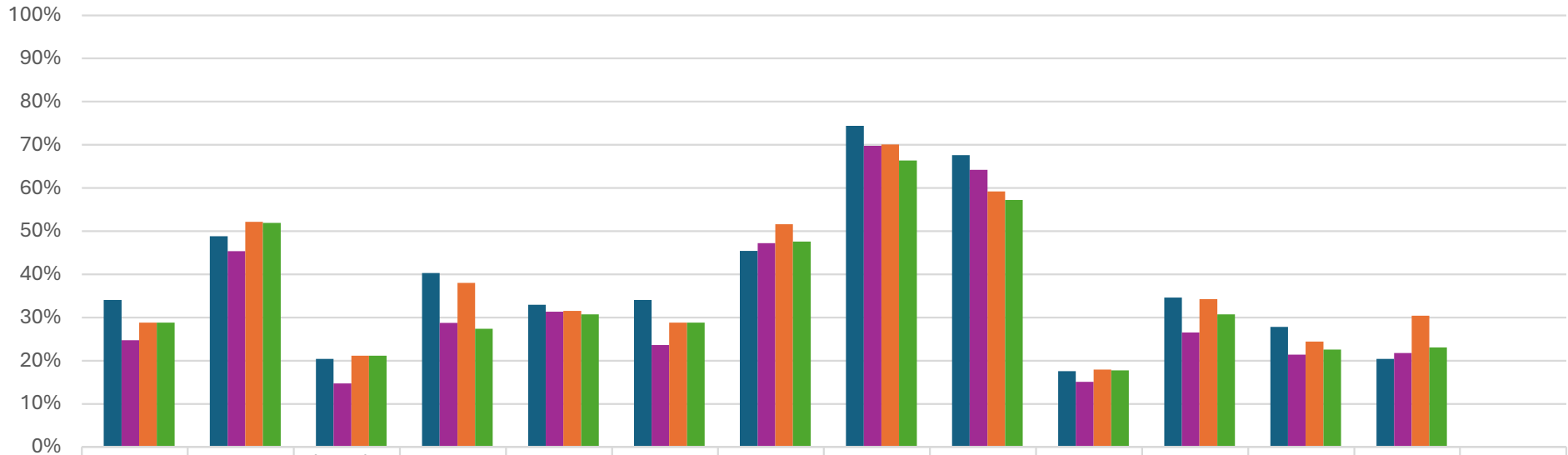
Respondents were able to provide multiple answers

Fresno County Department of Behavioral Health

Staff Cultural Humility Survey

Comparison: 2022-2025

Participation in Professional Development (last 6 months): Hispanic/Latino Respondents



	I recognized a prejudice I have about certain people.	I talked to a colleague about a racial and/or cultural issue.	I sought guidance about a racial/ cultural issue that arose during therapy/ service delivery.	I attended a multi-cultural training seminar.	I attended a multi-cultural event.	I attended an event in which most of the other people were not my race.	I reflected on my racial identity and how it affects my work with clients/ persons served.	I read/ watched/ listened to media about multi-cultural issues.	I learned something about a racial and/or cultural group other than my own.	I sought consultation or supervision about multi-cultural issues.	I talked to a friend/ associate about how our racial differences affect our relationship.	I challenged a racist remark – my own or someone else's.	I attended a training on Implicit Bias.	Total
2022 # Respondents	60	86	36	71	58	60	80	131	119	31	61	49	36	176
2022 % Respondents	34.1%	48.9%	20.5%	40.3%	33.0%	34.1%	45.5%	74.4%	67.6%	17.6%	34.7%	27.8%	20.5%	100.0%
2023 # Respondents	67	123	40	78	85	64	128	189	174	41	72	58	59	271
2023 % Respondents	24.7%	45.4%	14.8%	28.8%	31.4%	23.6%	47.2%	69.7%	64.2%	15.1%	26.6%	21.4%	21.8%	100.0%
2024 # Respondents	53	96	39	70	58	53	95	129	109	33	63	45	56	184
2024 % Respondents	28.8%	52.2%	21.2%	38.0%	31.5%	28.8%	51.6%	70.1%	59.2%	17.9%	34.2%	24.5%	30.4%	100.0%
2025 # Respondents	60	108	44	57	64	60	99	138	119	37	64	47	48	208
2025 % Respondents	28.8%	51.9%	21.2%	27.4%	30.8%	28.8%	47.6%	66.3%	57.2%	17.8%	30.8%	22.6%	23.1%	100.0%

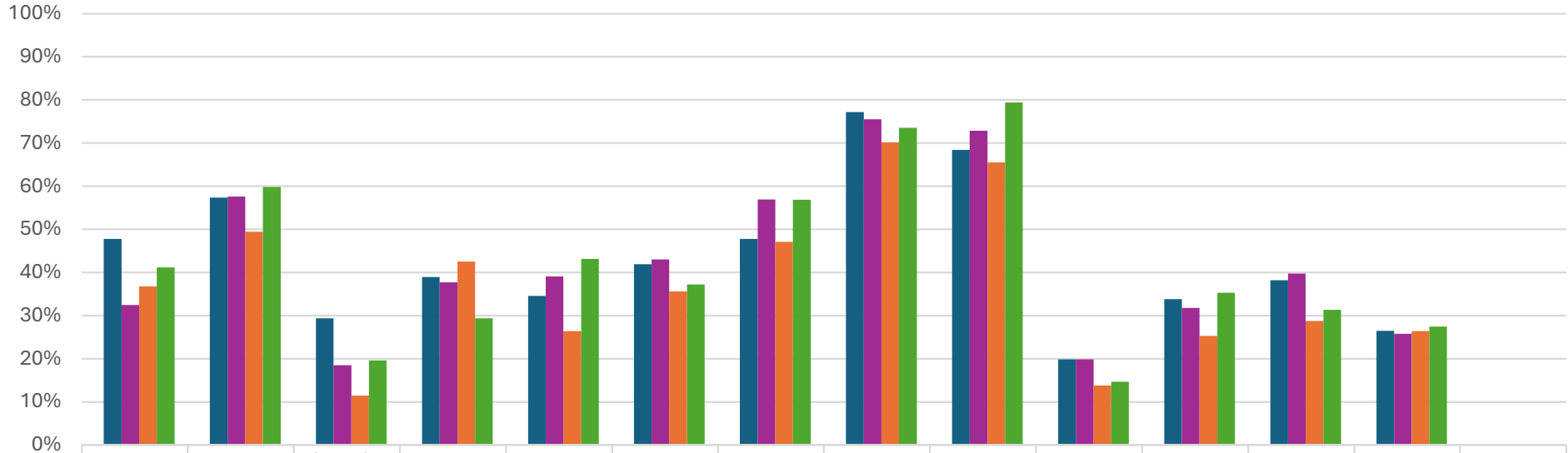
Respondents were able to provide multiple answers

Fresno County Department of Behavioral Health

Staff Cultural Humility Survey

Comparison: 2022-2025

Participation in Professional Development (last 6 months): White, Non-Hispanic/Latino Respondents



	I recognized a prejudice I have about certain people.	I talked to a colleague about a racial and/or cultural issue.	I sought guidance about a racial/ cultural issue that arose during therapy/ service delivery.	I attended a multi-cultural training seminar.	I attended a multi-cultural event.	I attended an event in which most of the other people were not my race.	I reflected on my racial identity and how it affects my work with clients/ persons served.	I read/ watched/ listened to media about multi-cultural issues.	I learned something about a racial and/or cultural group other than my own.	I sought consultation or supervision about multi-cultural issues.	I talked to a friend/ associate about how our racial differences affect our relationship.	I challenged a racist remark – my own or someone else's.	I attended a training on Implicit Bias.	Total
2022 # Respondents	65	78	40	53	47	57	65	105	93	27	46	52	36	136
2022 % Respondents	47.8%	57.4%	29.4%	39.0%	34.6%	41.9%	47.8%	77.2%	68.4%	19.9%	33.8%	38.2%	26.5%	100.0%
2023 # Respondents	49	87	28	57	59	65	86	114	110	30	48	60	39	151
2023 % Respondents	32.5%	57.6%	18.5%	37.7%	39.1%	43.0%	57.0%	75.5%	72.8%	19.9%	31.8%	39.7%	25.8%	100.0%
2024 # Respondents	32	43	10	37	23	31	41	61	57	12	22	25	23	87
2024 % Respondents	36.8%	49.4%	11.5%	42.5%	26.4%	35.6%	47.1%	70.1%	65.5%	13.8%	25.3%	28.7%	26.4%	100.0%
2025 # Respondents	42	61	20	30	44	38	58	75	81	15	36	32	28	102
2025 % Respondents	41.2%	59.8%	19.6%	29.4%	43.1%	37.3%	56.9%	73.5%	79.4%	14.7%	35.3%	31.4%	27.5%	100.0%

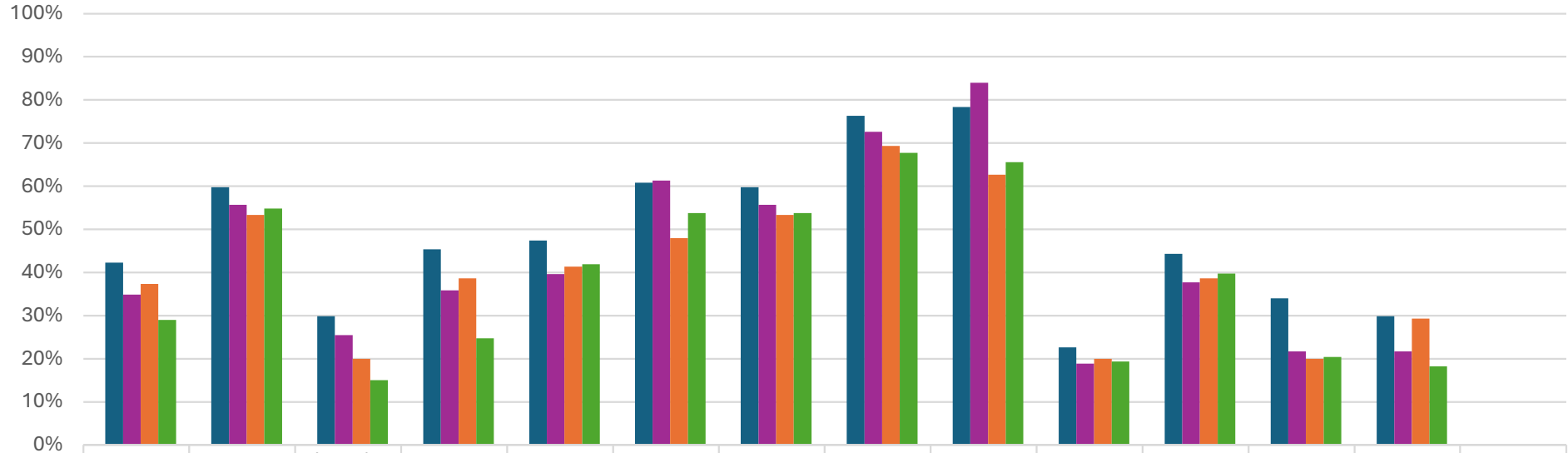
Respondents were able to provide multiple answers

Fresno County Department of Behavioral Health

Staff Cultural Humility Survey

Comparison: 2022-2025

Participation in Professional Development (last 6 months): Non-White, Non-Hispanic/Latino Respondents



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2022 # Respondents	41	58	29	44	46	59	58	74	76	22	43	33	29	97
2022 % Respondents	42.3%	59.8%	29.9%	45.4%	47.4%	60.8%	59.8%	76.3%	78.4%	22.7%	44.3%	34.0%	29.9%	100.0%
2023 # Respondents	37	59	27	38	42	65	59	77	89	20	40	23	23	106
2023 % Respondents	34.9%	55.7%	25.5%	35.8%	39.6%	61.3%	55.7%	72.6%	84.0%	18.9%	37.7%	21.7%	21.7%	100.0%
2024 # Respondents	28	40	15	29	31	36	40	52	47	15	29	15	22	75
2024 % Respondents	37.3%	53.3%	20.0%	38.7%	41.3%	48.0%	53.3%	69.3%	62.7%	20.0%	38.7%	20.0%	29.3%	100.0%
2025 # Respondents	27	51	14	23	39	50	50	63	61	18	37	19	17	93
2025 % Respondents	29.0%	54.8%	15.1%	24.7%	41.9%	53.8%	53.8%	67.7%	65.6%	19.4%	39.8%	20.4%	18.3%	100.0%

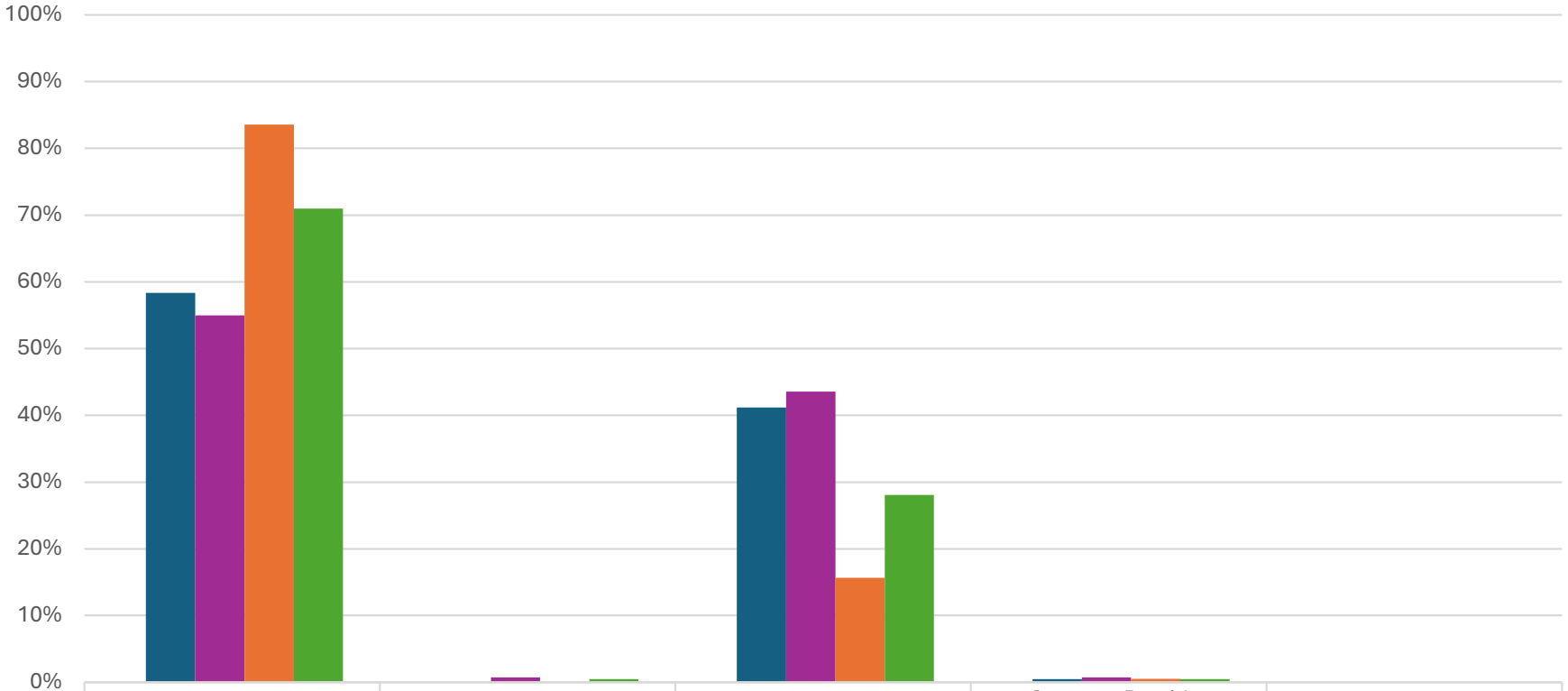
Respondents were able to provide multiple answers

Fresno County Department of Behavioral Health

Staff Cultural Humility Survey

Comparison: 2022-2025

Employment Status



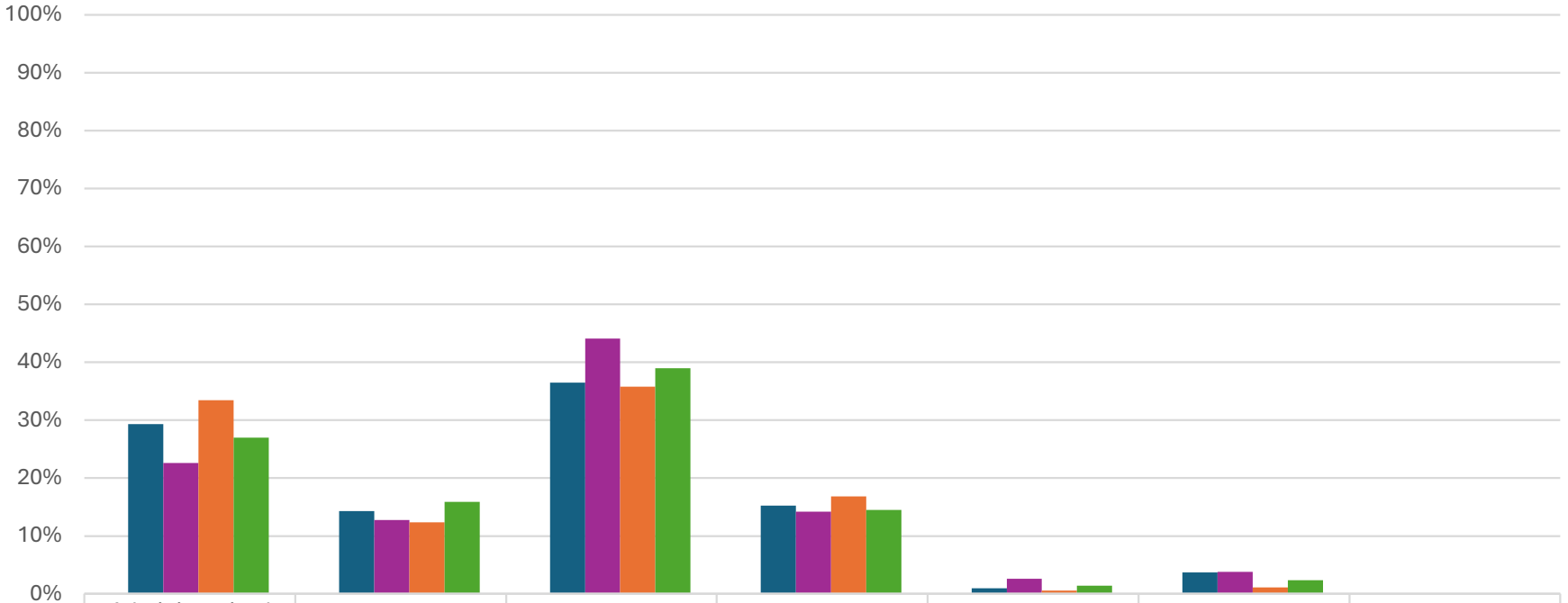
	County Staff	County Volunteer	Contract Provider Staff	Contract Provider Volunteer	Total
2022 # Respondents	252	0	178	2	432
2022 % Respondents	58.3%	0.0%	41.2%	0.5%	100.0%
2023 # Respondents	303	4	240	4	551
2023 % Respondents	55.0%	0.7%	43.6%	0.7%	100.0%
2024 # Respondents	315	0	59	2	377
2024 % Respondents	83.6%	0.0%	15.6%	0.5%	100.0%
2025 # Respondents	303	2	120	2	427
2025 % Respondents	71.0%	0.5%	28.1%	0.5%	100.0%

Fresno County Department of Behavioral Health

Staff Cultural Humility Survey

Comparison: 2022-2025

Primary Job Function



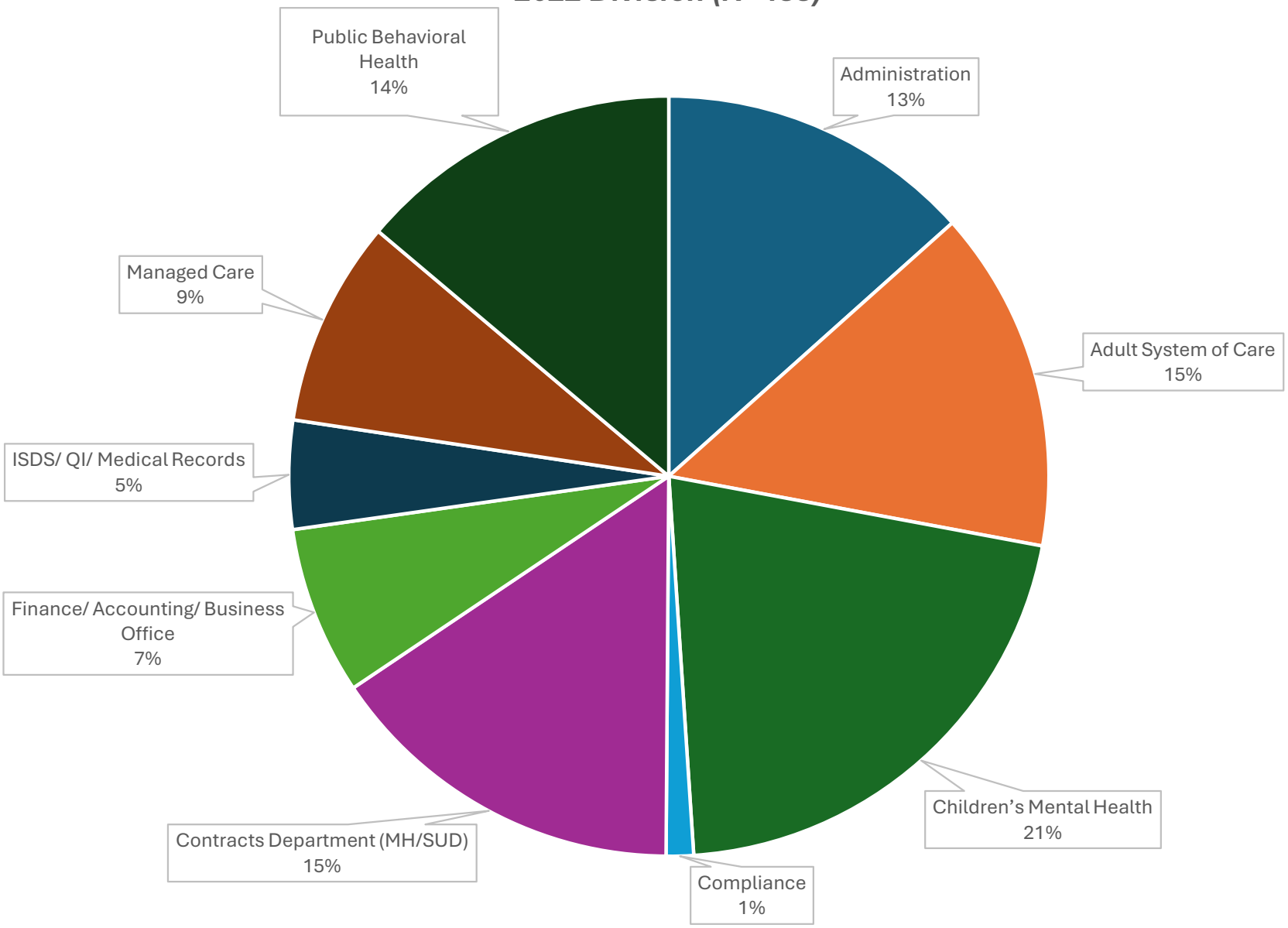
	Administration/ Clerical (Does not routinely interact with persons served)	Administration/ Clerical (Routinely interacts with persons served)	Direct Service/ Clinical/ Case Management	Management	Paid Peer Staff	Peer Support	Total
2022 # Respondents	127	62	158	66	4	16	433
2022 % Respondents	29.3%	14.3%	36.5%	15.2%	0.9%	3.7%	100.0%
2023 # Respondents	124	70	242	78	14	21	549
2023 % Respondents	22.6%	12.8%	44.1%	14.2%	2.6%	3.8%	100.0%
2024 # Respondents	127	47	136	64	2	4	380
2024 % Respondents	33.4%	12.4%	35.8%	16.8%	0.5%	1.1%	100.0%
2025 # Respondents	117	69	169	63	6	10	434
2025 % Respondents	27.0%	15.9%	38.9%	14.5%	1.4%	2.3%	100.0%

Fresno County Department of Behavioral Health

Staff Cultural Humility Survey

Comparison: 2022-2025

2022 Division (N=433)

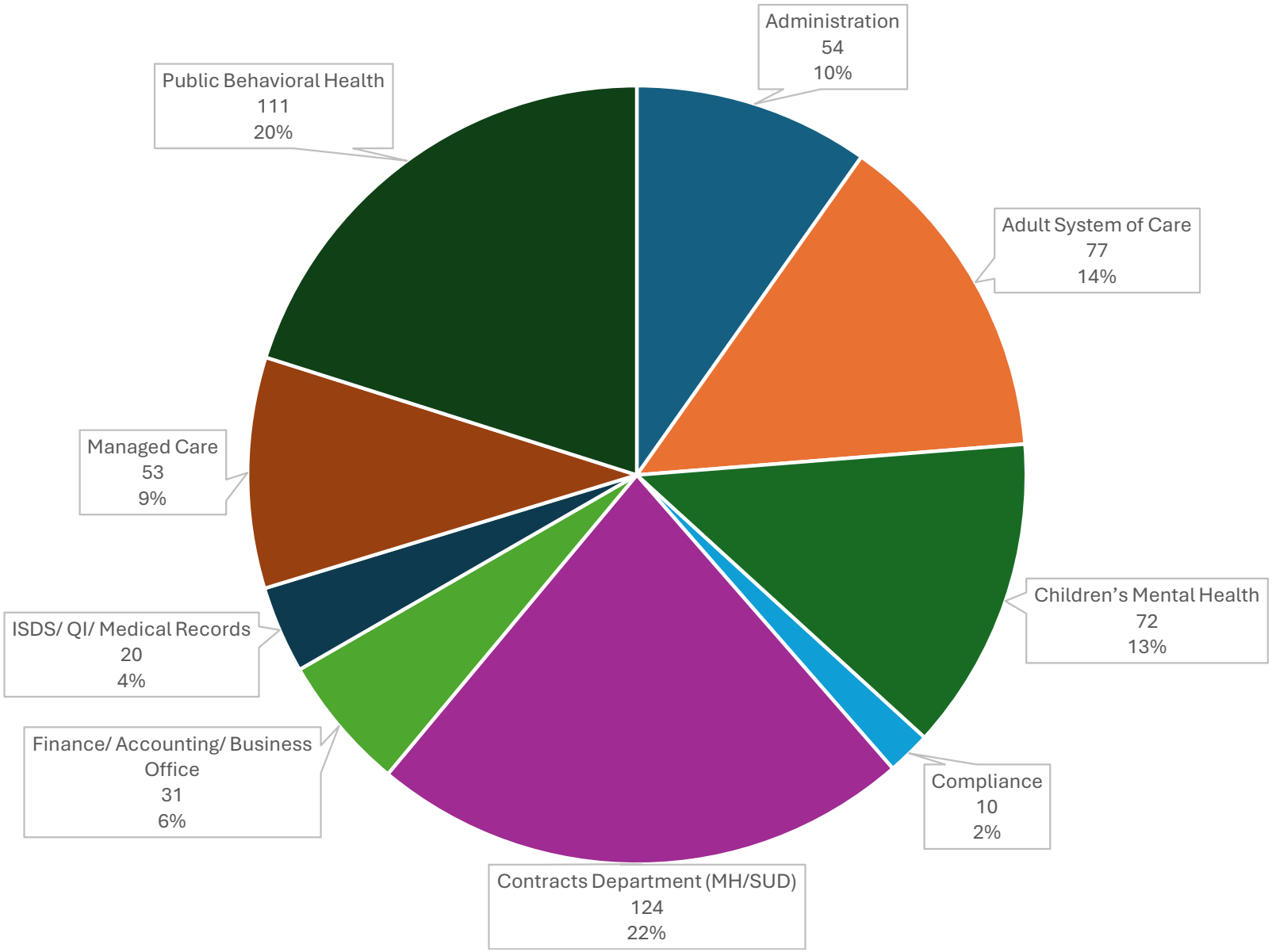


Fresno County Department of Behavioral Health

Staff Cultural Humility Survey

Comparison: 2022-2025

2023 Division (N=552)

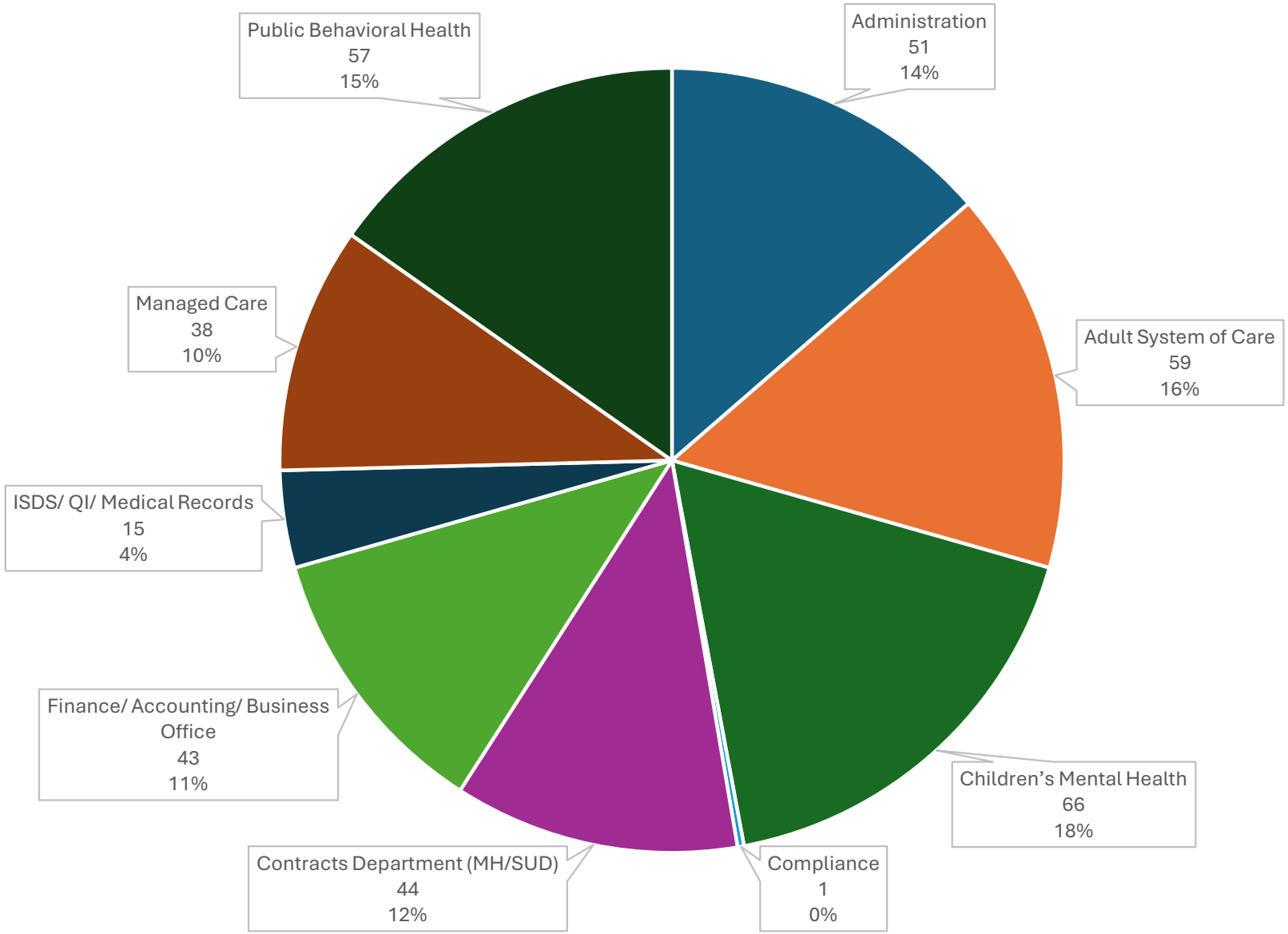


Fresno County Department of Behavioral Health

Staff Cultural Humility Survey

Comparison: 2022-2025

2024 Division (N=374)

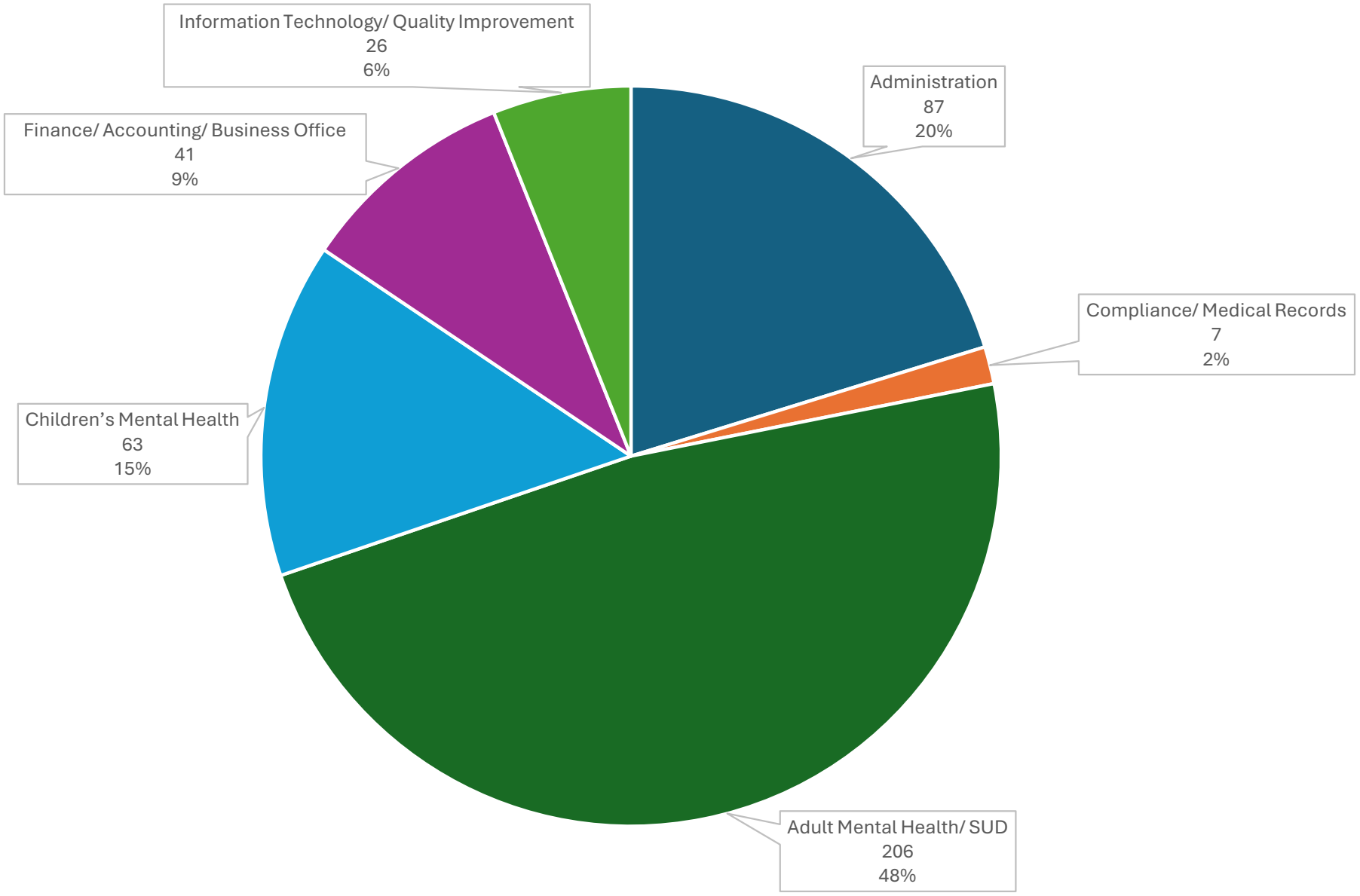


Fresno County Department of Behavioral Health

Staff Cultural Humility Survey

Comparison: 2022-2025

2025 Division (N=430)

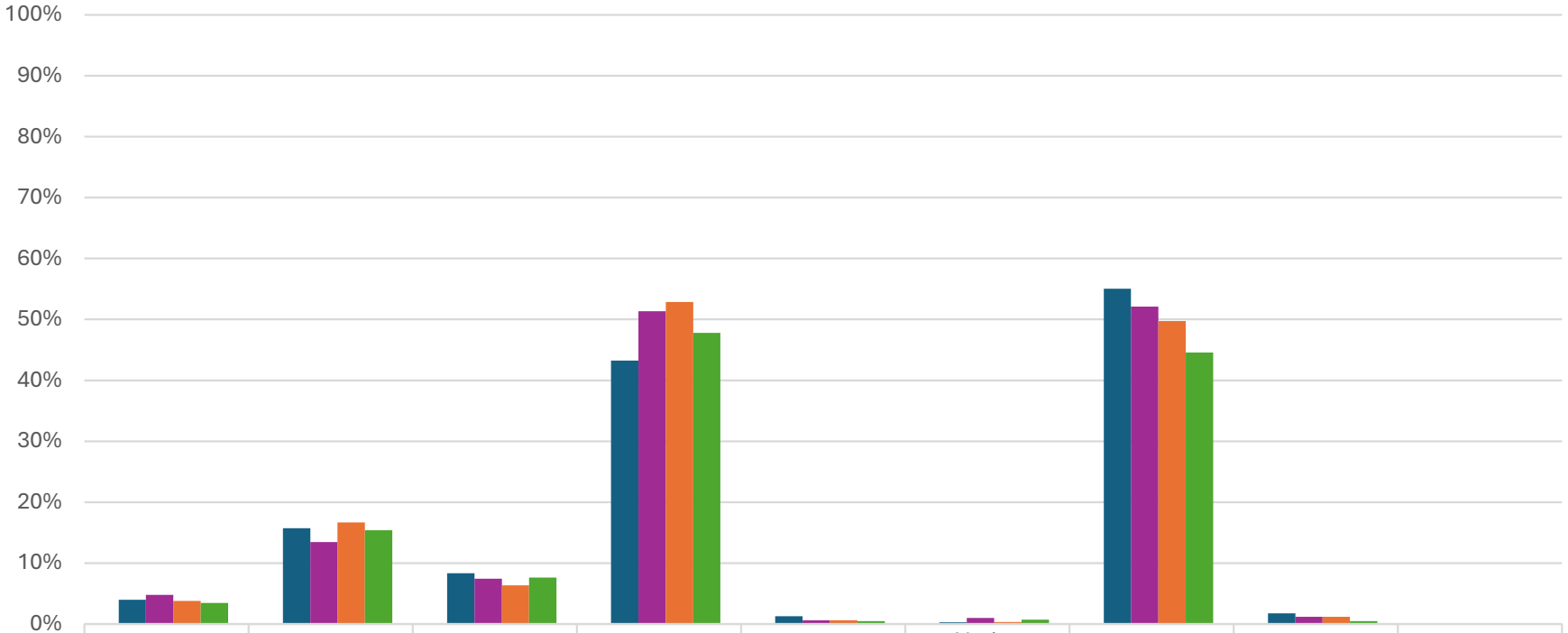


Fresno County Department of Behavioral Health

Staff Cultural Humility Survey

Comparison: 2022-2025

Race and Ethnicity



	American Indian or Alaska Native	Asian	Black or African American	Hispanic or Latino	Middle Eastern	Native Hawaiian or Other Pacific Islander	White/ Caucasian	Other	Total
2022 # Respondents	16	64	34	176	5	1	224	7	407
2022 % Respondents	3.9%	15.7%	8.4%	43.2%	1.2%	0.2%	55.0%	1.7%	100.0%
2023 # Respondents	25	71	39	271	3	5	275	6	528
2023 % Respondents	4.7%	13.4%	7.4%	51.3%	0.6%	0.9%	52.1%	1.1%	100.0%
2024 # Respondents	13	58	22	184	2	1	173	4	348
2024 % Respondents	3.7%	16.7%	6.3%	52.9%	0.6%	0.3%	49.7%	1.1%	100.0%
2025 # Respondents	15	67	33	208	2	3	194	2	435
2025 % Respondents	3.4%	15.4%	7.6%	47.8%	0.5%	0.7%	44.6%	0.5%	100.0%

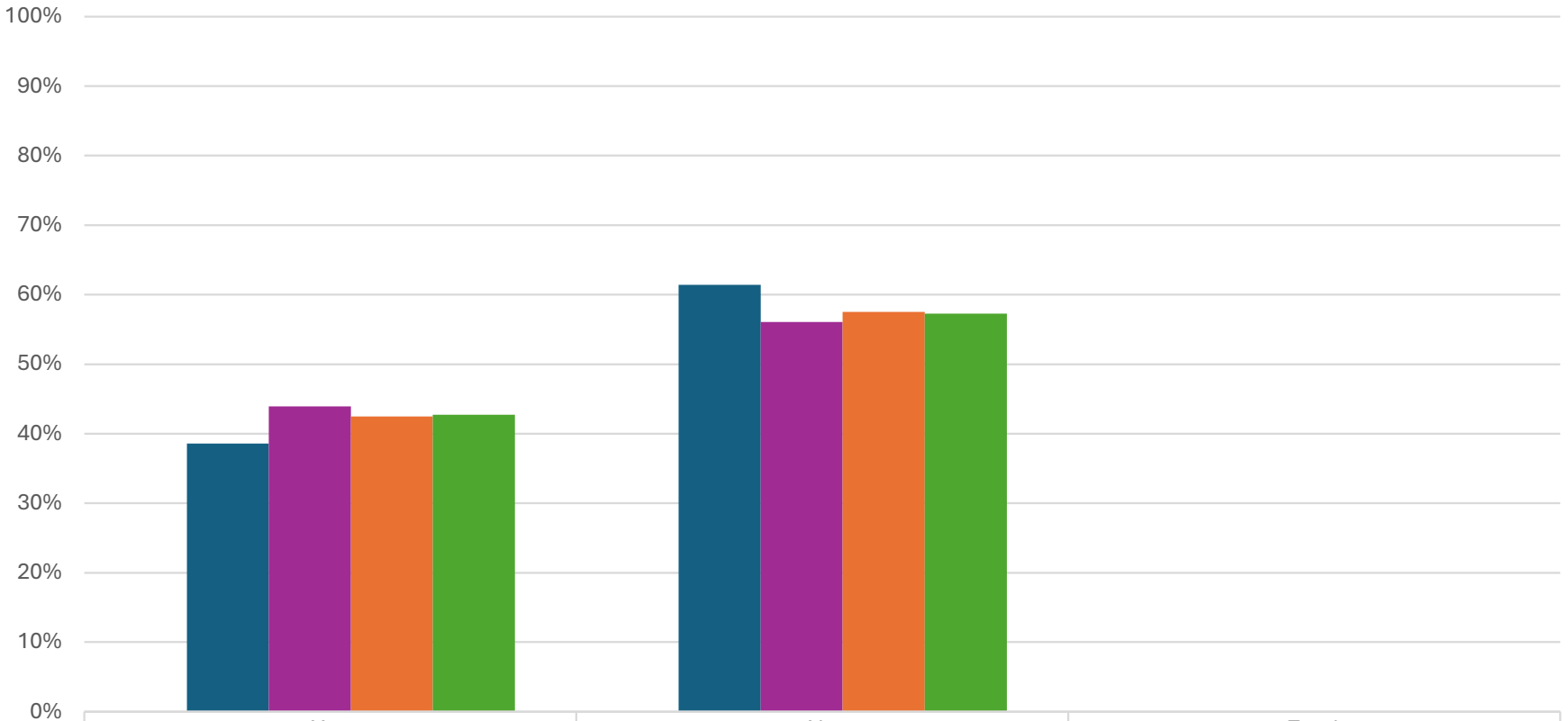
Respondents were able to provide multiple answers

Fresno County Department of Behavioral Health

Staff Cultural Humility Survey

Comparison: 2022-2025

Do you consder yourself bilingual?



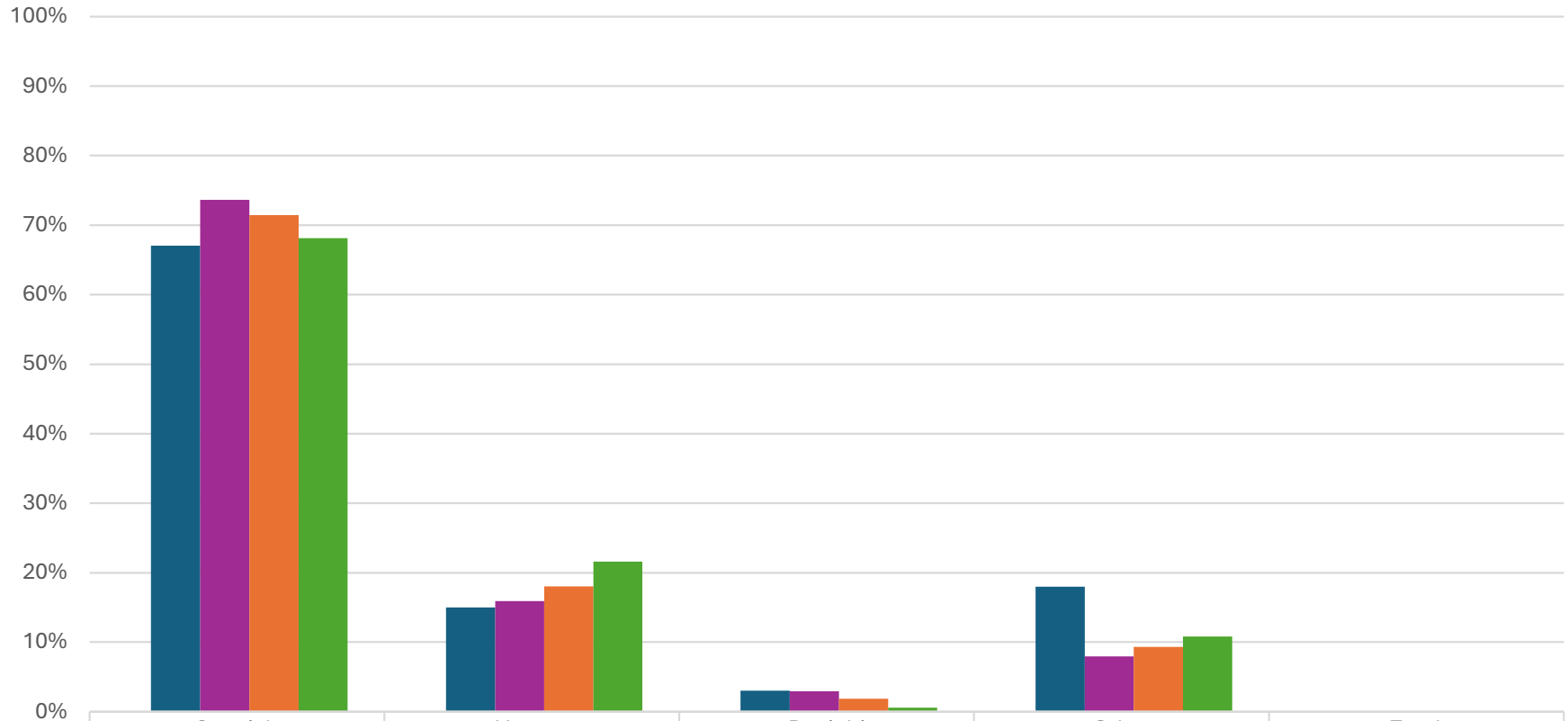
	Yes	No	Total
2022 # Respondents	167	266	433
2022 % Respondents	38.6%	61.4%	100.0%
2023 # Respondents	242	309	551
2023 % Respondents	43.9%	56.1%	100.0%
2024 # Respondents	161	218	379
2024 % Respondents	42.5%	57.5%	100.0%
2025 # Respondents	185	248	433
2025 % Respondents	42.7%	57.3%	100.0%

Fresno County Department of Behavioral Health

Staff Cultural Humility Survey

Comparison: 2022-2025

If you are bilingual, what language(s) do you speak?



	Spanish	Hmong	Punjabi	Other	Total
2022 # Respondents	112	25	5	30	167
2022 % Respondents	67.1%	15.0%	3.0%	18.0%	100.0%
2023 # Respondents	176	38	7	19	239
2023 % Respondents	73.6%	15.9%	2.9%	7.9%	100.0%
2024 # Respondents	115	29	3	15	161
2024 % Respondents	71.4%	18.0%	1.9%	9.3%	100.0%
2025 # Respondents	126	40	1	20	185
2025 % Respondents	68.1%	21.6%	0.5%	10.8%	100.0%

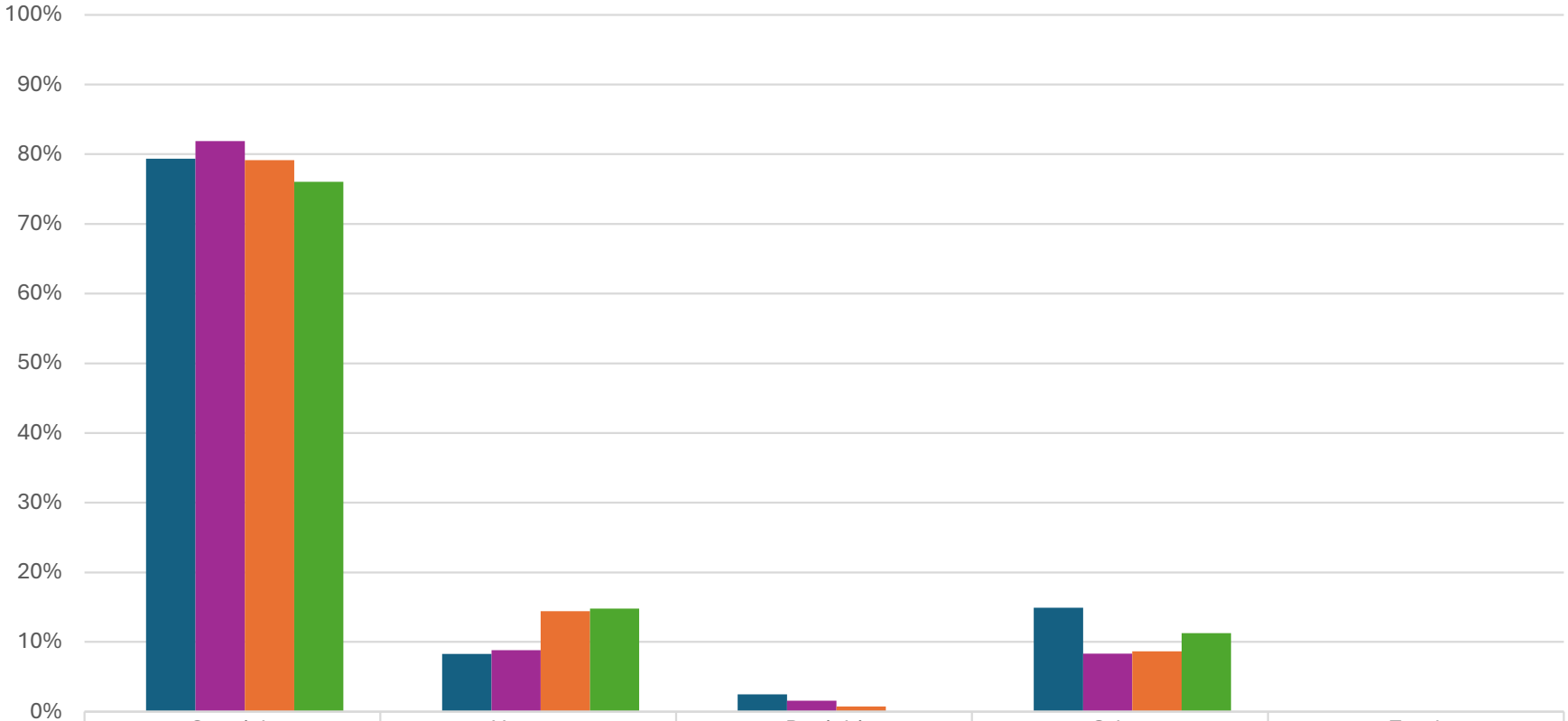
Respondents were able to provide multiple answers

Fresno County Department of Behavioral Health

Staff Cultural Humility Survey

Comparison: 2022-2025

If you are bilingual, what language(s) are you proficient in reading/writing?



	Spanish	Hmong	Punjabi	Other	Total
2022 # Respondents	96	10	3	18	121
2022 % Respondents	79.3%	8.3%	2.5%	14.9%	100.0%
2023 # Respondents	158	17	3	16	193
2023 % Respondents	81.9%	8.8%	1.6%	8.3%	100.0%
2024 # Respondents	110	20	1	12	139
2024 % Respondents	79.1%	14.4%	0.7%	8.6%	100.0%
2025 # Respondents	108	21	0	16	142
2025 % Respondents	76.1%	14.8%	0.0%	11.3%	100.0%

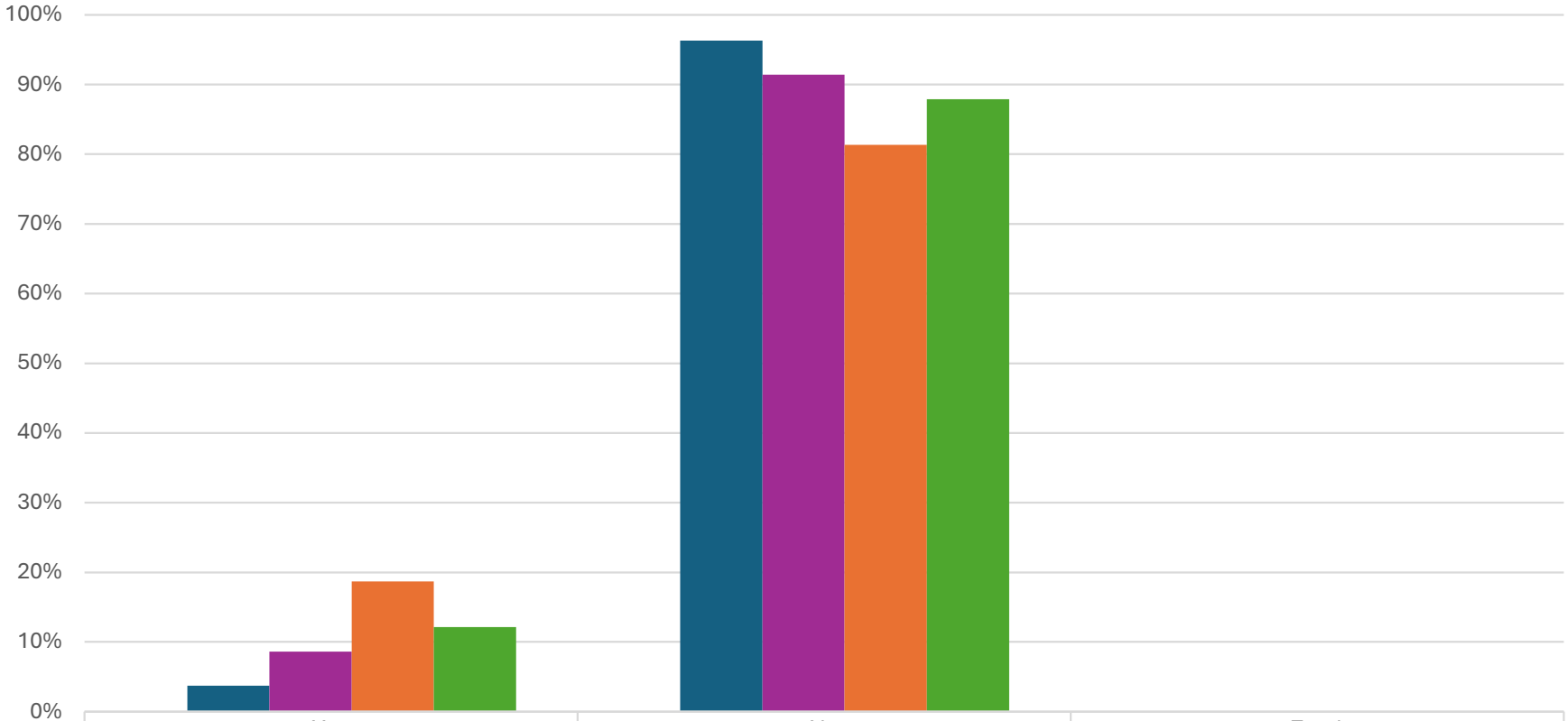
Respondents were able to provide multiple answers

Fresno County Department of Behavioral Health

Staff Cultural Humility Survey

Comparison: 2022-2025

Do you receive bilingual pay?



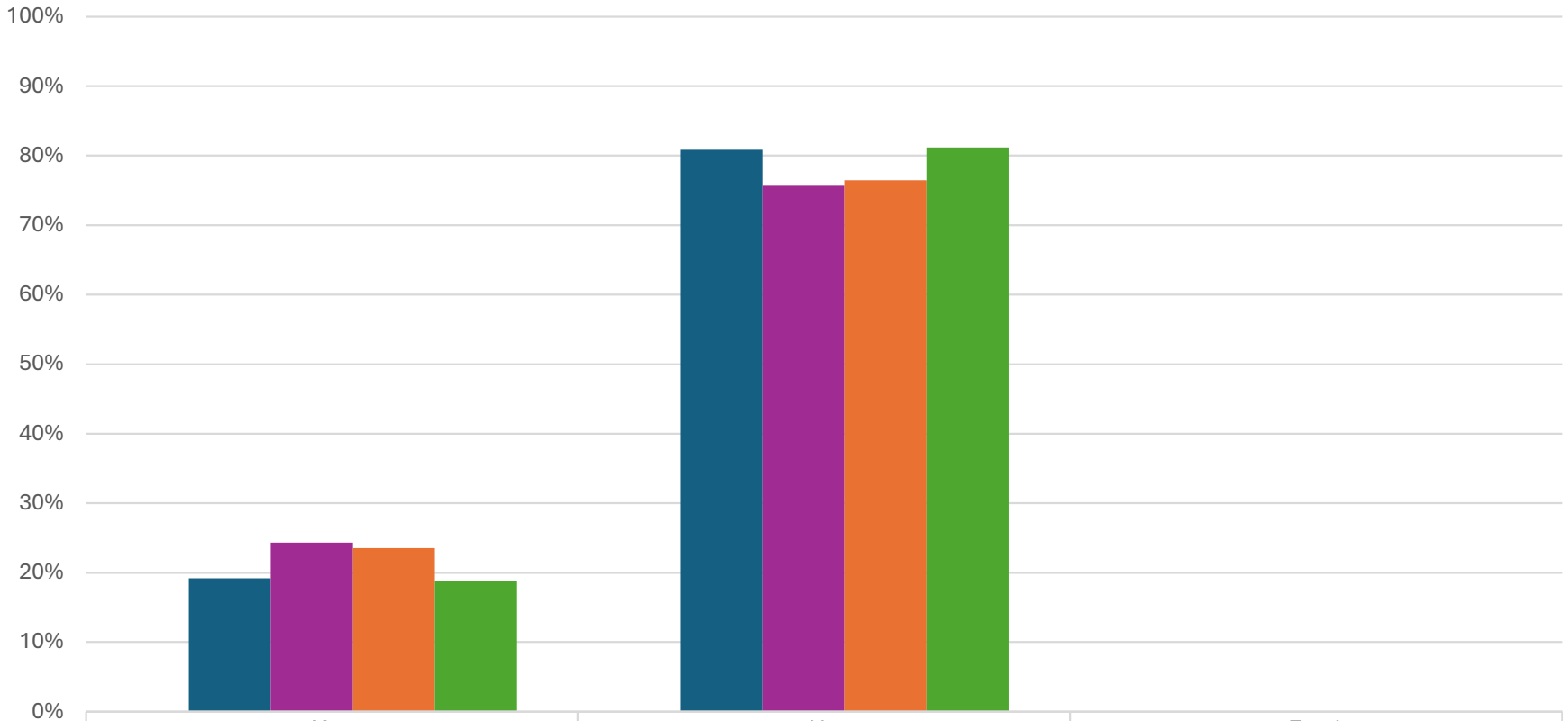
	Yes	No	Total
2022 # Respondents	16	415	431
2022 % Respondents	3.7%	96.3%	100.0%
2023 # Respondents	47	500	547
2023 % Respondents	8.6%	91.4%	100.0%
2024 # Respondents	65	283	348
2024 % Respondents	18.7%	81.3%	100.0%
2025 # Respondents	49	356	405
2025 % Respondents	12.1%	87.9%	100.0%

Fresno County Department of Behavioral Health

Staff Cultural Humility Survey

Comparison: 2022-2025

Do you act as an interpreter as part of your job function?



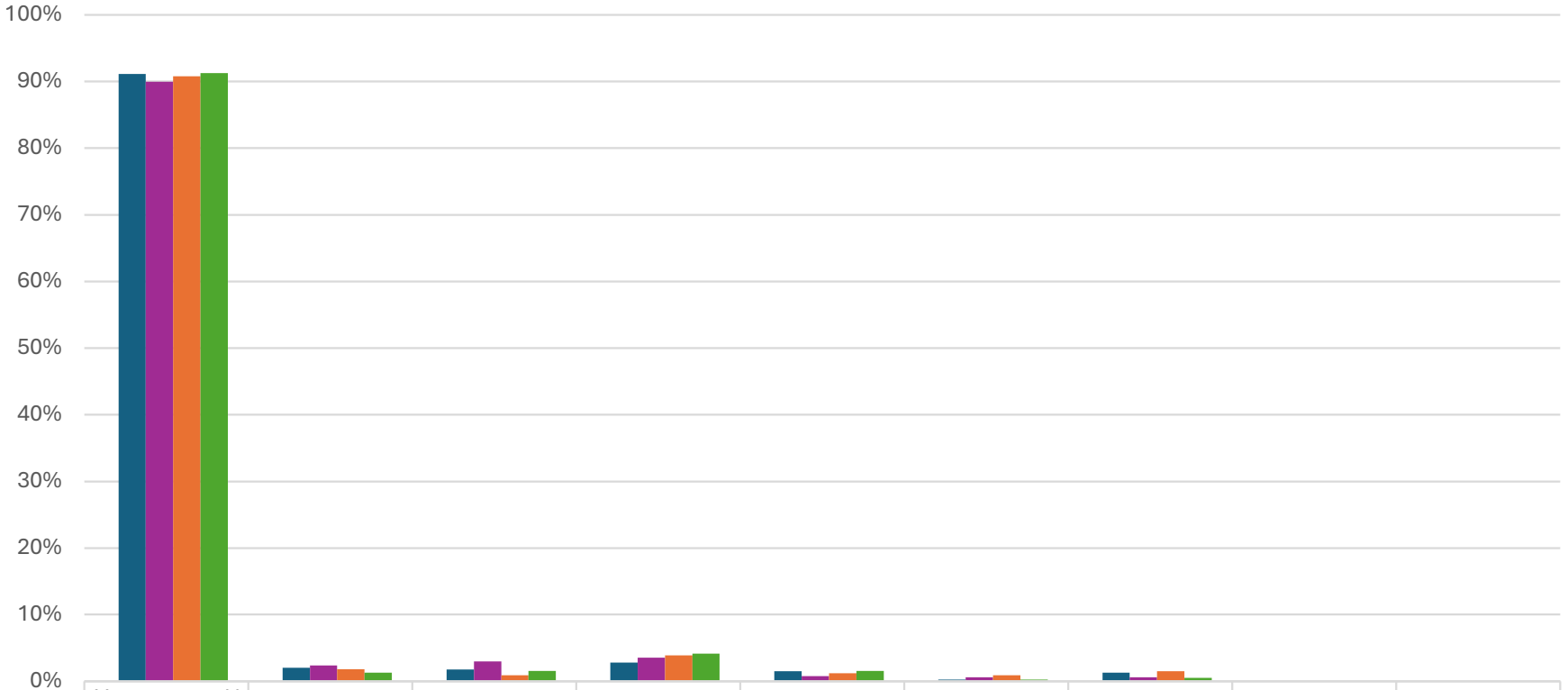
	Yes	No	Total
2022 # Respondents	83	350	433
2022 % Respondents	19.2%	80.8%	100.0%
2023 # Respondents	134	417	551
2023 % Respondents	24.3%	75.7%	100.0%
2024 # Respondents	90	292	382
2024 % Respondents	23.6%	76.4%	100.0%
2025 # Respondents	79	341	420
2025 % Respondents	18.8%	81.2%	100.0%

Fresno County Department of Behavioral Health

Staff Cultural Humility Survey

Comparison: 2022-2025

Sexual Orientation



	Heterosexual/ Straight	Gay	Lesbian	Bisexual	Queer	Questioning	Other	Cat	Total
2022 # Respondents	359	8	7	11	6	1	5		394
2022 % Respondents	91.1%	2.0%	1.8%	2.8%	1.5%	0.3%	1.3%	0.0%	100.0%
2023 # Respondents	456	12	15	18	4	3	3		507
2023 % Respondents	89.9%	2.4%	3.0%	3.6%	0.8%	0.6%	0.6%	0.0%	100.0%
2024 # Respondents	305	6	3	13	4	3	5		336
2024 % Respondents	90.8%	1.8%	0.9%	3.9%	1.2%	0.9%	1.5%	0.0%	100.0%
2025 # Respondents	354	5	6	16	6	1	2		388
2025 % Respondents	91.2%	1.3%	1.5%	4.1%	1.5%	0.3%	0.5%	0.0%	100.0%

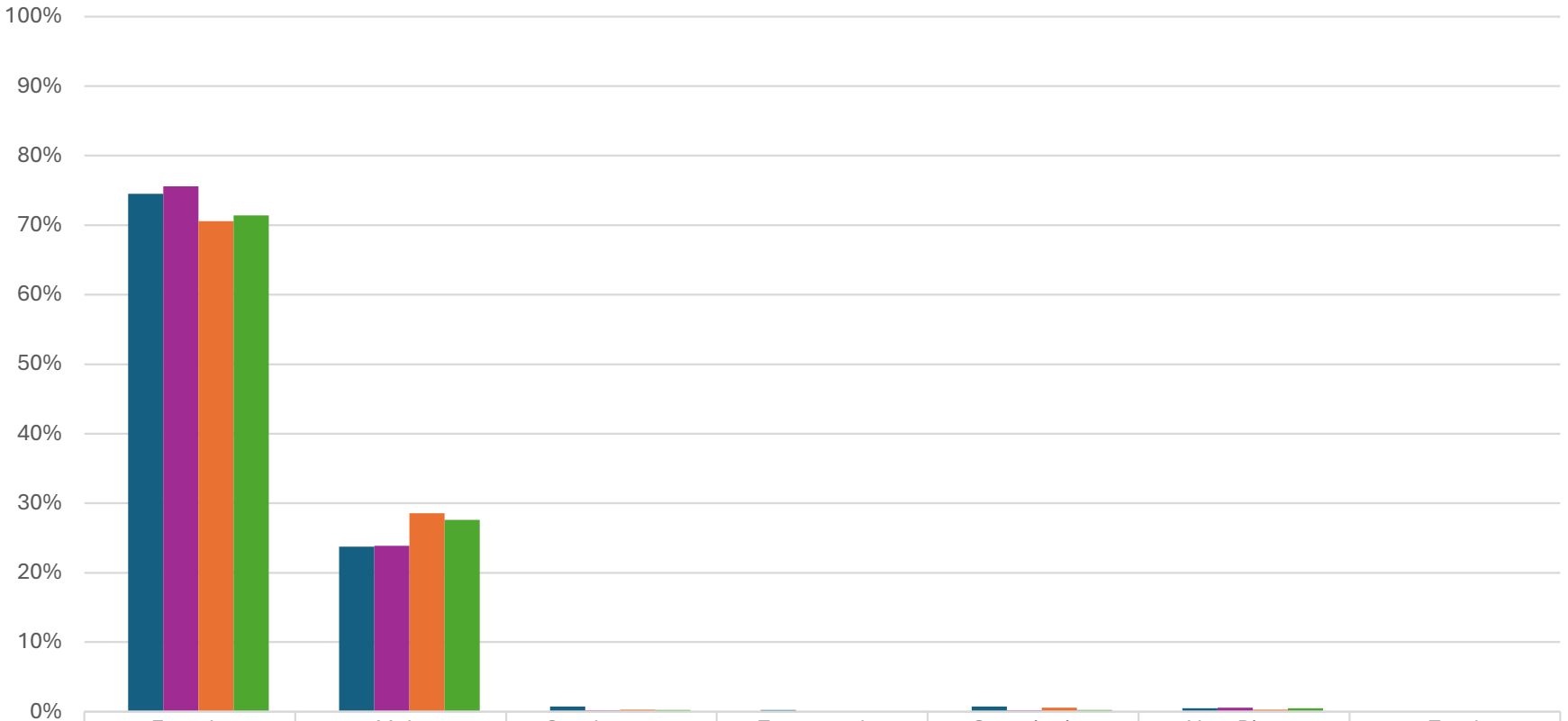
Respondents were able to provide multiple answers

Fresno County Department of Behavioral Health

Staff Cultural Humility Survey

Comparison: 2022-2025

Current Gender Identity



	Female	Male	Genderqueer	Transgender	Questioning	Non-Binary	Total
2022 # Respondents	304	97	3	1	3	2	408
2022 % Respondents	74.5%	23.8%	0.7%	0.2%	0.7%	0.5%	100.0%
2023 # Respondents	402	127	1	0	1	3	532
2023 % Respondents	75.6%	23.9%	0.2%	0.0%	0.2%	0.6%	100.0%
2024 # Respondents	247	100	1	0	2	1	350
2024 % Respondents	70.6%	28.6%	0.3%	0.0%	0.6%	0.3%	100.0%
2025 # Respondents	292	113	1	0	1	2	409
2025 % Respondents	71.4%	27.6%	0.2%	0.0%	0.2%	0.5%	100.0%

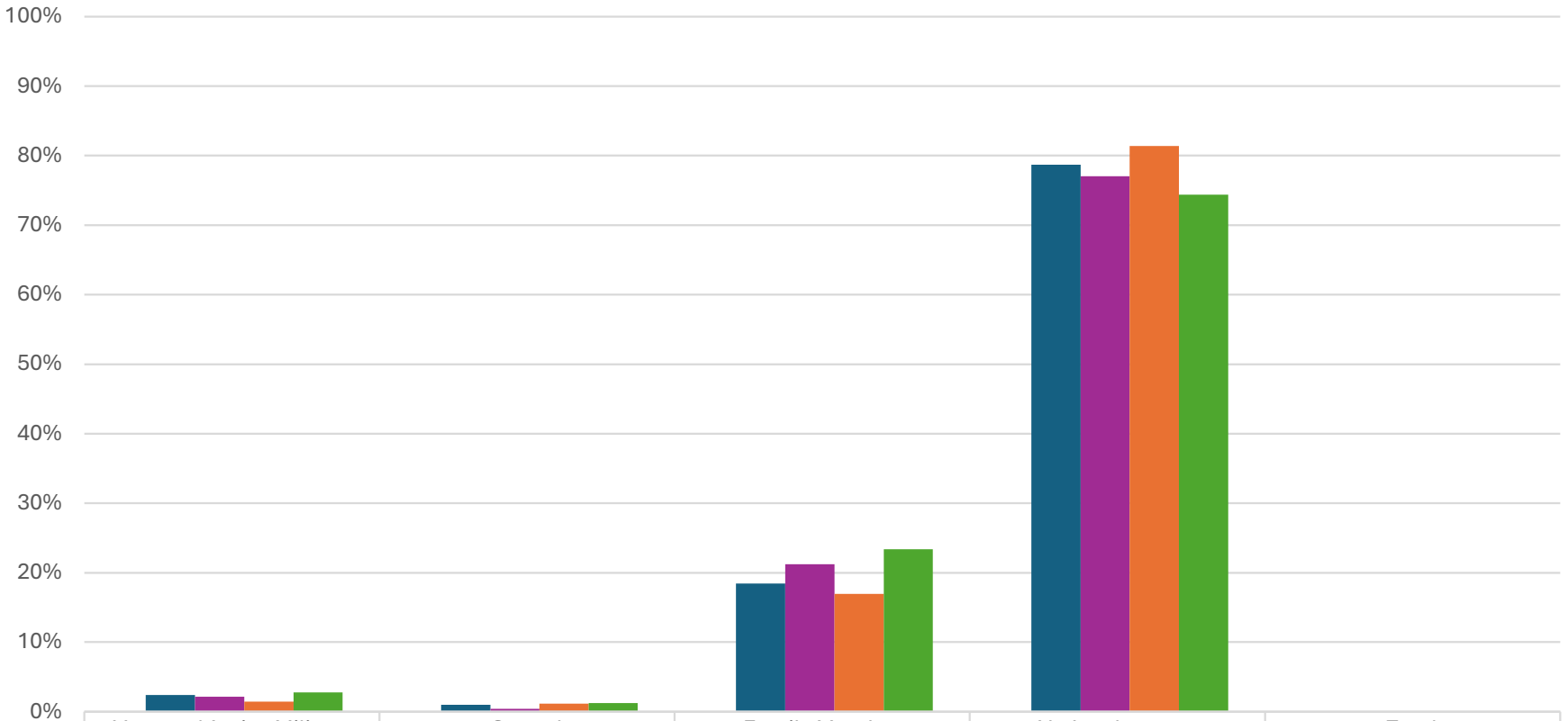
Respondents were able to provide multiple answers

Fresno County Department of Behavioral Health

Staff Cultural Humility Survey

Comparison: 2022-2025

Military Involvement



	Veteran/ Active Military	Served	Family Member	No Involvement	Total
2022 # Respondents	10	4	77	329	418
2022 % Respondents	2.4%	1.0%	18.4%	78.7%	100.0%
2023 # Respondents	11	2	110	399	518
2023 % Respondents	2.1%	0.4%	21.2%	77.0%	100.0%
2024 # Respondents	5	4	59	284	349
2024 % Respondents	1.4%	1.1%	16.9%	81.4%	100.0%
2025 # Respondents	11	5	94	299	402
2025 % Respondents	2.7%	1.2%	23.4%	74.4%	100.0%

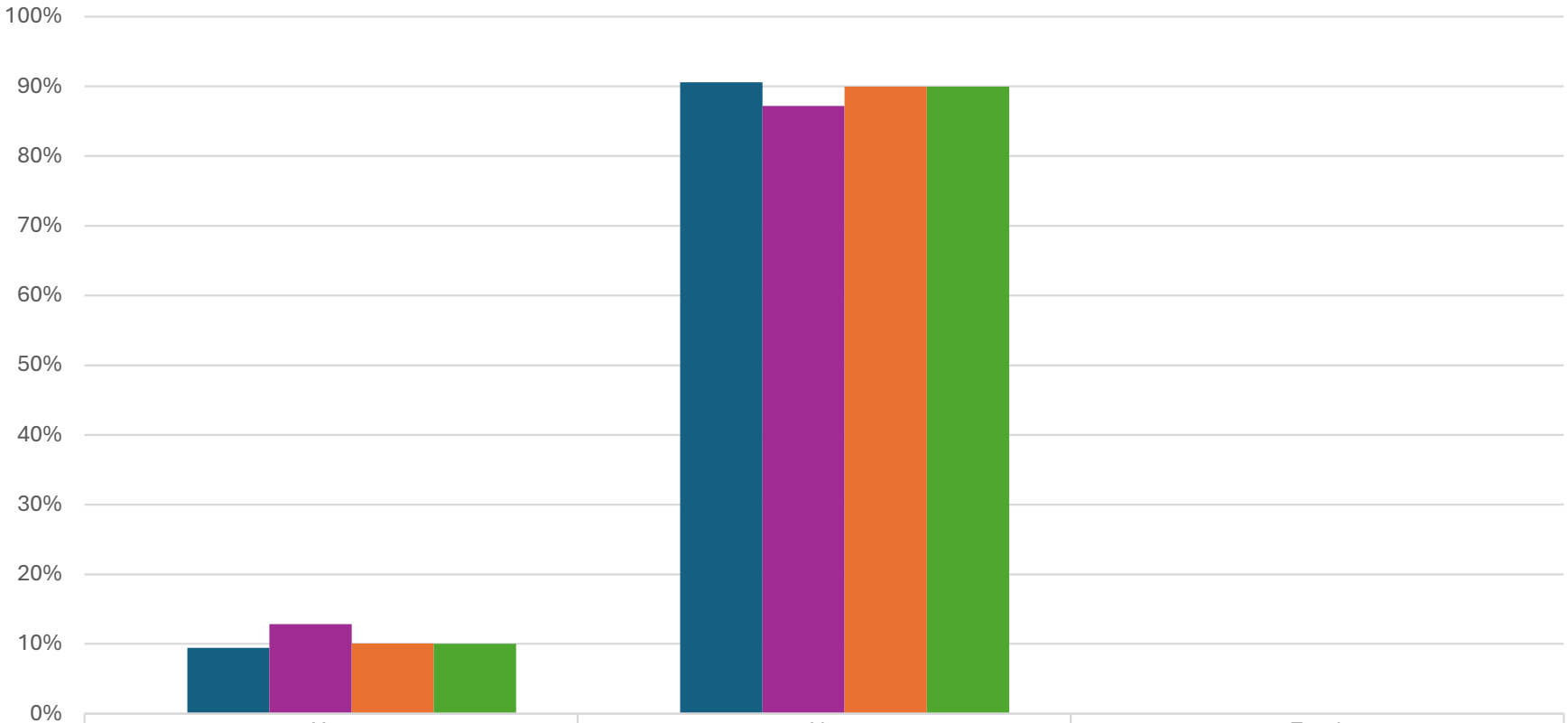
Respondents were able to provide multiple answers

Fresno County Department of Behavioral Health

Staff Cultural Humility Survey

Comparison: 2022-2025

Do you have a disability?



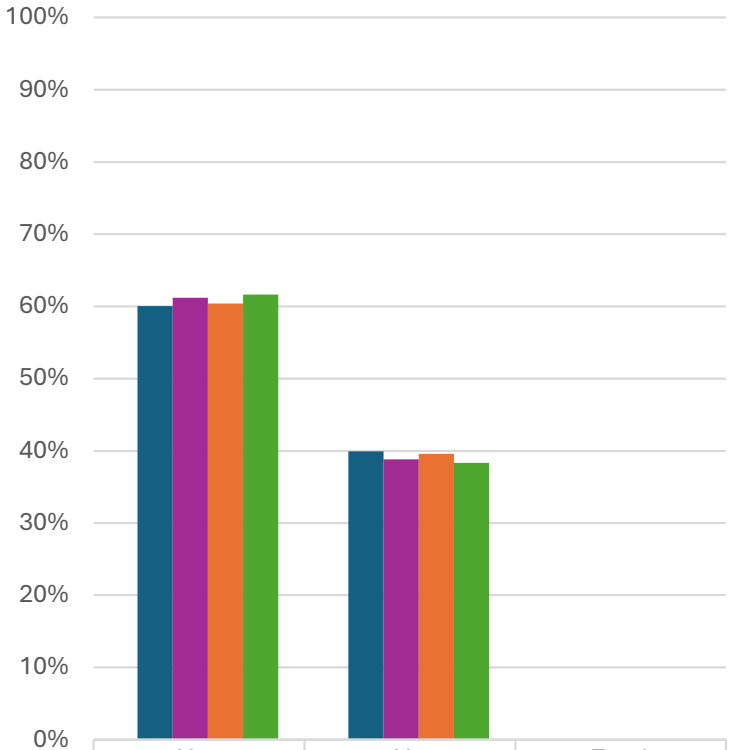
	Yes	No	Total
2022 # Respondents	38	365	403
2022 % Respondents	9.4%	90.6%	100.0%
2023 # Respondents	64	435	499
2023 % Respondents	12.8%	87.2%	100.0%
2024 # Respondents	34	304	338
2024 % Respondents	10.1%	89.9%	100.0%
2025 # Respondents	39	350	389
2025 % Respondents	10.0%	90.0%	100.0%

Fresno County Department of Behavioral Health

Staff Cultural Humility Survey

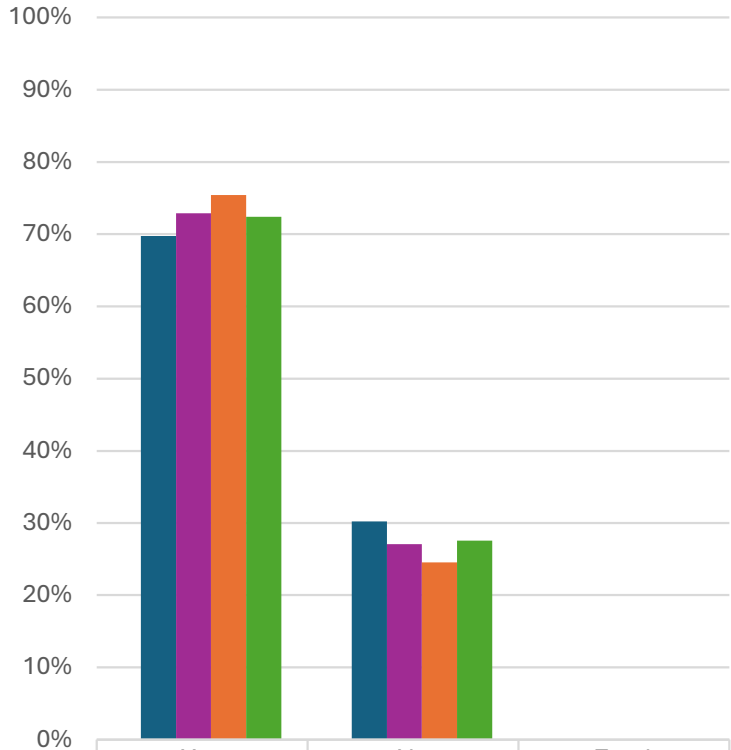
Comparison: 2022-2025

Do you consider yourself to be a person with lived Mental Health experience?



	Yes	No	Total
2022 # Respondents	227	151	378
2022 % Respondents	60.1%	39.9%	100.0%
2023 # Respondents	298	189	487
2023 % Respondents	61.2%	38.8%	100.0%
2024 # Respondents	200	131	331
2024 % Respondents	60.4%	39.6%	100.0%
2025 # Respondents	238	148	386
2025 % Respondents	61.7%	38.3%	100.0%

Are you a Family Member of a person with lived Mental Health experience?



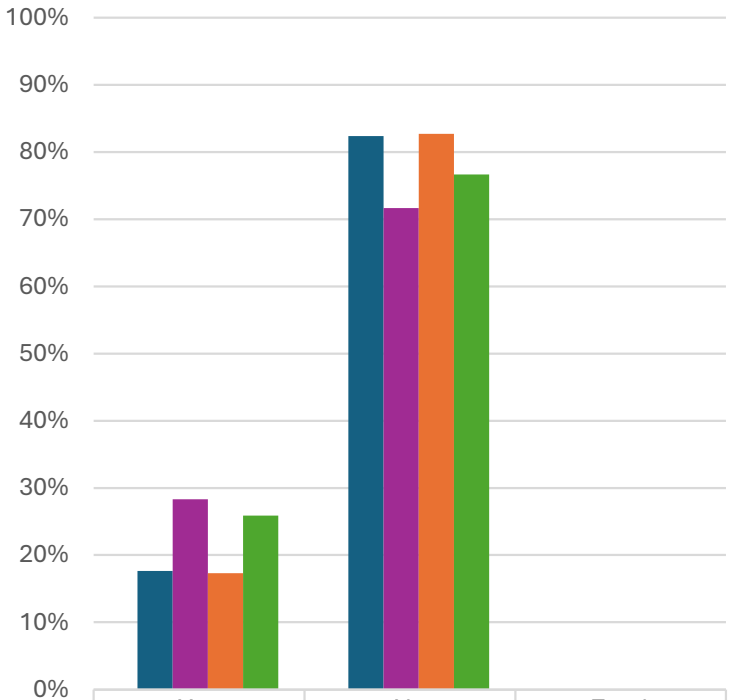
	Yes	No	Total
2022 # Respondents	270	117	387
2022 % Respondents	69.8%	30.2%	100.0%
2023 # Respondents	363	135	498
2023 % Respondents	72.9%	27.1%	100.0%
2024 # Respondents	255	83	338
2024 % Respondents	75.4%	24.6%	100.0%
2025 # Respondents	281	107	388
2025 % Respondents	72.4%	27.6%	100.0%

Fresno County Department of Behavioral Health

Staff Cultural Humility Survey

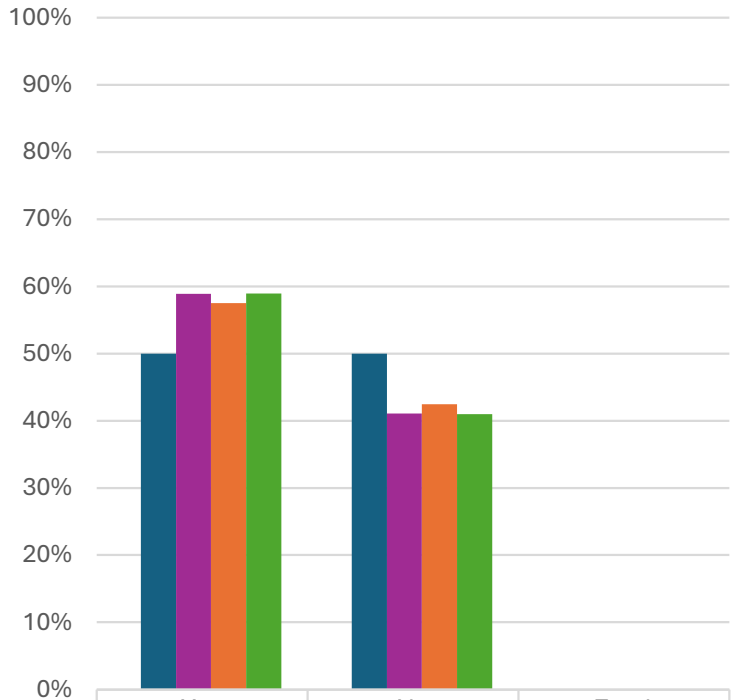
Comparison: 2022-2025

Do you consider yourself to be a person with lived Substance Use Disorder experience?



	Yes	No	Total
2022 # Respondents	71	332	403
2022 % Respondents	17.6%	82.4%	100.0%
2023 # Respondents	142	359	501
2023 % Respondents	28.3%	71.7%	100.0%
2024 # Respondents	59	282	341
2024 % Respondents	17.3%	82.7%	100.0%
2025 # Respondents	100	296	386
2025 % Respondents	25.9%	76.7%	100.0%

Are you a Family Member of a person with lived Substance Use Disorder experience?



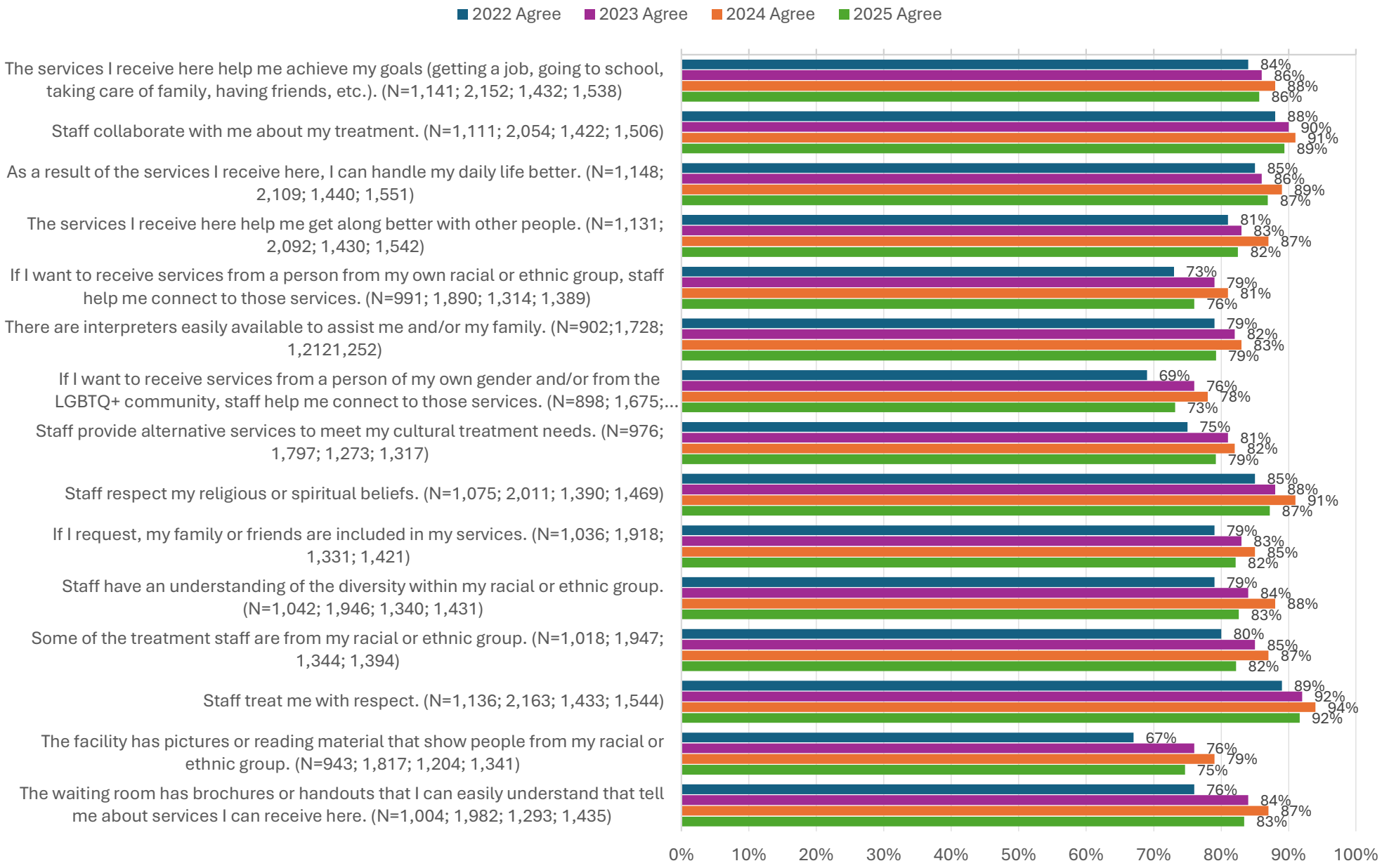
	Yes	No	Total
2022 # Respondents	199	199	398
2022 % Respondents	50.0%	50.0%	100.0%
2023 # Respondents	298	208	506
2023 % Respondents	58.9%	41.1%	100.0%
2024 # Respondents	199	147	346
2024 % Respondents	57.5%	42.5%	100.0%
2025 # Respondents	230	160	390
2025 % Respondents	59.0%	41.0%	100.0%

Appendix F: Client/Person Served Cultural Humility Survey Results

Fresno County Department of Behavioral Health

Client Cultural Humility Survey

Comparison: 2022-2025

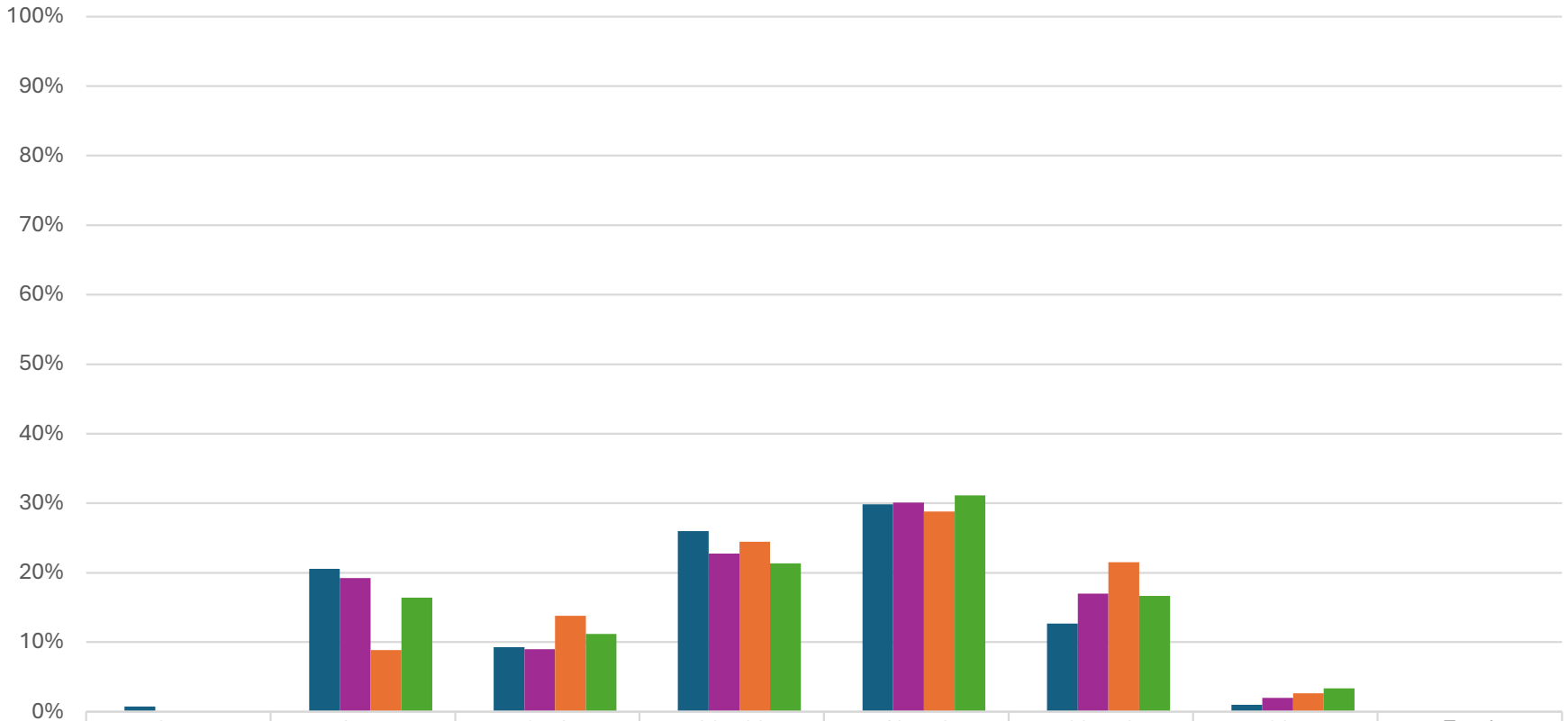


Fresno County Department of Behavioral Health

Client Cultural Humility Survey

Comparison: 2022-2025

Age



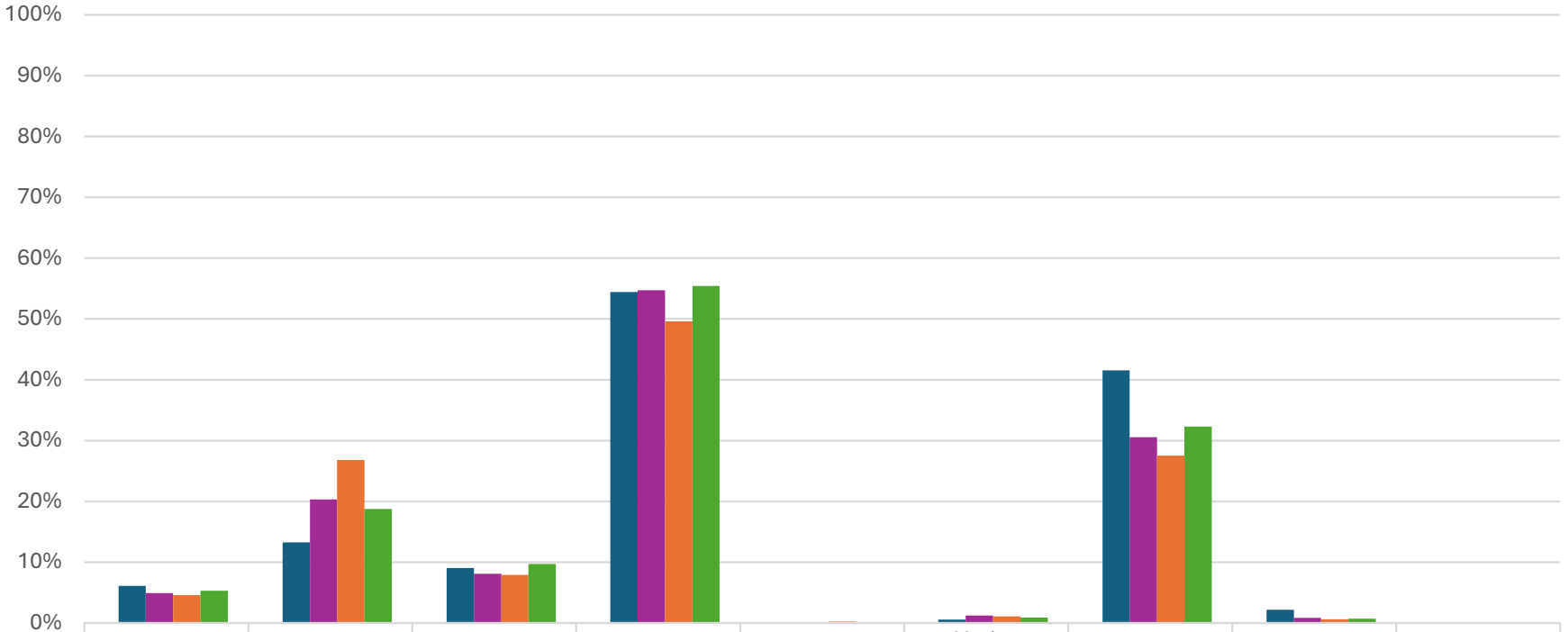
	0-11	12 – 17	18 – 25	26 – 39	40 – 59	60 – 79	80+	Total
2022 # Respondents	8	231	104	292	335	142	11	1,123
2022 % Respondents	0.7%	20.6%	9.3%	26.0%	29.8%	12.6%	1.0%	100.0%
2023 # Respondents	0	406	190	481	636	359	42	2,114
2023 % Respondents	0.0%	19.2%	9.0%	22.8%	30.1%	17.0%	2.0%	100.0%
2024 # Respondents	0	124	193	343	404	302	37	1,403
2024 % Respondents	0.0%	8.8%	13.8%	24.4%	28.8%	21.5%	2.6%	100.0%
2025 # Respondents	0	251	171	327	477	255	51	1,532
2025 % Respondents	0.0%	16.4%	11.2%	21.3%	31.1%	16.6%	3.3%	100.0%

Fresno County Department of Behavioral Health

Client Cultural Humility Survey

Comparison: 2022-2025

Race/Ethnicity



	American Indian or Alaska Native	Asian	Black or African American	Hispanic/ Latino	Middle Eastern	Native Hawaiian or Other Pacific Islander	White/ Caucasian	Other	Total
2022 # Respondents	68	148	101	607	1	6	463	24	1,115
2022 % Respondents	6.1%	13.3%	9.1%	54.4%	0.1%	0.5%	41.5%	2.2%	100.0%
2023 # Respondents	103	426	170	1,147	2	25	641	17	2,096
2023 % Respondents	4.9%	20.3%	8.1%	54.7%	0.1%	1.2%	30.6%	0.8%	100.0%
2024 # Respondents	64	375	110	693	3	15	385	8	1,398
2024 % Respondents	4.6%	26.8%	7.9%	49.6%	0.2%	1.1%	27.5%	0.6%	100.0%
2025 # Respondents	79	281	146	830	1	13	484	10	1,498
2025 % Respondents	5.3%	18.8%	9.7%	55.4%	0.1%	0.9%	32.3%	0.7%	100.0%

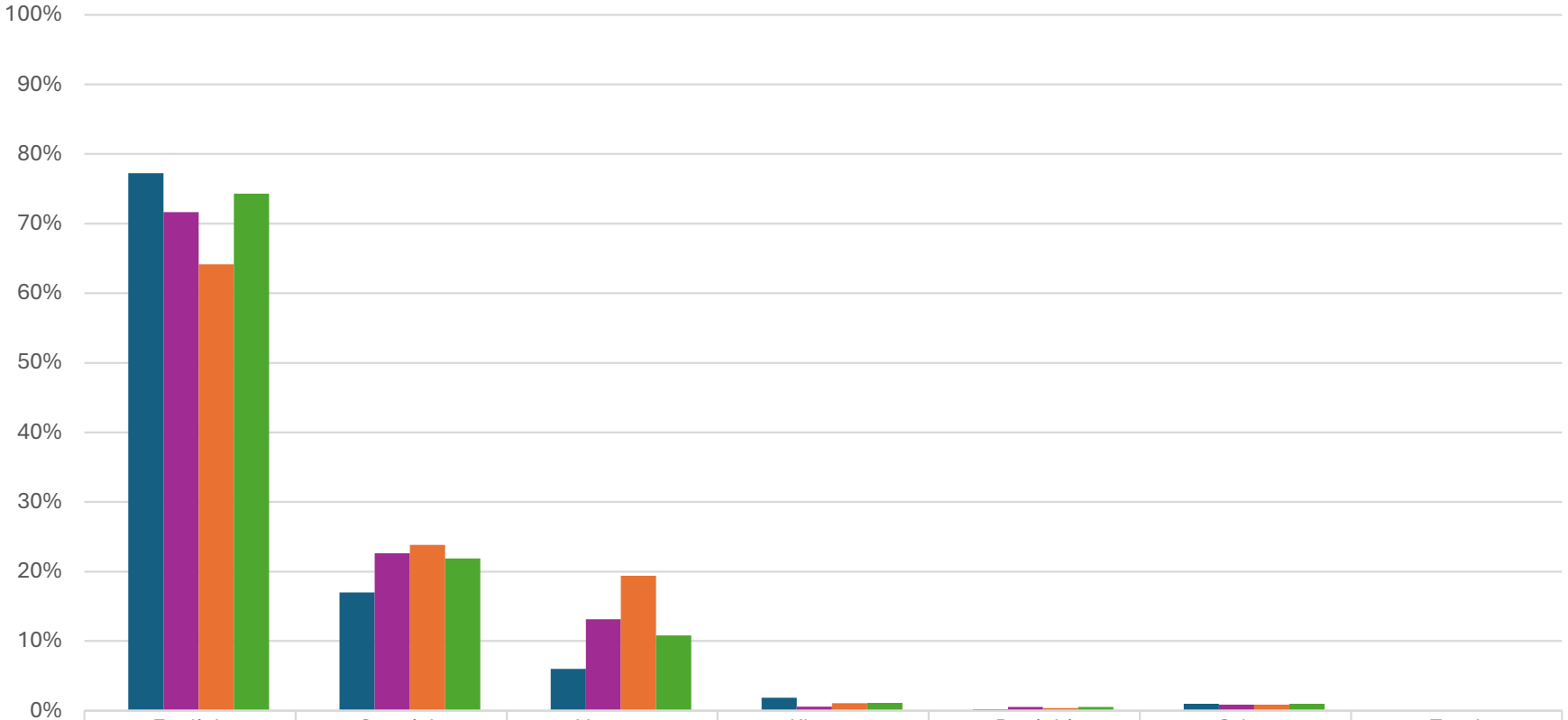
Respondents were able to provide multiple answers

Fresno County Department of Behavioral Health

Client Cultural Humility Survey

Comparison: 2022-2025

Primary Language



	English	Spanish	Hmong	Khmer	Punjabi	Other	Total
2022 # Respondents	875	192	68	21	2	11	1,133
2022 % Respondents	77.2%	16.9%	6.0%	1.9%	0.2%	1.0%	100.0%
2023 # Respondents	1,523	481	279	12	11	18	2,126
2023 % Respondents	71.6%	22.6%	13.1%	0.6%	0.5%	0.8%	100.0%
2024 # Respondents	914	340	276	15	5	12	1,425
2024 % Respondents	64.1%	23.9%	19.4%	1.1%	0.4%	0.8%	100.0%
2025 # Respondents	1136	335	165	17	8	15	1,529
2025 % Respondents	74.3%	21.9%	10.8%	1.1%	0.5%	1.0%	100.0%

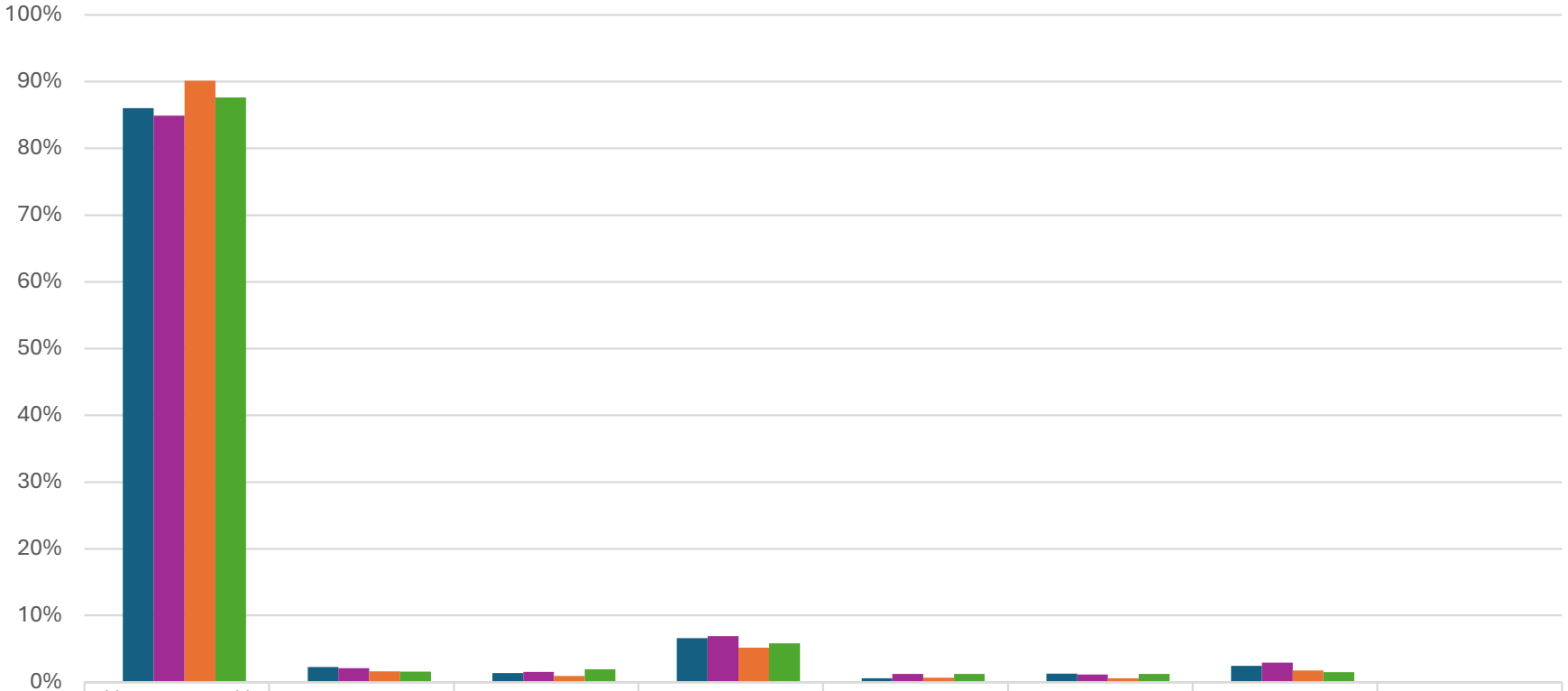
Respondents were able to provide multiple answers

Fresno County Department of Behavioral Health

Client Cultural Humility Survey

Comparison: 2022-2025

Sexual Orientation



	Heterosexual/ Straight	Gay	Lesbian	Bisexual	Queer	Questioning	Other	Total
2022 # Respondents	873	23	14	67	6	13	25	1,015
2022 % Respondents	86.0%	2.3%	1.4%	6.6%	0.6%	1.3%	2.5%	100.0%
2023 # Respondents	1,610	40	29	131	24	22	56	1,897
2023 % Respondents	84.9%	2.1%	1.5%	6.9%	1.3%	1.2%	3.0%	100.0%
2024 # Respondents	1,169	21	12	67	9	8	23	1,297
2024 % Respondents	90.1%	1.6%	0.9%	5.2%	0.7%	0.6%	1.8%	100.0%
2025 # Respondents	1,215	22	27	81	17	17	21	1,387
2025 % Respondents	87.6%	1.6%	1.9%	5.8%	1.2%	1.2%	1.5%	100.0%

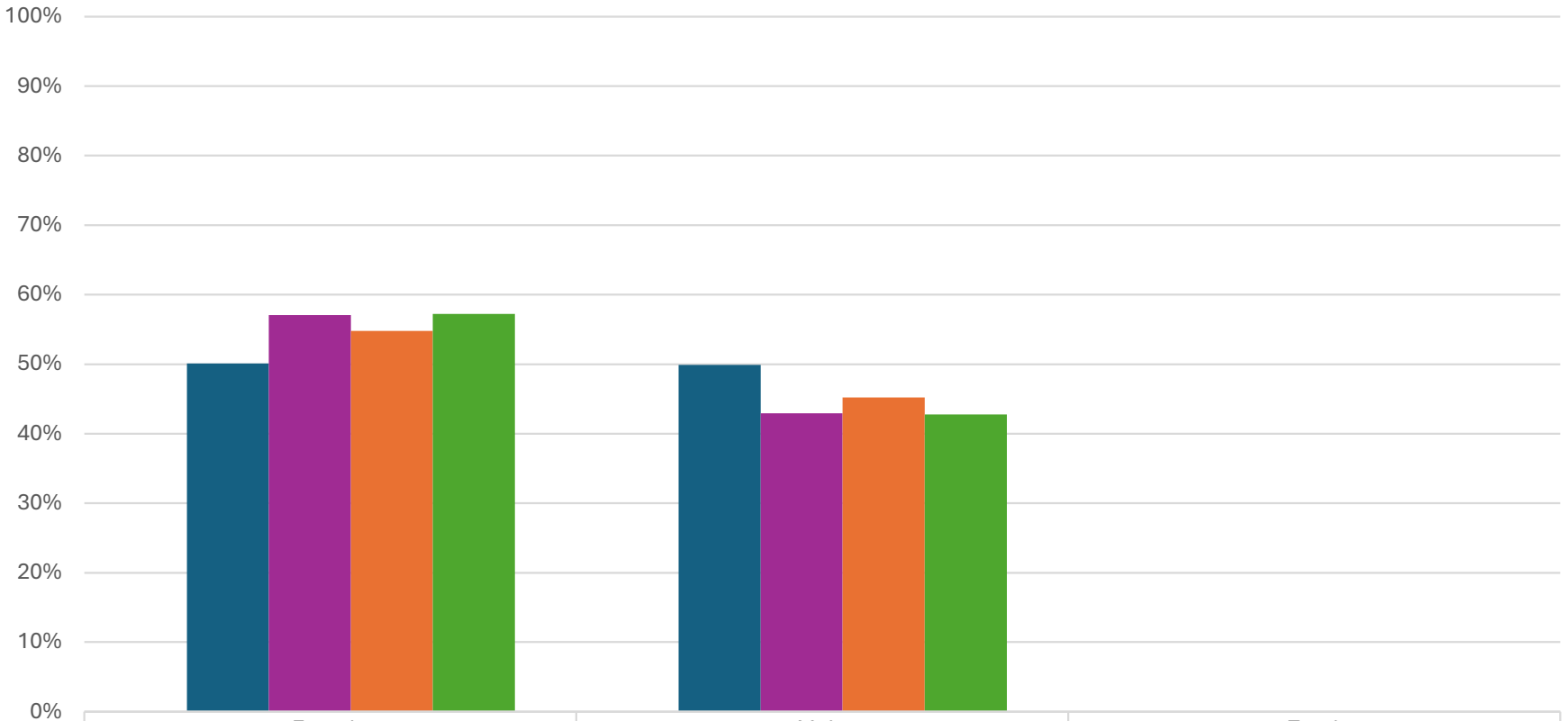
Respondents were able to provide multiple answers

Fresno County Department of Behavioral Health

Client Cultural Humility Survey

Comparison: 2022-2025

Gender Assigned at Birth



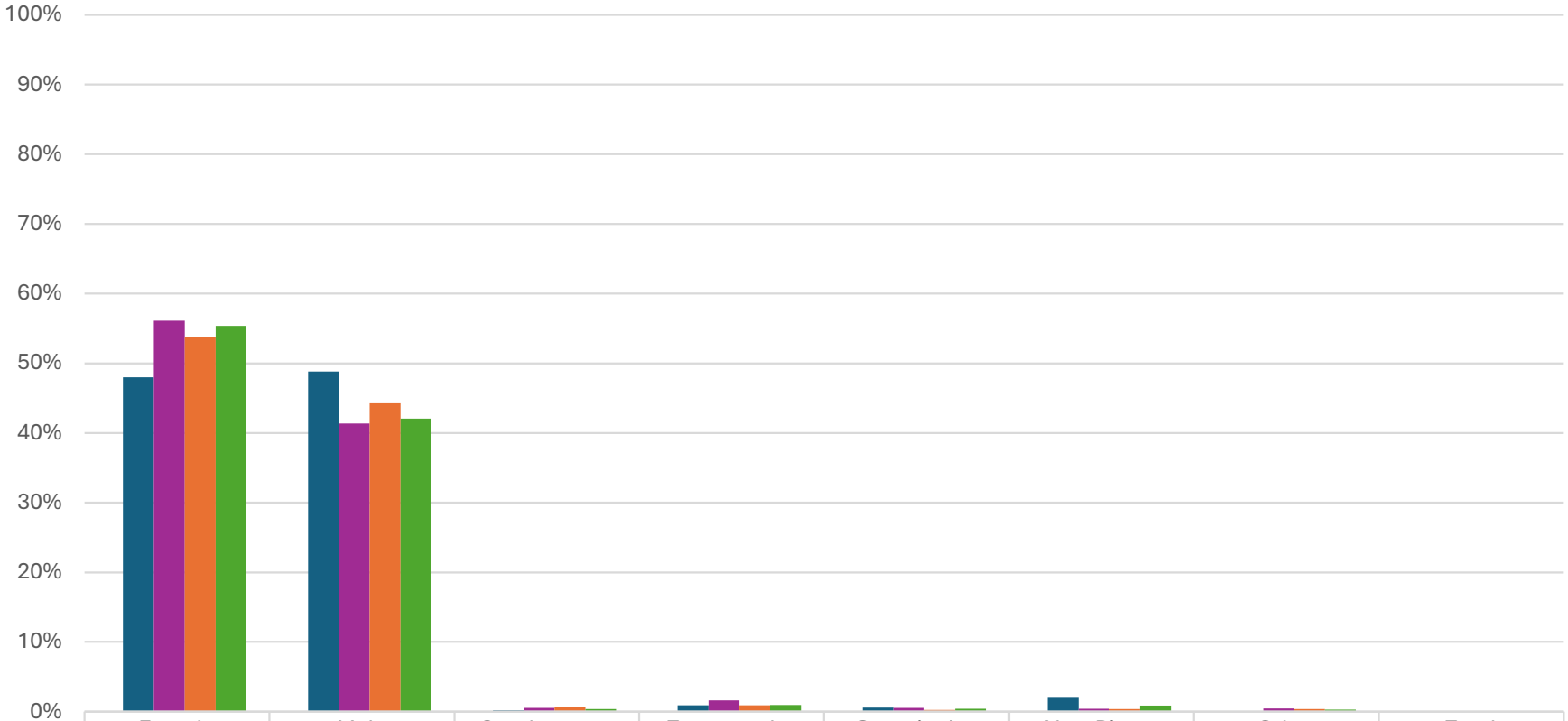
	Female	Male	Total
2022 # Respondents	559	557	1,116
2022 % Respondents	50.1%	49.9%	100.0%
2023 # Respondents	1,193	898	2,091
2023 % Respondents	57.1%	42.9%	100.0%
2024 # Respondents	767	633	1,400
2024 % Respondents	54.8%	45.2%	100.0%
2025 # Respondents	851	636	1,487
2025 % Respondents	57.2%	42.8%	100.0%

Fresno County Department of Behavioral Health

Client Cultural Humility Survey

Comparison: 2022-2025

Current Gender Identity



	Female	Male	Genderqueer	Transgender	Questioning	Non-Binary	Other	Total
2022 # Respondents	529	538	2	10	6	23	0	1,102
2022 % Respondents	48.0%	48.8%	0.2%	0.9%	0.5%	2.1%	0.0%	100.0%
2023 # Respondents	1,155	852	11	33	11	8	9	2,059
2023 % Respondents	56.1%	41.4%	0.5%	1.6%	0.5%	0.4%	0.4%	100.0%
2024 # Respondents	739	609	8	12	3	5	5	1,376
2024 % Respondents	53.7%	44.3%	0.6%	0.9%	0.2%	0.4%	0.4%	100.0%
2025 # Respondents	828	629	5	14	6	13	4	1,495
2025 % Respondents	55.4%	42.1%	0.3%	0.9%	0.4%	0.9%	0.3%	100.0%

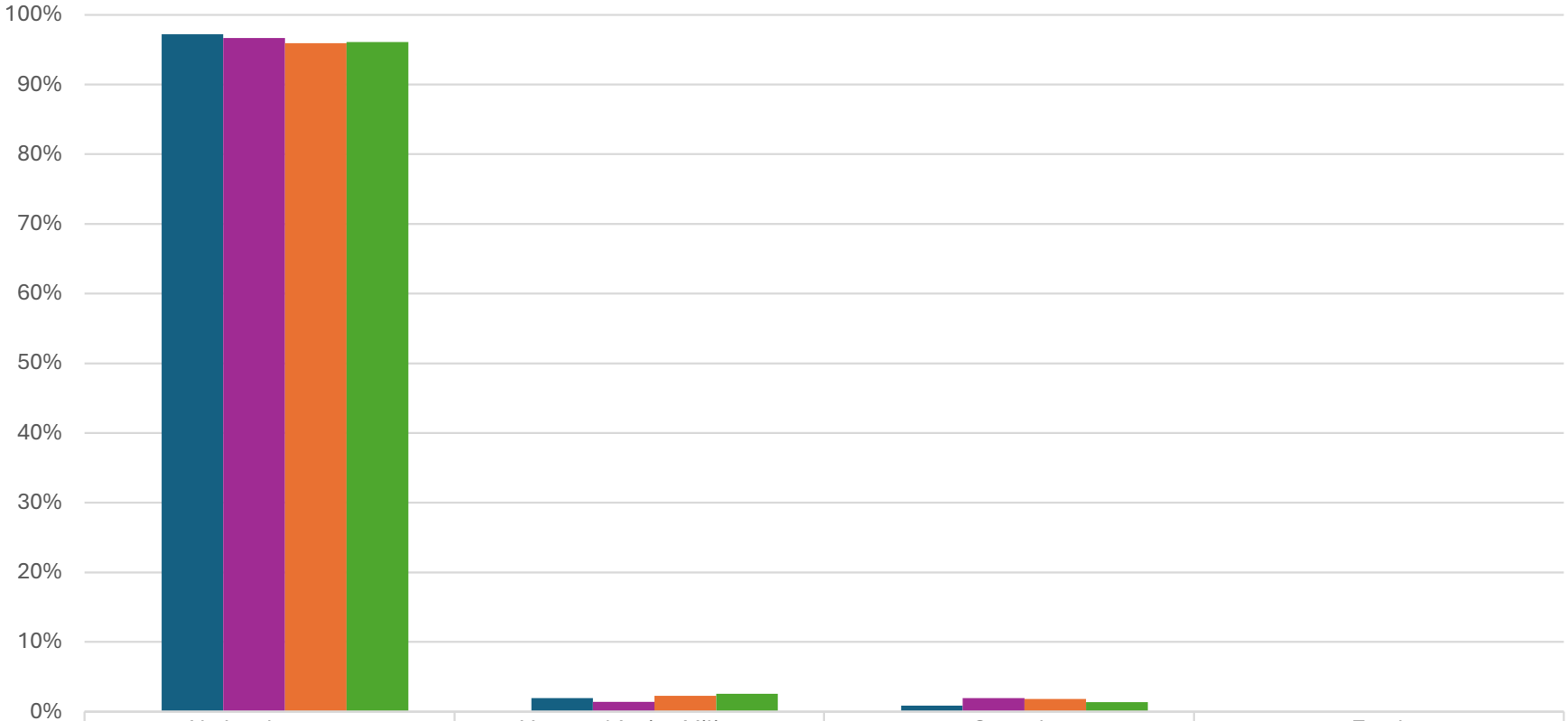
Respondents were able to provide multiple answers

Fresno County Department of Behavioral Health

Client Cultural Humility Survey

Comparison: 2022-2025

Military Involvement



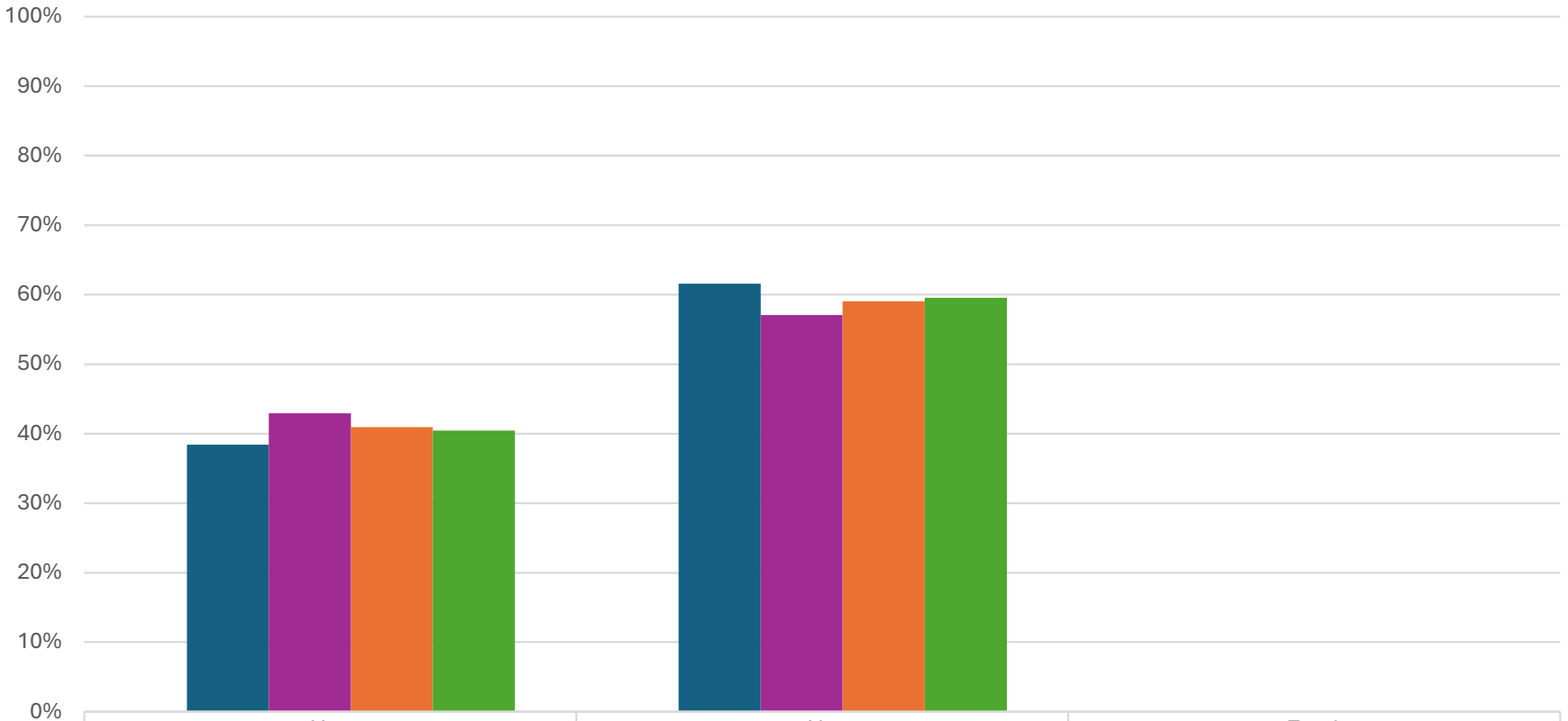
	No Involvement	Veteran/ Active Military	Served	Total
2022 # Respondents	1,014	20	9	1,043
2022 % Respondents	97.2%	1.9%	0.9%	100.0%
2023 # Respondents	1,890	27	38	1,955
2023 % Respondents	96.7%	1.4%	1.9%	100.0%
2024 # Respondents	1,263	30	24	1,317
2024 % Respondents	95.9%	2.3%	1.8%	100.0%
2025 # Respondents	1349	36	19	1404
2025 % Respondents	96.1%	2.6%	1.4%	100.0%

Fresno County Department of Behavioral Health

Client Cultural Humility Survey

Comparison: 2022-2025

Do you have a disability?



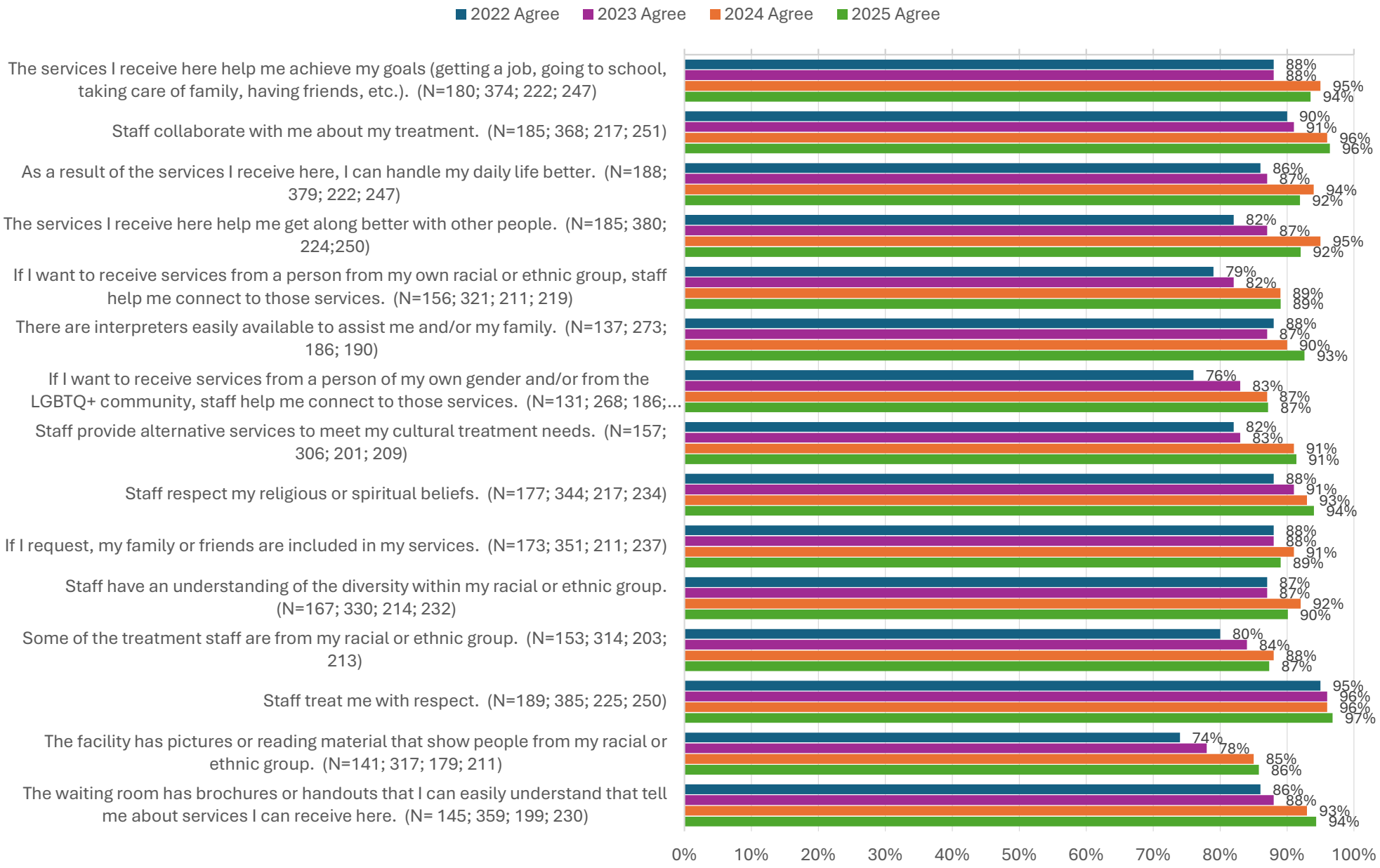
	Yes	No	Total
2022 # Respondents	381	611	992
2022 % Respondents	38.4%	61.6%	100.0%
2023 # Respondents	837	1,113	1,950
2023 % Respondents	42.9%	57.1%	100.0%
2024 # Respondents	530	764	1,294
2024 % Respondents	41.0%	59.0%	100.0%
2025 # Respondents	562	827	1389
2025 % Respondents	40.5%	59.5%	100.0%

Appendix G: Family/Caregiver Cultural Humility Survey Results

Fresno County Department of Behavioral Health

Caregiver Cultural Humility Survey

Comparison: 2022-2025

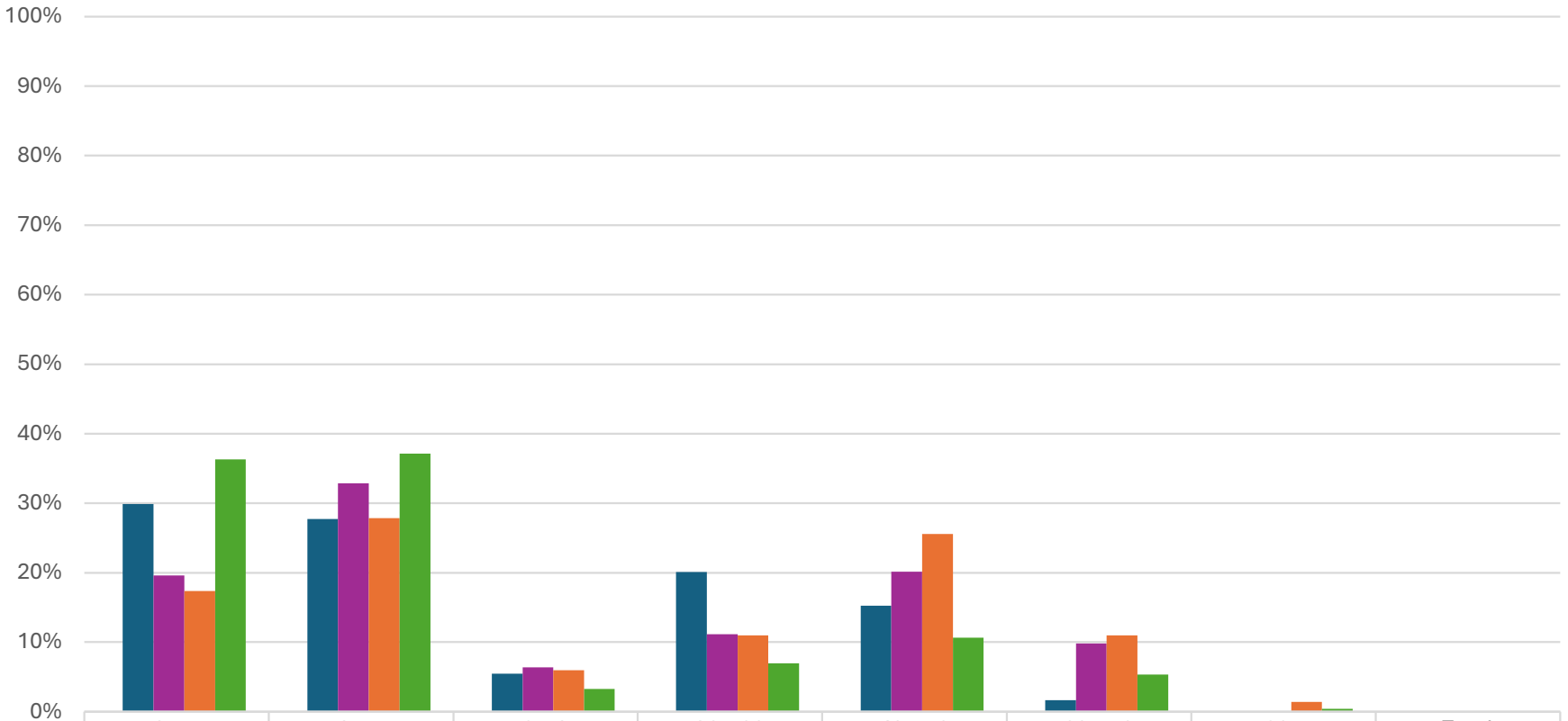


Fresno County Department of Behavioral Health

Caregiver Cultural Humility Survey

Comparison: 2022-2025

Age



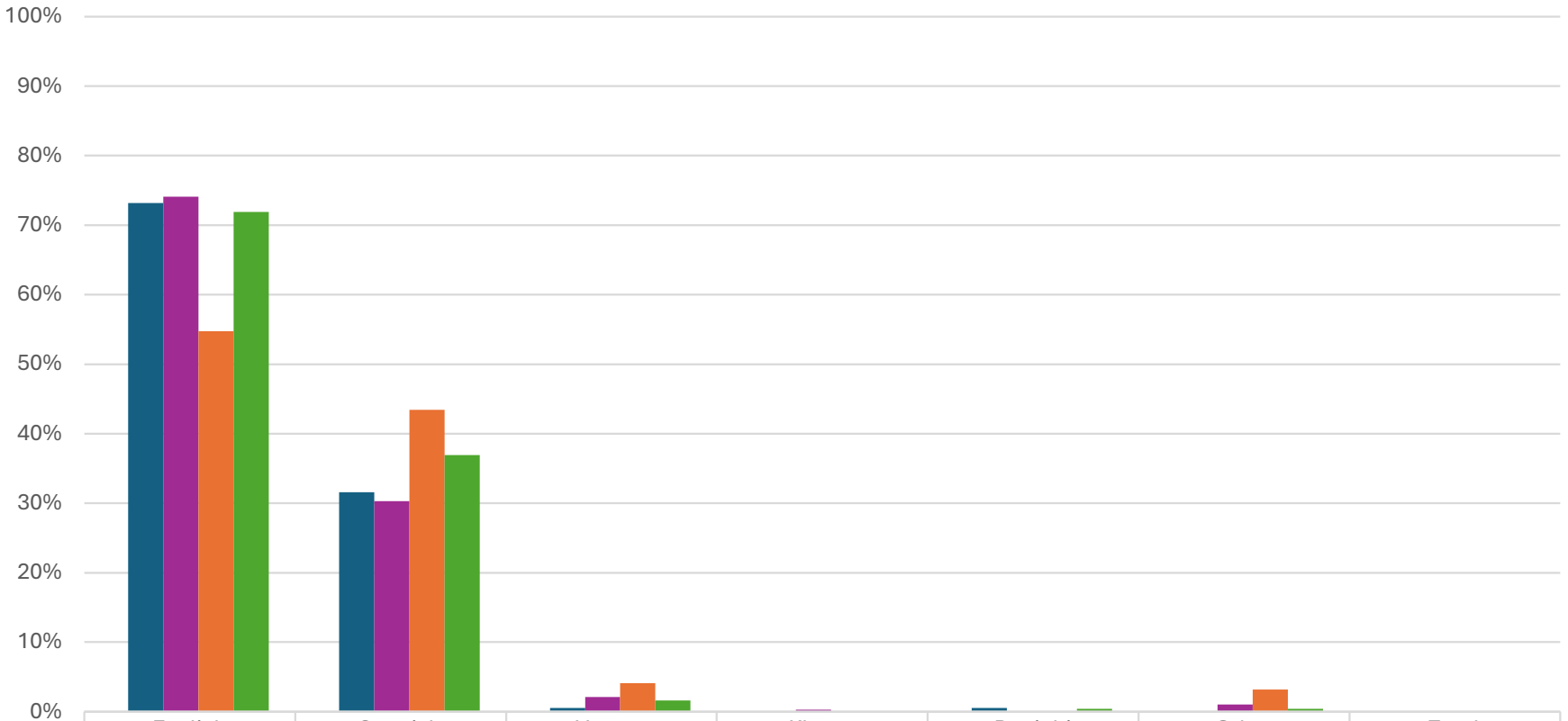
	0-11	12 – 17	18 – 25	26 – 39	40 – 59	60 – 79	80+	Total
2022 # Respondents	55	51	10	37	28	3	0	184
2022 % Respondents	29.9%	27.7%	5.4%	20.1%	15.2%	1.6%	0.0%	100.0%
2023 # Respondents	74	124	24	42	76	37	0	377
2023 % Respondents	19.6%	32.9%	6.4%	11.1%	20.2%	9.8%	0.0%	100.0%
2024 # Respondents	38	61	13	24	56	24	3	219
2024 % Respondents	17.4%	27.9%	5.9%	11.0%	25.6%	11.0%	1.4%	100.0%
2025 # Respondents	89	91	8	17	26	13	1	245
2025 % Respondents	36.3%	37.1%	3.3%	6.9%	10.6%	5.3%	0.4%	100.0%

Fresno County Department of Behavioral Health

Caregiver Cultural Humility Survey

Comparison: 2022-2025

Primary Language



	English	Spanish	Hmong	Khmer	Punjabi	Other	Total
2022 # Respondents	139	60	1	0	1	0	190
2022 % Respondents	73.2%	31.6%	0.5%	0.0%	0.5%	0.0%	100.0%
2023 # Respondents	286	117	8	1	0	4	386
2023 % Respondents	74.1%	30.3%	2.1%	0.3%	0.0%	1.0%	100.0%
2024 # Respondents	121	96	9	0	0	7	221
2024 % Respondents	54.8%	43.4%	4.1%	0.0%	0.0%	3.2%	100.0%
2025 # Respondents	179	92	4	0	1	1	249
2025 % Respondents	71.9%	36.9%	1.6%	0.0%	0.4%	0.4%	100.0%

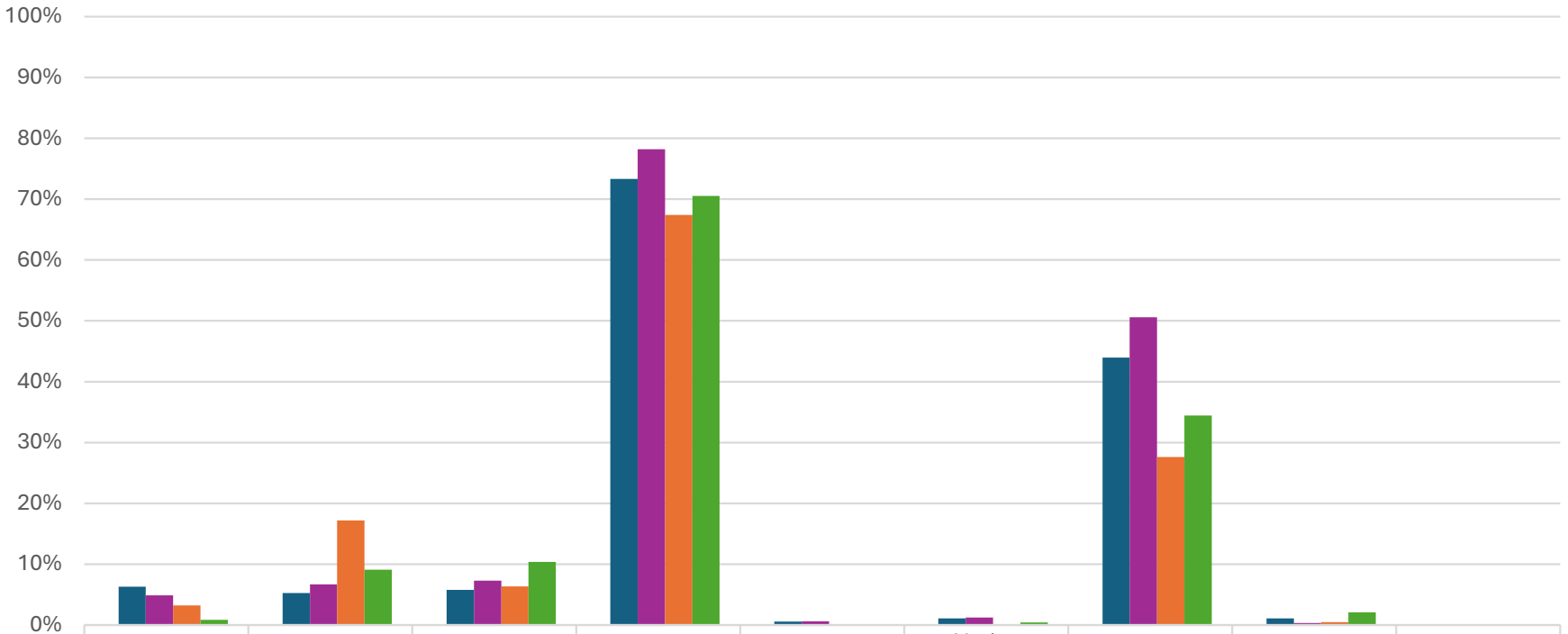
Respondents were able to provide multiple answers

Fresno County Department of Behavioral Health

Caregiver Cultural Humility Survey

Comparison: 2022-2025

Race/Ethnicity



	American Indian or Alaska Native	Asian	Black or African American	Hispanic/ Latino	Middle Eastern	Native Hawaiian or Other Pacific Islander	White/ Caucasian	Other	Total
2022 # Respondents	12	10	11	140	1	2	84	2	191
2022 % Respondents	6.3%	5.2%	5.8%	73.3%	0.5%	1.0%	44.0%	1.0%	100.0%
2023 # Respondents	16	22	24	258	2	4	167	1	330
2023 % Respondents	4.8%	6.7%	7.3%	78.2%	0.6%	1.2%	50.6%	0.3%	100.0%
2024 # Respondents	7	38	14	149	0	0	61	1	221
2024 % Respondents	3.2%	17.2%	6.3%	67.4%	0.0%	0.0%	27.6%	0.5%	100.0%
2025 # Respondents	2	22	25	170	0	1	83	5	241
2025 % Respondents	0.8%	9.1%	10.4%	70.5%	0.0%	0.4%	34.4%	2.1%	100.0%

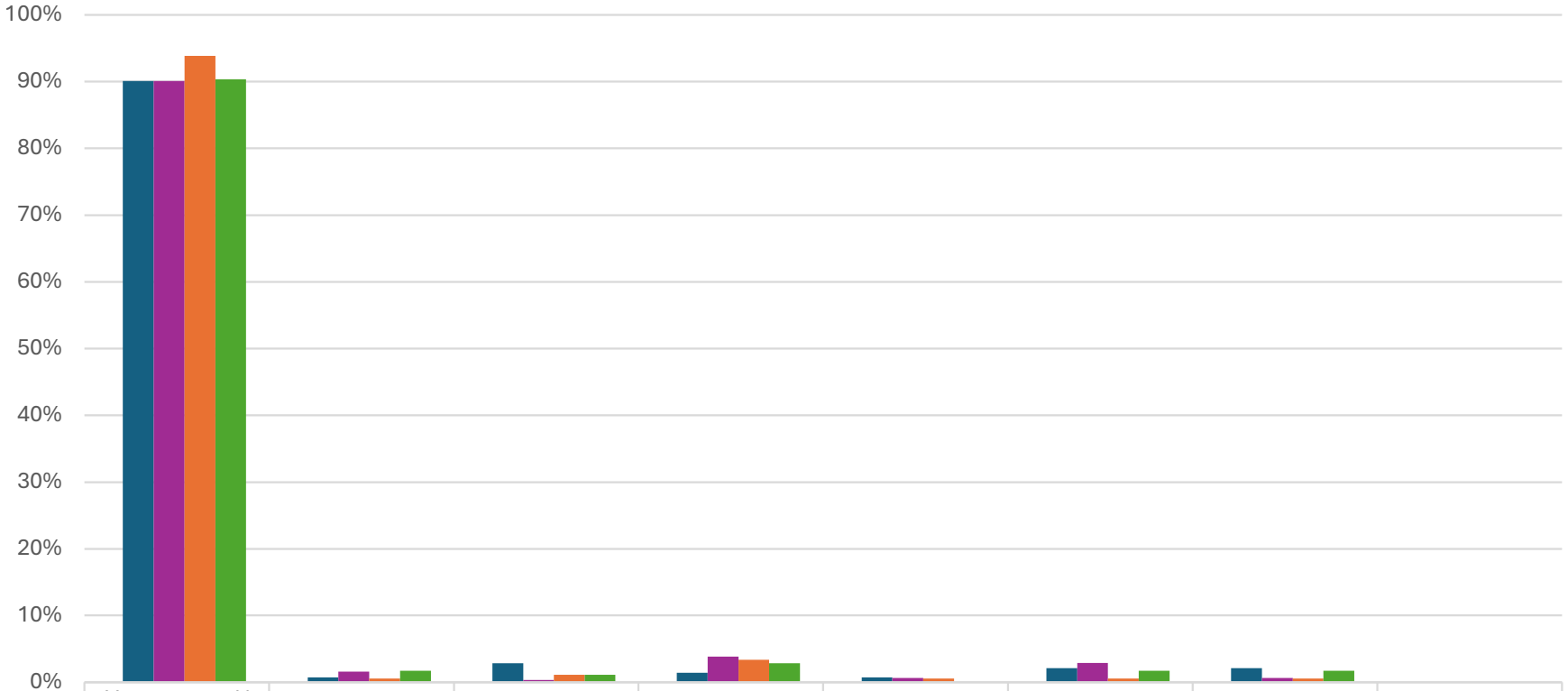
Respondents were able to provide multiple answers

Fresno County Department of Behavioral Health

Caregiver Cultural Humility Survey

Comparison: 2022-2025

Sexual Orientation



	Heterosexual/ Straight	Gay	Lesbian	Bisexual	Queer	Questioning	Other	Total
2022 # Respondents	127	1	4	2	1	3	3	141
2022 % Respondents	90.1%	0.7%	2.8%	1.4%	0.7%	2.1%	2.1%	100.0%
2023 # Respondents	281	5	1	12	2	9	2	312
2023 % Respondents	90.1%	1.6%	0.3%	3.8%	0.6%	2.9%	0.6%	100.0%
2024 # Respondents	168	1	2	6	1	1	1	179
2024 % Respondents	93.9%	0.6%	1.1%	3.4%	0.6%	0.6%	0.6%	100.0%
2025 # Respondents	159	3	2	5	0	3	3	176
2025 % Respondents	90.3%	1.7%	1.1%	2.8%	0.0%	1.7%	1.7%	100.0%

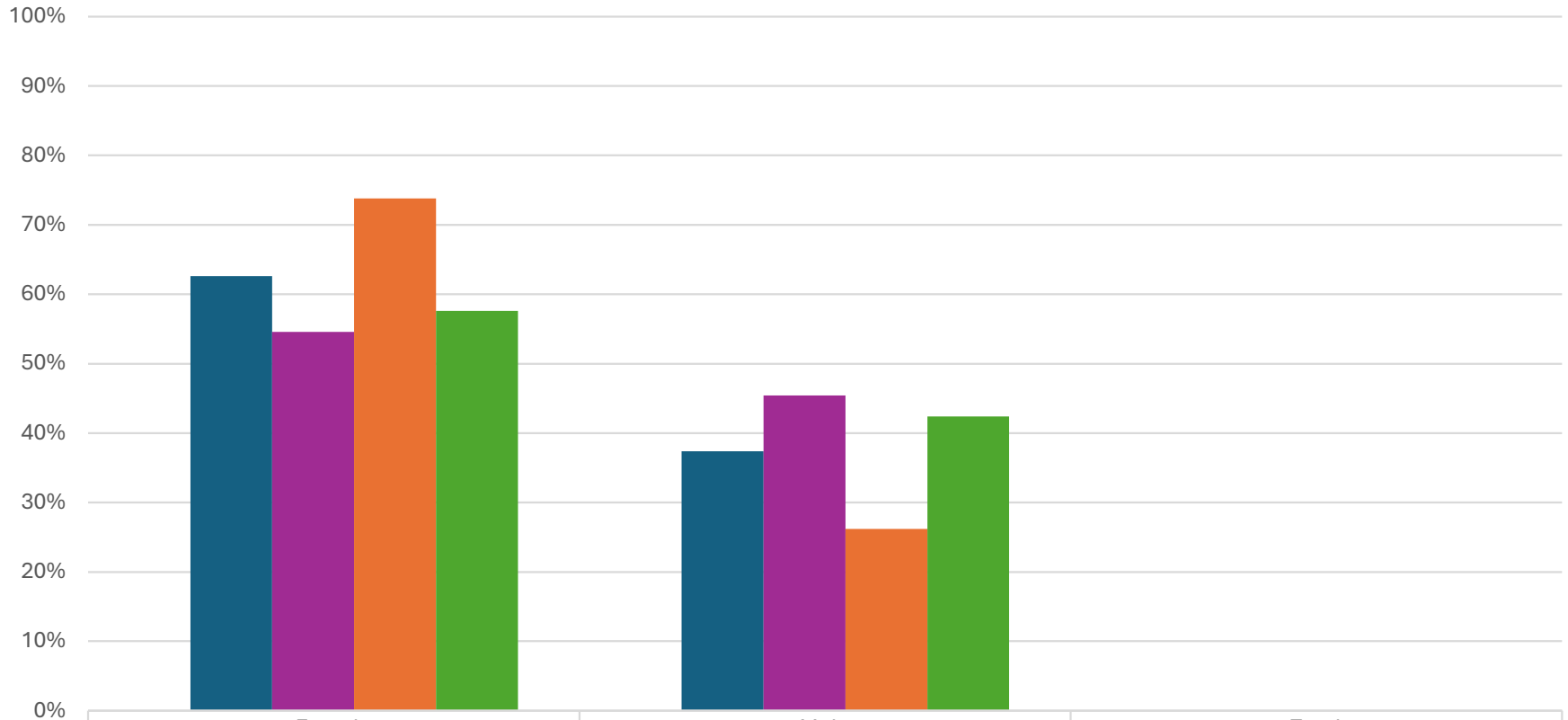
Respondents were able to provide multiple answers

Fresno County Department of Behavioral Health

Caregiver Cultural Humility Survey

Comparison: 2022-2025

Gender Assigned at Birth



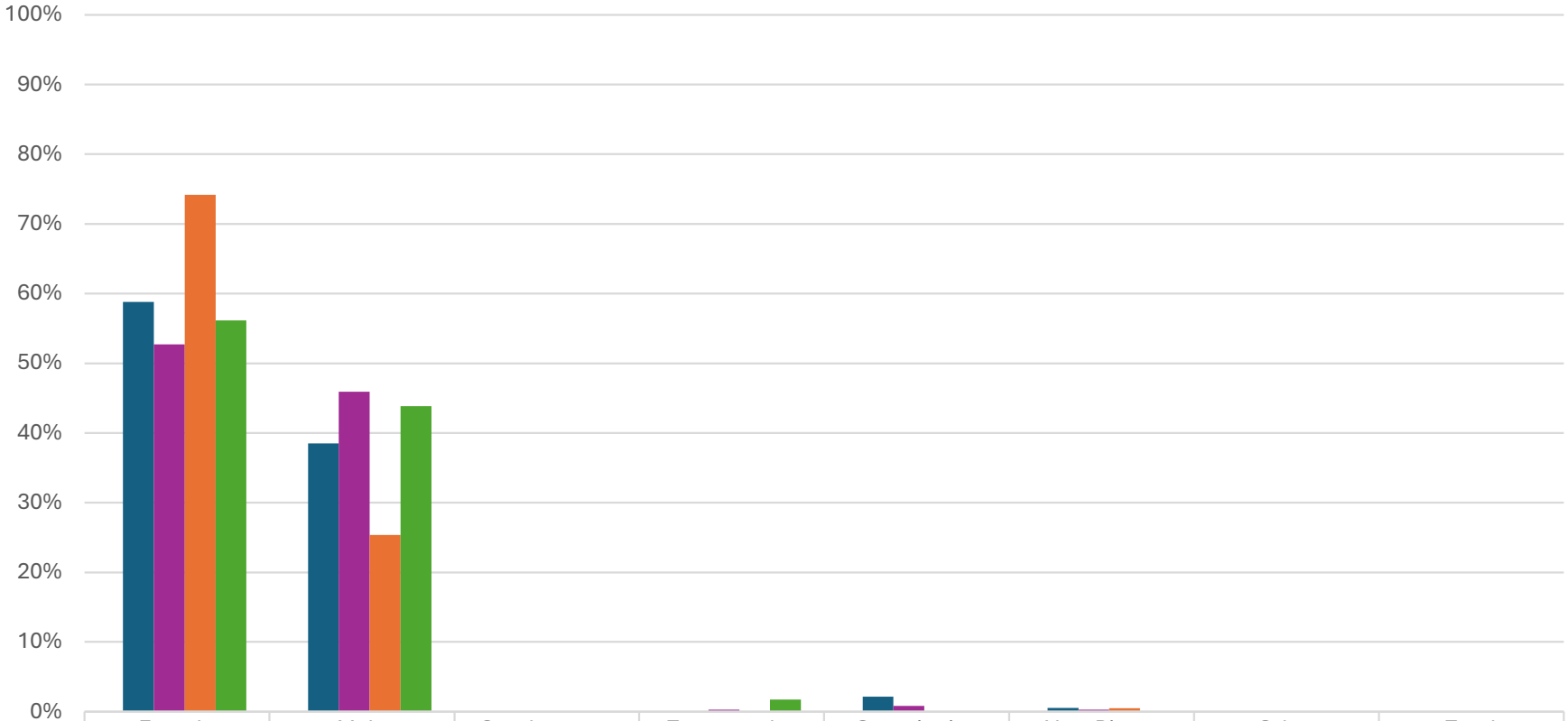
	Female	Male	Total
2022 # Respondents	119	71	190
2022 % Respondents	62.6%	37.4%	100.0%
2023 # Respondents	208	173	381
2023 % Respondents	54.6%	45.4%	100.0%
2024 # Respondents	155	55	210
2024 % Respondents	73.8%	26.2%	100.0%
2025 # Respondents	140	103	243
2025 % Respondents	57.6%	42.4%	100.0%

Fresno County Department of Behavioral Health

Caregiver Cultural Humility Survey

Comparison: 2022-2025

Current Gender Identity



	Female	Male	Genderqueer	Transgender	Questioning	Non-Binary	Other	Total
2022 # Respondents	110	72	0	0	4	1	0	187
2022 % Respondents	58.8%	38.5%	0.0%	0.0%	2.1%	0.5%	0.0%	100.0%
2023 # Respondents	193	168	0	1	3	1		366
2023 % Respondents	52.7%	45.9%	0.0%	0.3%	0.8%	0.3%	0.0%	100.0%
2024 # Respondents	155	53	0	0	0	1		209
2024 % Respondents	74.2%	25.4%	0.0%	0.0%	0.0%	0.5%	0.0%	100.0%
2025 # Respondents	132	103	0	4	0	0		235
2025 % Respondents	56.2%	43.8%	0.0%	1.7%	0.0%	0.0%	0.0%	100.0%

Respondents were able to provide multiple answers

Fresno County Department of Behavioral Health

Caregiver Cultural Humility Survey

Comparison: 2022-2025

Military Involvement

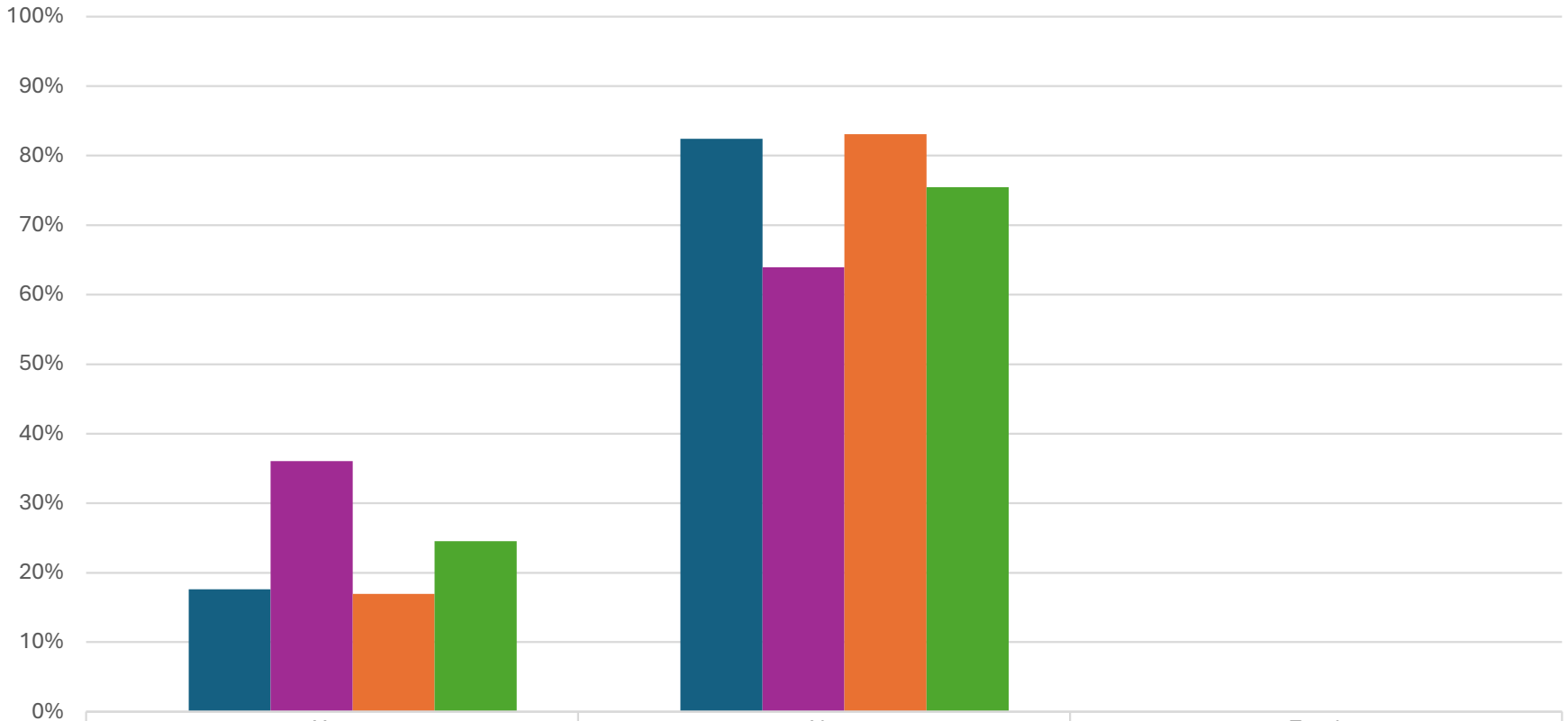
	No Involvement	Veteran/ Active Military	Served	Total
2022 # Respondents	179	1	1	181
2022 % Respondents	98.9%	0.6%	0.6%	100.0%
2023 # Respondents	347	1	2	350
2023 % Respondents	99.1%	0.3%	0.6%	100.0%
2024 # Respondents	194	0	0	194
2024 % Respondents	100.0%	0.0%	0.0%	100.0%
2025 # Respondents	219	1	1	221
2025 % Respondents	99.1%	0.5%	0.5%	100.0%

Fresno County Department of Behavioral Health

Caregiver Cultural Humility Survey

Comparison: 2022-2025

Does your family member have a disability?



	Yes	No	Total
2022 # Respondents	32	150	182
2022 % Respondents	17.6%	82.4%	100.0%
2023 # Respondents	123	218	341
2023 % Respondents	36.1%	63.9%	100.0%
2024 # Respondents	33	162	195
2024 % Respondents	16.9%	83.1%	100.0%
2025 # Respondents	55	169	224
2025 % Respondents	24.6%	75.4%	100.0%