



**County of Fresno**  
**Department of Behavioral Health**  
**Behavioral Health System of Care**

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**Culturally Responsive Plan**  
**Delivered with Humility**  
**FY 2021/2022**

FINAL 12/07/21

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# **Fresno County Department of Behavioral Health Behavioral Health System of Care Culturally Responsive Plan Delivered with Humility FY 2021/22**

## **OVERVIEW**

The Fresno County Department of Behavioral Health (DBH) System of Care (BHSOC) strives to deliver culturally, ethnically, and linguistically responsive services with humility to individuals 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.

In addition, we recognize the importance of developing 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.

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 from each other and by offering ongoing training and education. 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 following Culturally Responsive Plan (CRP): Delivered with Humility reflects our ongoing commitment to enhancing services to improve access to services, quality care, and positive outcomes. The CRP addresses the requirements from the California Department of Health Care Services (DHCS) for both Mental Health and Substance Use Disorder services, and reflects 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 a Quadruple Aim to guide the delivery of services: 1.) Deliver quality of care; 2.) Maximize resources while focusing on efficiency; 3.) Provide an excellent care experience; and 4.) Promote workforce well-being.

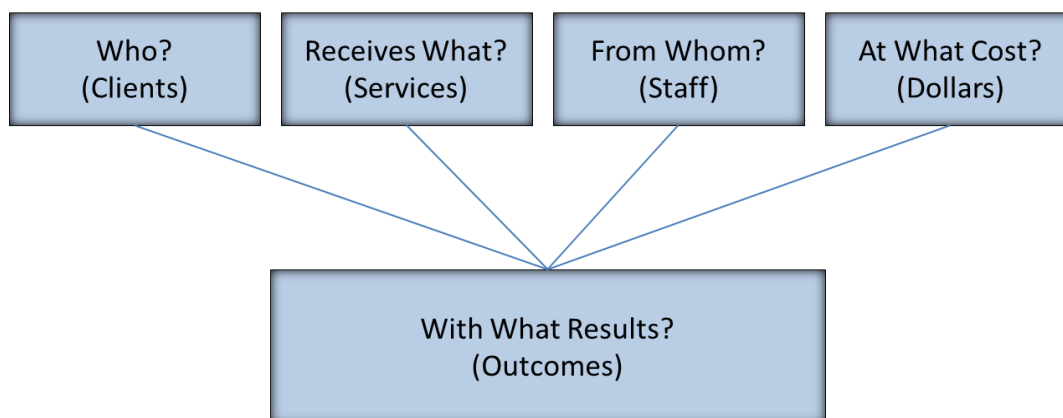
It is the vision and mission of the BHSOC to deliver culturally responsive services that promote individualized wellness and recovery to diverse cultures that reflect the health beliefs and practices of these communities. BHSOC has identified eleven guiding principles of care that are described on the 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 world 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 discuss opportunities to promote the delivery of culturally responsive services.

The FY 2021/22 CRP provides a vision and a blueprint for continually strengthening services across the next several years. The BHSOC has had a comprehensive planning process over the past four 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. During the planning process, there were over 12 different focus groups held to discuss the importance of understanding the term ‘culture,’ how everyone has several different ‘cultures,’ and how these individual differences in cultures impact successful treatment.

In addition, the BHSOC has made a commitment to creating a safe learning environment by offering ongoing cultural training to the BHSOC workforce which includes all county staff and organizational providers. This emphasis from the BHSOC management clearly illustrates their 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 a dynamic, working document that provides a blueprint for infusing culture into all components of the BHSOC. The Cultural Humility Committee (CHC) is the identified committee that will guide 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 2021/22 provided an opportunity to review data to have relevant and reliable information to understand our system of care and delivery of services to meet each individual's cultural 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.

This process will be an ongoing system of collecting data, analyzing it, reviewing it, identifying opportunities to improve data collection, and re-analyzing it to have additional information for strengthening services. This ongoing and 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 also include updating the data collection methodology to reflect new data requirements from the state and federal government.

The BHSOC is committed to continually improving access, quality, and how services are delivered with cultural responsiveness and humility and demonstrating the importance of culture 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 Behavioral Health System of Care (BHSOC), which includes county Department of Behavioral Health (DBH) staff and contracted organizational and individual providers who deliver Behavioral Health services in Fresno County. The BHSOC is committed to constantly improving services to meet the needs of culturally diverse individuals who are seeking and receiving services. A number of objectives were developed through a stakeholder process, with input from various committees 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.

- **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); persons who are justice involved and their families; immigrants and refugees; and other diverse cultures.**
  - **Objective 1a:** BHSOC will increase the number of 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. *The COVID-19 pandemic has had an overall impact reducing the number or “units” of service. Tele-health has been offered and is still available, but group services have been limited. DBH reviewed the data almost weekly to examine if any particular group has been left out. The data review shows the reductions are proportional across the various groups. SUD services had been the most impacted by COVID-19 as many of the services were provided in the group modality.*
  - **Objective 1b:** Whenever feasible, BHSOC will hire diverse/bilingual/LGBTQ+ staff to provide services in the preferred language of individuals served across the behavioral health system of care in order to provide services and improve access to individuals and their family members. In the past year, DBH has developed an Inclusion Statement which is now included on all job flyers for DBH positions.
  - **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 county peer positions in the region. It found the wages as being some of the highest. Yet, there is still a high vacancy, so efforts will be made to explore what are barriers to hiring. DBH had three MHSA Innovation plans approved in FY 2019-20 which had full time peer components, including one that has a majority of the workforce being peers. In addition, the State of California has recently passed SB 803, which provides a certification for Peers to expand the types of services they can deliver. This will also help to increase the number of peers in the BHSOC.*

- **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, to ensure that services are provided in the individual's preferred language, whenever possible. *This is a process the CHC is developing this year. It was delayed by COVID-19. DBH is continuously working to identify training and staff qualifications to develop a process for individual preference.* This year, DBH began to explore language barriers for indigenous persons from southern Mexico and Central American, who do not speak Spanish, and working on a multi-county training and support to help increase and improve access for these communities.
- **Objective 1e:** BHSOC will ensure that the access line is culturally sensitive 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 CHC and QIC.*
- **Objective 1f:** BHSOC will 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.
  - *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 and respect are modeled, so all BHSOC staff experience equitable opportunities for professional and personal growth.**

- **Objective 2a:** BHSOC will offer foundational culturally responsive trainings for BHSOC staff, as outlined by the Policy and Procedure Guidelines (PPGs). *Revisions to the PPGs with regards to the CLAS have been developed and will soon be finalized. All DBH supervisors were offered an Applied CLAS training specific to CLAS application. DBH had over 50 of the 70 supervisors/managers complete the training. DBH has also established an Equity Library with over 30 different books and discussion questions that are accessible to all DBH staff to use for their own development.* Throughout the year DBH highlights different cultural events and recognition months for the BHSOC which include panel discussions and sharing of related resources.
- **Objective 2b:** BHSOC will identify and provide trainings on topics including, but not limited to, equity; inclusion; diversity; social determinants of behavioral health; cultural and community practices; consumer culture; recovery culture; Wellness and Recovery Plans (WRAP); access barriers; implicit bias; historical trauma; veteran and family services; and sustainable partnerships, on a regular basis for BHSOC. *DBH is also developing trainings on the following topics: Microaggressions, Racial Equity Impact Survey, Clinical Cultural Responsiveness, and Social Determinants of Health.*

DBH supervisors participated in 12 hours of Diversity, Equity and Inclusion training in the past year provided by Terry Berman and Associates. All DBH staff in any supervisory capacity (including non-direct services participated).

- **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. *This year DBH has updated the PPGs and developed new guidelines related to Cultural Competence training, language access, interpretation services, etc. Also, DBH has contracted with an organizational provider to translate documents, so that translations are conducted by a professional third party and reviewed by “native speakers” who may be staff or other community providers. Behavioral Health Interpreter Training (BHIT) was offered to providers who provide services in languages other than English.*
- **Objective 2d:** BHSOC will support the development of a Language Services Committee 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 committee will support the ongoing development of a list of commonly used Behavioral Health terms to support the use of consistent translation of terms. This strategy will 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 will post these documents on the DBH website for easy access to updated documents.
- **Objective 2e:** BHSOC will 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. DBH has a workgroup currently seeking to improve recruitment practices as a result of the REIA work.
  - *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 may include, but not limited to, trauma informed Cognitive Behavioral Therapy; Motivational Interviewing; Stages of

Change; Harm Reduction; Wellness and Recovery Action Plans (WRAP), Reaching Recovery; and other identified treatment models and tools.

- **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.
- **Objective 3c:** BHSOC will support the delivery of person-centered, culturally responsive services which includes family and other natural supports.
- **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). *While COVID-19 has limited in-home, in-school, and many in-person service opportunities, the system of care has increased and improved its service delivery using Tele-health.*
- **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.

*DBH is currently working on several projects. One project will be partially funded with MHSA Innovation funds and is designing a process to collaborate with local youth to develop a program designed for youth, by youth.*

*A second project will utilize MHSA Innovation funding to explore collaboration with local Black leaders and faith communities in the coming year to enhance behavioral health literacy through community participatory action research. DBH had an Innovation Plan that will fund three local California Reducing Disparities Project Phase II programs which are community defined and population specific. DBH has work underway for the coming year using MHSA funds to develop an LGBTQ-BIPOC training which will be developed by input from LGBTQ community and behavioral health professionals.*

DBH also has work occurring by a third party in the coming year to examine its own county RFP process. The review is to help identify possible structural barriers which hinder or limit community organizations, or service providers based some of the underserved or inappropriately served communities from being able to become providers in the BHSOC.

*In addition, DBH is working through MHSA PEI to address Suicide Prevention opportunities with local LGBTQ+ providers.*

- *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 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. Behavioral health developed and launched a page on its website that is translated into Spanish (vs using the Google translation) with its own easy to use/identify URL ([www.DBHespanol.com](http://www.DBHespanol.com)) to help improve access to information by Spanish speakers and is now working on translation and development of such a page in Hmong.
- **Objective 4b:** BHSOC will participate in at least four diverse community events each fiscal year that targets diverse community outreach activities in a coordinated manner that may include supporting health literacy and disseminating information related to accessing Behavioral Health services. *The Hmong New Year, Rainbow Pride and Juneteenth events were canceled due to COVID-19. DBH held a drive through resource fair in May for Mental Health Month (as a way around COVID-19 restrictions).* Fresno County participated in the virtual Rainbow Pride Event and an LGBTQ drive-thru event at Fresno City College in June 2021. The Department hosted numerous virtual panels and discussions in the past year including but not limited to National Coming Out Day (focused on youth); one on Veterans around Veterans Day exploring ways to render services effectively to veterans; two African American History Month panels and discussions exploring code-switching and local black wellness; two for Women's History Month; one in Spanish in May for Mental Health Month; an API #StopAsianHate in late May; and two virtual panels in June for LGBTQ Pride. These were all streamed on the Department's social media platforms and are still available for public viewing.
- **Objective 4c:** BHSOC will offer 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). *COVID-19 has limited many of these trainings. In the past several years, DBH had offered these trainings and they were included with the cultural competence portion of the CIT trainings. DBH participated in four of these CITs in the past year. In May 2020, eight (8) feedback/market research groups with different target populations were held to help understand how to communicate information about behavioral health, services, stigma reduction, etc. This feedback also helped to structure how outreach was conducted for DBH.*

Many of the Department's live stream events and panel discussions were also made available on Relias as additional training opportunities. Many trainings have been placed on hold during the COVID 19 pandemic including things like CIT, ASIST, and Mental Health First Aid. However, the county and the suicide prevention collaborative made

over 110 virtual training licenses (funded by the Department) available through the Living Works on suicide prevention to the community and other agencies and those were all used. It has collaborated in developing the first Central California Suicide Prevention Summit, which provided free training and free Continuing Education Credits to licensed professionals in 2020. It has also shared and utilized a number of webinars from Each Mind Matters and California Department of Education for suicide prevention and stigma reduction throughout the past year.

- *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 will provide guidance and training on collecting consistent and reliable demographic data on individuals, services delivered, staff areas of specialization, and outcomes. *Guidance was issued in July of 2019 for PEI services to enhance data collection and outcomes. The Rand Corp will conduct an evaluation for 10 of the county's 17 PEI programs.* The Rand Corp is also developing a PEI database for the County for all programs that do not utilize the EHR to input data into this system and will develop a supporting data submission training.
- **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. *In FY 2019/20 DBH contracted with Rand Corp for evaluation of PEI programs (many which have a culturally specific focus). DBH is working with Third Sector as part of the statewide evaluation of Full-Service Partnerships.* Fresno County is one of few counties to have population specific FSPs (such as for justice involved persons, or Southeast Asian populations).
- **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 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 delivered.
- **Objective 5e:** Data will be collected and analyzed on an ongoing basis and periodically reviewed by the BHSOC Leadership Team, management teams, Cultural Humility Committee, Quality Improvement Committee, BHSOC staff, individuals, and family

members to identify opportunities to continually improve access, quality, cost-effectiveness, and service outcomes.

- *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. Cultural Humility Committee***

The Cultural Humility Committee (CHC) 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 CHC meets monthly on the first Thursday. Attendees include representatives from DBH Leadership, Technology & Quality Management, Managed Care, Contracted Providers, Public Health, and local community-based organizations. Results and activities are reported to the QIC on an annual basis. Accomplishments by the CHC include developing the official CHC Charter (*See Attachment C*) and making a change in Avatar, the Electronic Health Record (EHR) to allow for an individual served/ client's preferred name to be entered in system. A Policy and Procedure Guide (PPG) for the CHC and CHC membership has also been developed and will be finalized shortly.

In FY 2020/21, the DBH produced a number of materials to promote outreach during the early stages of the COVID-19 pandemic. This includes the development of a two-part "Cultural Humility Can't Stop with COVID-19" outreach series that are available on the Behavioral Health website. In addition, the DBH also developed a Participation Agreement for Providers to ensure a specific time commitment for CHC activities. In collaboration with the Diversity Services Coordinator, the DBH ESM also supported the development of the RAVEN Approach tool (*See Attachment D*), which provides practical methods for responding to micro-aggressions in the workplace and online.

In addition, the DBH also supported the development of two cultural support groups: the LGBTQ+ Coalition and the Behavioral Health for Black Lives group and the LGBTQ+ Coalition that will develop recommendations to improve and expand behavioral health services for members of the LGBTQ+ community in Fresno County.

The Behavioral Health for Black Lives 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. This group is currently only open to Black DBH staff, which helps to foster a safe space and sense of belonging among current Black DBH staff. Goals of the group include recommending resources, information, and training to all DBH staff and contract providers; developing processes for onboarding new Black Staff; advocating for expanding job opportunities and recruiting activities for aspiring Black Behavioral Health Professionals; providing continued professional development and training to current Black DBH staff; offering quality, culturally responsive supervision to Black service providers; and recommending activities that promote wellness and reduce stigma. These activities will help the system of care obtaining training to better serve and support both Black staff and individuals receiving services.



An additional affinity group was developed in the spring of 2021 for the department's API staff in response to the rise in hate crimes and other acts of violence toward API persons. This group was organized and then facilitated by API staff. The group purpose was to create a safe space for API staff to come together to share experiences, concerns and find support. The group was meeting twice a month initially but planned to move to meet on an as needed basis once the group felt they had obtained the supports they needed at that time.

### ***F. Cultural Humility Committee: Subcommittees***

There are three (3) separate CHC Subcommittees: Policy and Cultural Enrichment, Language, and Access. Due to COVID-19 and the subsequent Shelter-in-Place order in March 2020, changes have been made to the CHC Subcommittee meeting schedule to accommodate a transition to virtual meetings. The CHC Subcommittees now meet virtually each month on the third Monday, Tuesday, and Wednesday of the 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 CHC, and it has a second page the DBH equity page where diversity, equity and inclusion information is available.

#### **1. Policy and Cultural Enrichment**

The goals of the CHC Policy and Cultural Enrichment subcommittee correspond to CRP 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, and to develop education and training activities in collaboration with diverse community groups and organizations. The goal of this subcommittee is to: (1) identify relevant PPGs for relevancy and consistency with updated CHC activities and make recommendations for updates to the PPGs; (2) support recruitment of bilingual, bicultural staff; (3) support recruitment of persons with lived experience and/or family members; (4) support staff retention efforts; (5) identify and recommend training opportunities and culturally relevant conferences for county and contract provider staff; and (6) identify four (4) community events to attend in FY 2022/23.

In FY 2021/22, the CHC Governance, Policy & Human Resources subcommittee helped examine DBH's staff recruitment and retention strategies in order to make recommendations to increase recruitment efforts by increasing outreach in the community and strengthening partnerships with local community-based organizations. In addition, the subcommittee assisted to issue the Mental Health Directive Regarding Cultural Competency Responsibilities to the BHSOC.

#### **2. Language**

The CHC 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 2021/22, the CHC 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, to certify bilingual staff's skills in Spanish and/or Hmong. In addition, the CHC 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.

### **3. Access**

Similar to the Language subcommittee, the CHC 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 2021/22, the CHC 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), Beacon and Exodus, 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.

## 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 930,450) 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

Figure 1 shows age and race/ethnicity, and gender of the general population. For the 930,450 residents who live in Fresno County, 24.7% are children ages 0-14; 16.8% are Transition Age Youth (TAY) ages 15-24; 44.2% are adults ages 25-59; and 14.3% are older adults ages 60 years and older. The majority of persons in Fresno County are Hispanic/Latino (50.3%). Persons who are White represent 32.7% of the population, Asian/Pacific Islander represent 9.3% of the population, Black represent 4.8% of the population, Alaskan Native/Native American represent 0.7% of the population, and Other/Unknown represent 2.2% of the population. There are an equal proportion of females (50.0%) and males (50.0%) in the county.

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

	<b>Fresno County Population 2010 Census</b>	
<b>Age Distribution</b>	<b>Number</b>	<b>Percent</b>
<b>0 - 14 years</b>	229,429	24.7%
<b>15 - 24 years</b>	156,596	16.8%
<b>25 - 59 years</b>	411,057	44.2%
<b>60+ years</b>	133,368	14.3%
<b>Total</b>	<b>930,450</b>	<b>100.0%</b>
<b>Race/Ethnicity Distribution</b>	<b>Number</b>	<b>Percent</b>
<b>Black</b>	44,662	4.8%
<b>Alaskan Native/American Indian</b>	6,513	0.7%
<b>Asian/Pacific Islander</b>	86,532	9.3%
<b>White</b>	304,257	32.7%
<b>Hispanic/Latino</b>	468,016	50.3%
<b>Other/Not Reported</b>	20,470	2.2%
<b>Total</b>	<b>930,450</b>	<b>100.0%</b>
<b>Gender Distribution</b>	<b>Number</b>	<b>Percent</b>
<b>Male</b>	464,811	50.0%
<b>Female</b>	465,639	50.0%
<b>Total</b>	<b>930,450</b>	<b>100.0%</b>

It is estimated that about 44.8% of the population of Fresno County speaks a language other than English at home. Spanish and Hmong are the threshold languages in Fresno County (2012 – 2018 American Community Survey).

### 3. Socioeconomic Factors

Healthcare, retail trade, and agriculture are the three largest industries in Fresno County. The unemployment rate in the Fresno County was 13.5% in July 2020; the state unemployment rate was 13.5% in the same period (2019 California Employment Development Department). The high rate of unemployment in Fresno County, and the state of California as a whole, is a result of the Covid-19 crisis and subsequent Shelter in Place Order that began in March 2020.

The median household income in Fresno County was \$51,261 in 2018, which is significantly lower than the statewide data of \$71,22 in the same year. The county has a high percentage of its population living under the poverty level (21.3%), compared to statewide (12.8%) (2018 American Community Survey).

#### 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 also provides information on the number of persons who received mental health services (FY 2020/21). From this data, a penetration rate was calculated, showing the percent of persons in the general population that received mental health services in FY 2020/21. 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 26,239 people who received one or more mental health services in FY 2020/21. Of these individuals, 32.9% were children ages 0-15; 17.6% were Transition Age Youth (TAY) ages 16-24; 42.1% were adults ages 25-59; and 7.4% were 60 and older. There were 21.6% of the individuals who were White, 45.8% Hispanic/Latino, 10.2% Black, 4.5% Asian/Pacific Islander and 0.8% Alaska Native/American Indian. 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 (81.6%), 11.8% have a primary language of Spanish, and 1.7% have a primary language of Hmong/Lao.

The penetration rate data shows that 2.8% of the Fresno County population received mental health services. Of these individuals, children ages 0-15 had a penetration rate of 3.8%, TAY ages 16-24 had a penetration rate of 3.0%, adults ages 25-59 had a penetration rate of 2.7%, and older adults ages 60 and older had a penetration rate of 1.4%. This data shows that there are 3,107 individuals who reported Spanish as their primary language and 438 who reported Hmong/Lao as their primary language.

For race/ethnicity, persons who are White had a penetration rate of 1.9%, persons who are Hispanic/Latino had a penetration rate of 2.6%, 6.0% Black, and 1.4% Asian/Pacific Islander. 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 slightly higher mental health penetration rate (2.9%), compared to females (2.7%).

**NOTE:** *This data was collected from the Avatar Electronic Health Record (EHR). It does not include all persons served through the Mental Health Services Act (MHSA) funding as only some utilize the EHR and/or from organizational providers who do not report data to Avatar.*

**NOTE:** *All data sections have been updated to reflect the most recent data shown in the tables. Last year's data is also shown in the data tables, but **not** referenced in the updated words (we did not strike out the old words, it would have been too difficult to read).*

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

	Fresno County Population 2010 Census		All Mental Health Participants FY 2020-21		Fresno County Population Mental Health Penetration Rate FY 2020-21
Age Distribution					
0 - 15 years	229,429	24.7%	8,632	32.9%	8,632 / 229,429 = 3.8%
16 - 25 years	156,596	16.8%	4,623	17.6%	4,623 / 156,596 = 3.0%
26 - 59 years	411,057	44.2%	11,052	42.1%	11,052 / 411,057 = 2.7%
60+ years	133,368	14.3%	1,932	7.4%	1,932 / 133,368 = 1.4%
Total	930,450	100.0%	26,239	100.0%	26,239 / 930,450 = 2.8%
Race/Ethnicity Distribution					
Black	44,662	4.8%	2,680	10.2%	2,680 / 44,662 = 6.0%
American Indian/Alaskan Native	6,513	0.7%	211	0.8%	211 / 6,513 = 3.2%
Asian/Other Pacific Islander	86,532	9.3%	1,178	4.5%	1,178 / 86,532 = 1.4%
White	304,257	32.7%	5,671	21.6%	5,671 / 304,257 = 1.9%
Hispanic/Latino	468,016	50.3%	12,020	45.8%	12,020 / 468,016 = 2.6%
Other/Not Reported	20,470	2.2%	4,479	17.1%	4,479 / 20,470 = 21.9%
Total	930,450	100.0%	26,239	100.0%	26,239 / 930,450 = 2.8%
Language Distribution					
English	-	-	21,398	81.6%	-
Spanish	-	-	3,107	11.8%	-
Hmong/ Lao	-	-	438	1.7%	-
Other/ Not Reported	-	-	1,296	4.9%	-
Total	-	-	26,239	100.0%	-
Gender Distribution					
Male	464,811	50.0%	13,434	51.2%	13,434 / 464,811 = 2.9%
Female	465,639	50.0%	12,780	48.7%	12,780 / 465,639 = 2.7%
Transgender	-	-	17	0.06%	-
Other/ Not Reported	-	-	8	0.03%	-
Total	930,450	100.0%	26,239	100.0%	26,239 / 930,450 = 2.8%

## 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 the individuals receiving mental health services. However, many older adults have Medicare insurance, and may be accessing mental health services through private providers. Therefore, their services are not delivered by or reported to BH.

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 2.8%. 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 2.6% with 12,020 out of 468,016 people accessing mental health services. The penetration rate for persons who are Black is 6.0%, with a smaller number of people served (2,680) and smaller population in the county (44,662). The penetration rate for persons who are White is 1.9%, with 5,671 persons served, out of 304,257 in the population. There were 4,479 out of 20,470 people with an 'Other/Not Reported' race/ethnicity, showing a penetration rate of 21.9%. There was a very high rate of Other/Not Reported race/ethnicity for FY 2020/21, 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.

This data highlights the need to further 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 collect race and ethnicity 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 hire 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 hire 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.

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 26,239 persons served, only 17 reported Transgender. This area will continue to be a focus for DBH, as well as the Cultural Humility Committee, to identify strategies for collecting this important information.

## 6. Mental Health Penetration Rate Trends for Four Years

Figure 3 shows the penetration rates data for four (4) years, FY 2017/18 to FY 2020/21, by age. The data shows an increase in the number of individuals served between FY 2017/18 through FY 2020/21 across all age groups. The total number of individuals served increased from 20,135 to 26,239 individuals in this period. The number of individuals served ages 0-15 increased from 6,499 to 8,632, and the number of TAY ages 16-25 increased from 3,279 to 4,623. The number of adult individuals served ages 26-59 increased from 8,967 to 11,052, and the number of Older Adults ages 60 and older increased from 1,390 to 1,932.

**Figure 3**  
**Fresno County Mental Health Services**  
**Mental Health Penetration Rate, by Age**  
FY 2017-18 to FY 2020-21

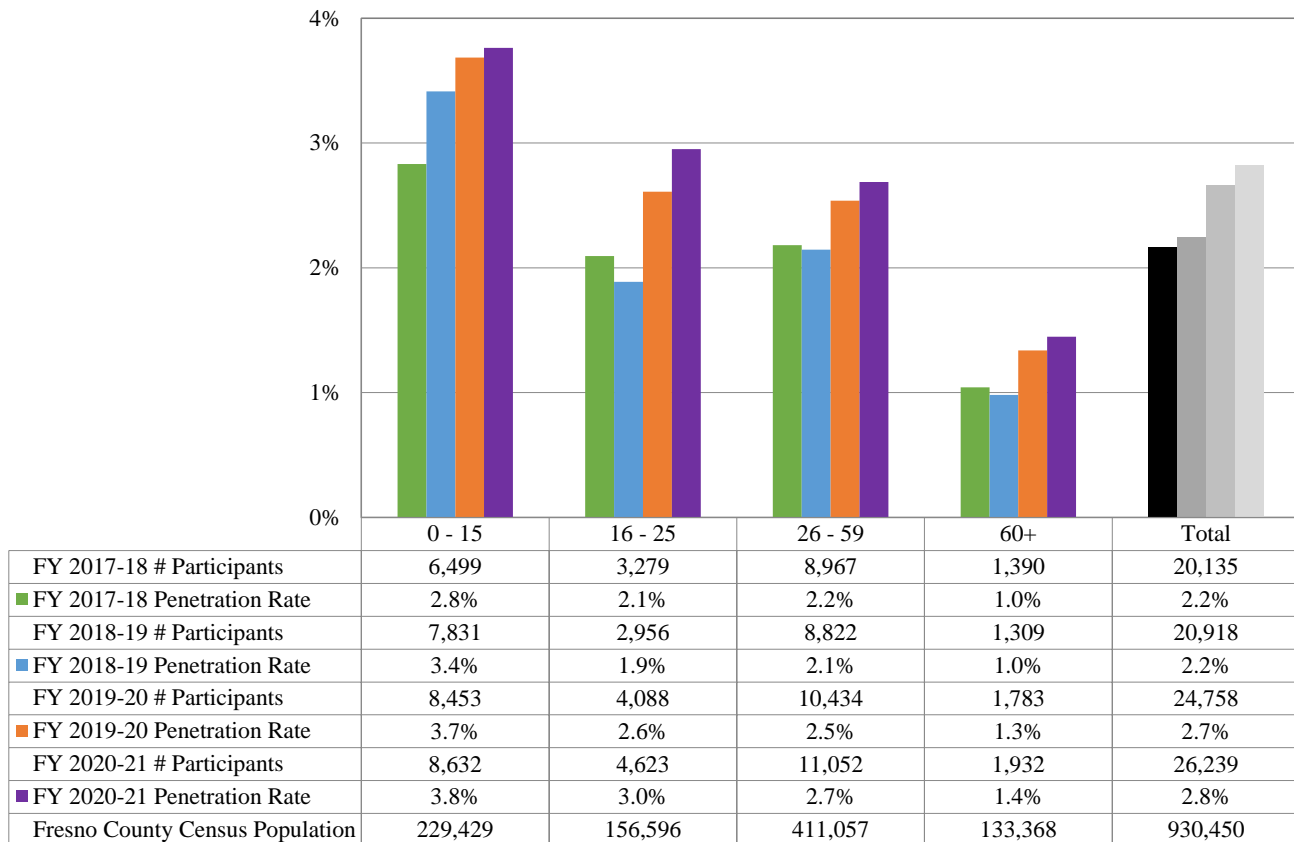


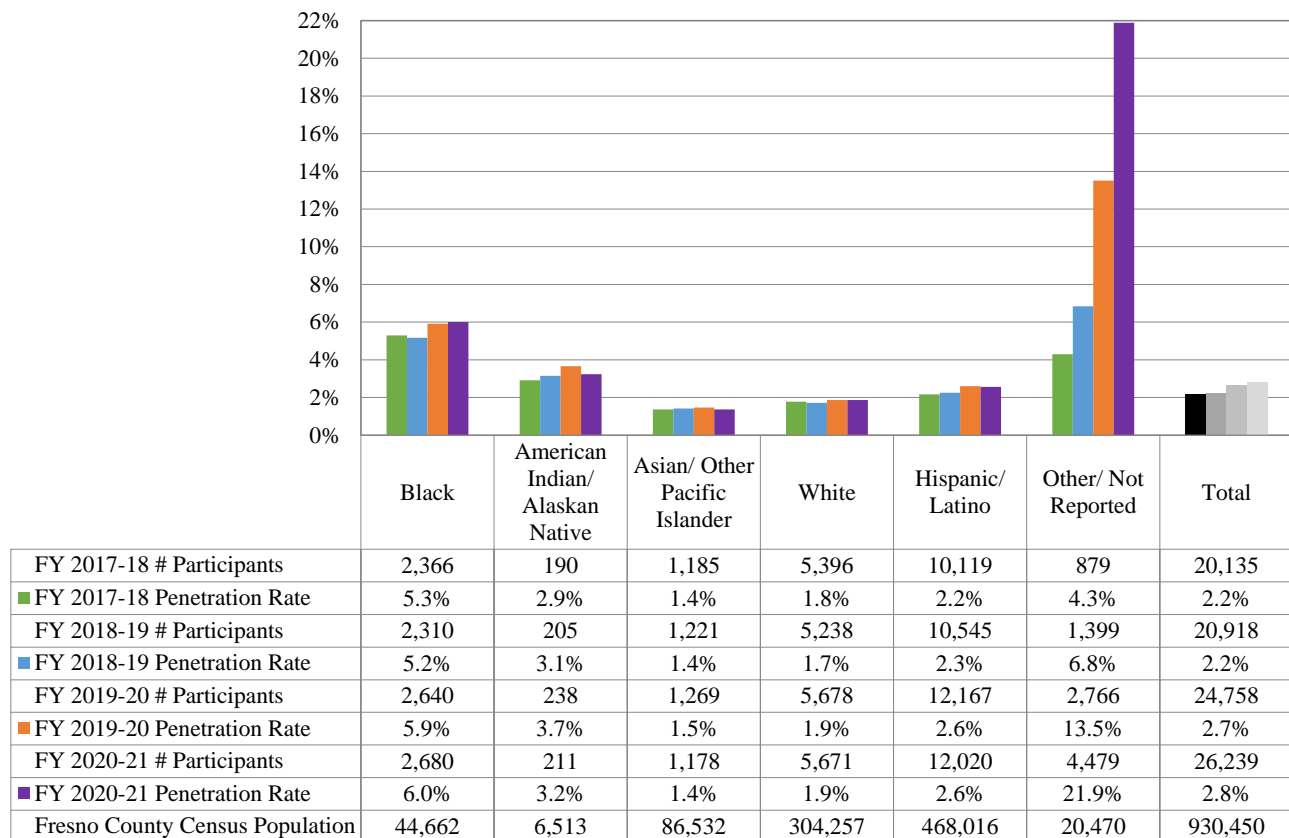


Figure 4 shows the Penetration Rate for the same four (4) years for race/ethnicity. The large number of persons who did not have race/ethnicity reported for FY 2020/21 is clearly shown in this figure. Overall, the penetration rate shows an increase, 2.2% to 2.8%. While each of the five primary race/ethnicity groups show an increase in the penetration rate, the total number of persons served show a slight decrease from the previous year. The number of individuals served who are Black increased slightly (2,640 to 2,680). The number of individuals served who are Indian/Alaska Native decreased from slightly (238 to 211). The number of individuals served who are Asian/Other Pacific Islander decreased slightly (1,269 to 1,178).

The number of individuals served who are White decreased slightly (5,678 to 5,671). The number of Hispanic/Latino individuals served also showed a decrease, from 12,167 to 12,020.

Across the four years, there has also been a large increase in the number of individuals served whose race/ethnicity is Not Reported (879 to 4,479). This increase was most significant in FY 2020/21 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.

**Figure 4**  
**Fresno County Mental Health Services**  
**Mental Health Penetration Rate, by Race/Ethnicity**  
FY 2017-18 to FY 2020-21



## **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. There were 26,239 people served. This column also shows the percent of persons by age (e.g., 32.9% were children ages 0-15); Race/Ethnicity (e.g., 10.2% were Black); Language (e.g., 81.6% reported English has their primary language); and Gender (e.g., 51.2% were male).

The second column of numbers shows the number of persons served who had Medi-Cal. There were 21,872 people with Medi-Cal served. This column also shows the percent of persons with Medi-Cal by age (e.g., 36.5% were children ages 0-15); Race/Ethnicity (e.g., 10.6% were Black); Language (e.g., 82.7% reported English has their primary language); and Gender (e.g., 48.4% were male).

The third column of numbers shows the proportion of the mental health population with Medi-Cal out of the total number of people served by the mental health system is calculated. For all persons served, 83.4% had Medi-Cal. This column also shows the proportion of persons with Medi-Cal out of the total served by age (e.g., 92.5% of children receiving mental health services had Medi-Cal); Race/Ethnicity (e.g., 86.1% of persons who were Black and received mental health services); Language (e.g., 84.5% persons who reported English has their primary language and received mental health services); and Gender (e.g., 78.7% were male and 88.2% of females with Medi-Cal).

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

	All Mental Health Participants FY 2020-21		Medi-Cal Mental Health Participants Served FY 2020-21		MH Medi-Cal Participants out of Total MH Participants FY 2020-21
Age Distribution					
0 - 15 years	8,632	32.9%	7,984	36.5%	7,984 / 8,632 = 92.5%
16 - 25 years	4,623	17.6%	3,898	17.8%	3,898 / 4,623 = 84.3%
26 - 59 years	11,052	42.1%	8,697	39.8%	8,697 / 11,052 = 78.7%
60+ years	1,932	7.4%	1,293	5.9%	1,293 / 1,932 = 66.9%
Total	26,239	100.0%	21,872	100.0%	21,872 / 26,239 = 83.4%
Race/Ethnicity Distribution					
Black	2,680	10.2%	2,308	10.6%	2,308 / 2,680 = 86.1%
American Indian/Alaskan Native	211	0.8%	185	0.8%	185 / 211 = 87.7%
Asian/Other Pacific Islander	1,178	4.5%	1,063	4.9%	1,063 / 1,178 = 90.2%
White	5,671	21.6%	4,781	21.9%	4,781 / 5,671 = 84.3%
Hispanic/Latino	12,020	45.8%	10,618	48.5%	10,618 / 12,020 = 88.3%
Other/Not Reported	4,479	17.1%	2,917	13.3%	2,917 / 4,479 = 65.1%
Total	26,239	100.0%	21,872	100.0%	21,872 / 26,239 = 83.4%
Language Distribution					
English	21,398	81.6%	18,081	82.7%	18,081 / 21,398 = 84.5%
Spanish	3,107	11.8%	2,733	12.5%	2,733 / 3,107 = 88.0%
Hmong/ Lao	438	1.7%	415	1.9%	415 / 438 = 94.7%
Other/ Not Reported	1,296	4.9%	643	2.9%	643 / 1,296 = 49.6%
Total	26,239	100.0%	21,872	100.0%	21,872 / 26,239 = 83.4%
Gender Distribution					
Male	13,434	51.2%	10,578	48.4%	10,578 / 13,434 = 78.7%
Female	12,780	48.7%	11,276	51.6%	11,276 / 12,780 = 88.2%
Transgender	17	0.06%	14	0.06%	14 / 17 = 82.4%
Other/ Not Reported	8	0.03%	4	0.02%	4 / 8 = 50.0%
Total	26,239	100.0%	21,872	100.0%	21,872 / 26,239 = 83.4%

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

Figure 5 shows that the vast majority of individuals served by the mental health system had Medi-Cal benefits. Overall, 85.9% of the persons served had Medi-Cal. Persons ages 60 and older had the lowest proportion of Medi-Cal benefits. For race/ethnicity, 65.1% of those with other/not reported had Medi-Cal benefits and those with other/not reported for Language 49.6%

Medi-Cal. Males had a lower proportion of males had Medi-Cal (78.7%) compared to females (88.2%). 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.

## **9. Penetration Rates for Substance Use Disorder Services**

Figure 6 shows the number of persons in the county *general* population (2010 Census) and the number of persons who received substance use disorder (SUD) services in FY 2020/21. 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 930,450 residents who live in Fresno County, 24.7% are children ages 0-15; 16.8% are TAY ages 16-25; 44.2% are adults ages 26-59; and 14.3% are older adults ages 60 years and older. The majority of persons in Fresno County identify as Hispanic/Latino (50.3%) and White (32.7%). There are an equal number of individuals who identify as male (50.0%) and female (50.0%) in the county.

As expected, the proportion of persons receiving SUD services shows a different proportion of individuals by age. There were 4,202 individuals who received one or more SUD services in FY 2020/21. Of these individuals, 1.8% were children ages 0-15; 14.2% were TAY ages 16-25; 74.5% were adults ages 26-59; and 9.5% were ages 60 and older.

Of the individuals who received SUD services, 32.2% identified as Hispanic/Latino and 25.8% identified as White. All other race/ethnicity groups represented a small number of individuals. Most individual's primary language was English (76.5%), 9.6% reported a primary language of Spanish, and 1.3% reported a primary language of Hmong/Lao. More individuals served identified as male (61.5%) as compared to female (38.5%).

The penetration rate data shows that 0.5% of the Fresno County population received SUD treatment services. Of these individuals, children ages 0-15 had a penetration rate of 0.0%, TAY ages 16-25 had a penetration rate of 0.4%, adults ages 26-59 had a penetration rate of 0.8%, and older adults ages 60 and older had a penetration rate of 0.3%.

For race/ethnicity, persons who identified as Hispanic/Latino had a penetration rate of 0.3% and persons who identified as White had a penetration rate of 0.4%. 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 slightly greater penetration rate (0.5%) compared to females (0.4%).

\*\* Note: The Race/Ethnicity data for FY 2020/21 had a large number of persons recorded as Other/Not Reported. This is due to a reporting issue with Avatar and Race/Ethnicity was not collected for several months in the fiscal year.

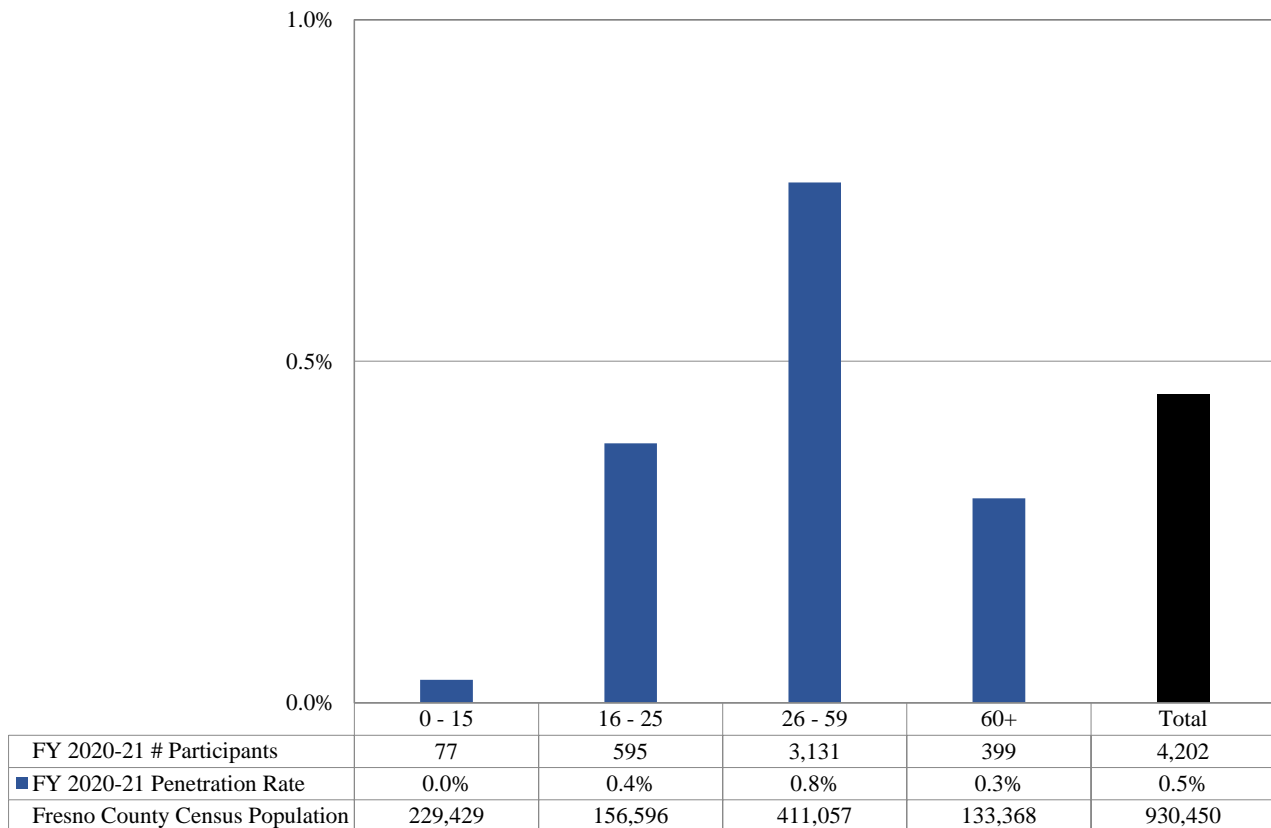
**Figure 6**  
**Fresno County Substance Use Disorder Outpatient Penetration Rates**  
**by Gender, Age, Race/Ethnicity, and Language**  
(Population Source: 2010 Census)

	Fresno County Population 2010 Census		All Substance Use Participants FY 2020-21		Fresno County Population Substance Use Penetration Rate FY 2020-21
Age Distribution					
0 - 15 years	229,429	24.7%	77	1.8%	77 / 229,429 = 0.0%
16 - 25 years	156,596	16.8%	595	14.2%	595 / 156,596 = 0.4%
26 - 59 years	411,057	44.2%	3,131	74.5%	3,131 / 411,057 = 0.8%
60+ years	133,368	14.3%	399	9.5%	399 / 133,368 = 0.3%
Total	930,450	100.0%	4,202	100.0%	4,202 / 930,450 = 0.5%
Race/Ethnicity Distribution					
Black	44,662	4.8%	235	5.6%	235 / 44,662 = 0.5%
American Indian/Alaskan Native	6,513	0.7%	35	0.8%	35 / 6,513 = 0.5%
Asian/Other Pacific Islander	86,532	9.3%	70	1.7%	70 / 86,532 = 0.1%
White	304,257	32.7%	1,116	26.6%	1,116 / 304,257 = 0.4%
Hispanic/Latino	468,016	50.3%	1,286	30.6%	1,286 / 468,016 = 0.3%
Other/Not Reported**	20,470	2.2%	1,460	34.7%	1,460 / 20,470 = 7.1%
Total	930,450	100.0%	4,202	100.0%	4,202 / 930,450 = 0.5%
Language Distribution					
English	-	-	3,576	85.1%	-
Spanish	-	-	419	10.0%	-
Hmong/ Lao	-	-	34	0.8%	-
Other/ Not Reported	-	-	173	4.1%	-
Total	-	-	4,202	100.0%	-
Gender Distribution					
Male	464,811	50.0%	2,507	59.7%	2,507 / 464,811 = 0.5%
Female	465,639	50.0%	1,695	40.3%	1,695 / 465,639 = 0.4%
Total	930,450	100.0%	4,202	100.0%	4,202 / 930,450 = 0.5%

\*\* Race/Ethnicity was not collected in Avatar for part of the year.

Figure 7 compares the penetration rate of persons in the population that received SUD services FY 2020/21, by age. Of the total number of individuals served (4,202) there were a small number of children ages 0-15 (N=77) and a penetration rate of 9.9%. Transition Age Youth, ages 16-25 had a penetration rate of 0.4, with 595 served. Adults ages 26-59 had a penetration rate of 0.8% with 3,131 served. Older adults had a penetration rate of 0.3%, with 399 served.

**Figure 7**  
**Fresno County Substance Use Disorder Outpatient Services**  
**Penetration Rate, by Age**  
**FY 2020-21**



## **10. Analysis of Disparities identified in SUD Services**

Figure 6 data also shows that the majority of SUD outpatient services individuals served are adults (74.5.7% compared to 44.2% of the population). Individuals served who identified as Hispanic/Latino represent 30.6% of the individuals served compared to 50.3% of the population. Individuals served who identified as Black had a slightly higher proportion of individuals served (5.6% compared to 4.8% in the population), as did American Indian/Alaskan (0.8% compared to 0.7% in the population). There was a higher proportion of individuals served who identified as male (60.2% compared to 50.0% of the population) than female (39.8% compared to 50.0% of the population). This data illustrates the need to provide culturally responsive/appropriate services to individuals receiving SUD services.

**\*\* Note:** The Race/Ethnicity data for FY 2020/21 had a large number of persons recorded as Other/Not Reported. This result is due to a reporting issue with Avatar, and Race/Ethnicity was not collected for several months in the 2020/21 fiscal year.

## B. Utilization of Behavioral Health Services

### 1. Mental Health Demographics

Figure 8 shows the number and percent of individuals who received mental health outpatient services by age group for four years, FY 2017/18 to FY 2020/21. This data is calculated from Avatar 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 Avatar. This Avatar data shows an unduplicated count of individuals served in each of the four fiscal years, by age group. Each fiscal year represents services delivered from July 1 through June 30.

Of the 26,239 people served in FY 2020/21:

- 32.9% were children ages 0-15;
- 17.6% were TAY, ages 16-25;
- 42.1% were Adults ages 26-59;
- 7.4% were Older Adults, ages 60+.

**Figure 8**  
**Fresno County Mental Health Outpatient Services**  
*Number and Percent of Individuals Served, by Age*  
 FY 2017-18 to FY 2020-21

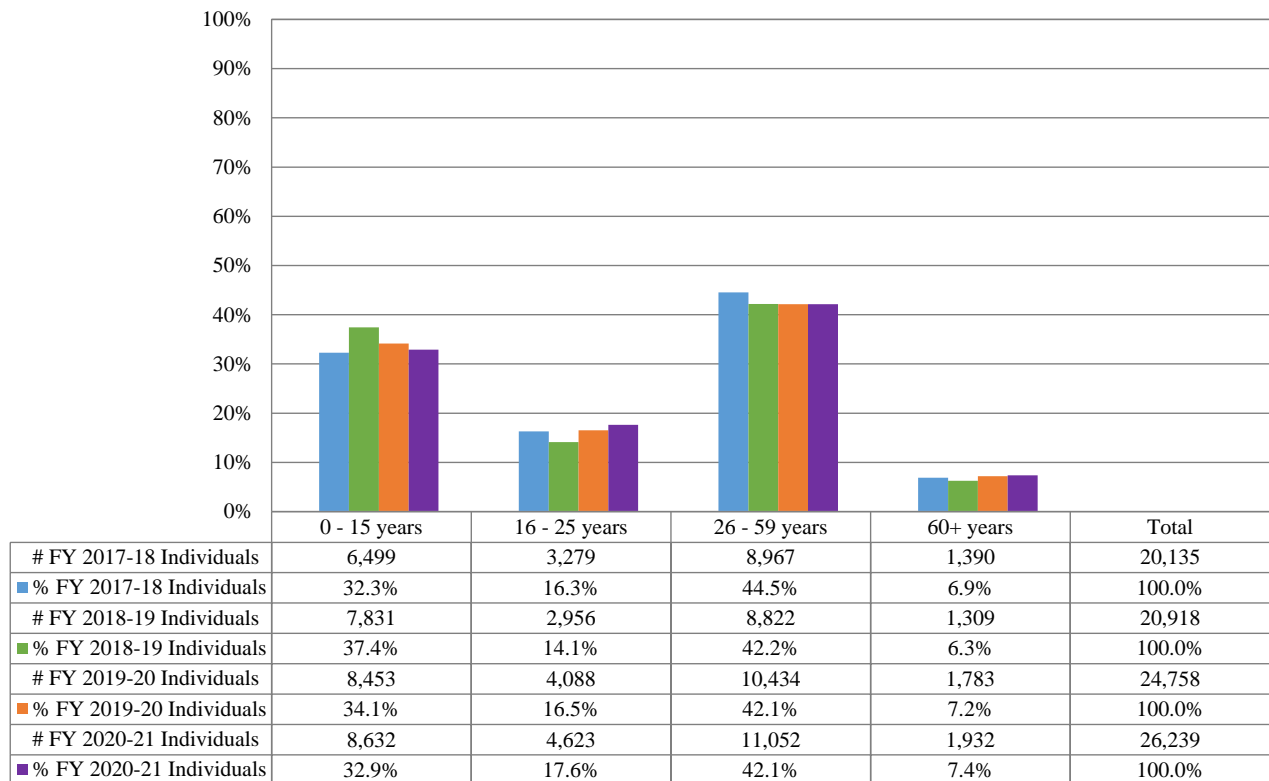
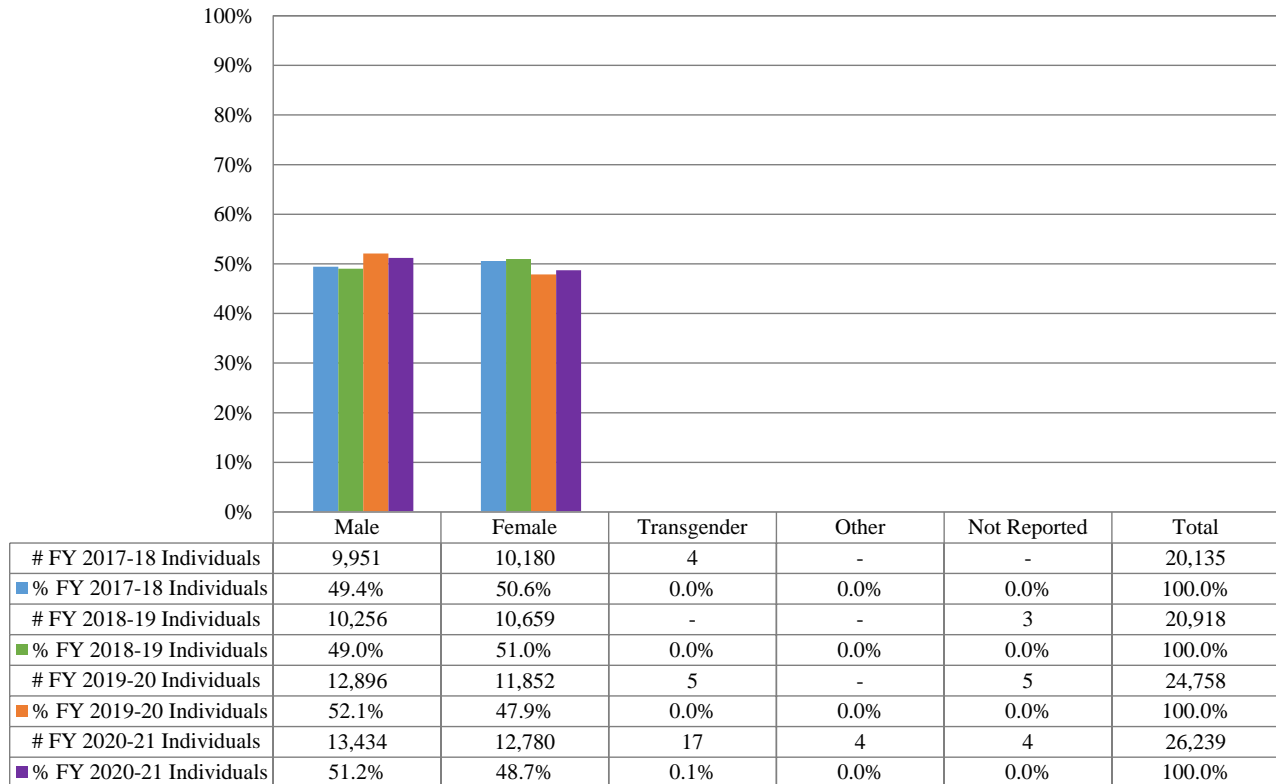




Figure 9 shows the number and percent of individuals who received one or more mental health outpatient services for four years, FY 2017/18 to FY 2020/21, by gender. This data was collected from Avatar. This data shows that in FY 2020/21, 52.1% males and 48.7% female. There were 17 individuals that were transgender (0.1%); 4 reported “Other;” and 4 did not report gender.

**Figure 9**  
**Fresno County Mental Health Outpatient Services**  
**Number and Percent of Individuals Served, by Gender**  
**FY 2017-18 to FY 2020-21**



**NOTE:** *This data illustrates the need to train staff on how to sensitively collect and report information on transgender individuals. 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 services to this vulnerable population. These individuals, and their families, could benefit from receiving welcoming and accessible mental health services.*

Figure 10 shows the number and percent of individuals who received one or more mental health outpatient services from FY 2017/18 to FY 2020/21, by race/ethnicity. This data is collected from Avatar. This data shows that in FY 2019/20, of the 26,239 individuals receiving mental health services, 21.6% are White, 45.8% are Hispanic/Latino, 0.8% are American Indian/Alaskan Native, 3.7% are Asian/Other Pacific Islander, 10.2% are Black, 0.9% are Hmong/Laotian, and 4.0% Other. There were 3,429 (13.1%) that did not report race/ethnicity. During a portion of the year, Avatar did not collect race/ethnicity, which likely contributed to the high number of “Not Reported” data entries.

**Figure 10**  
**Fresno County Mental Health Outpatient Services**  
*Number and Percent of Individuals Served, by Race/Ethnicity*  
FY 2017-18 to FY 2020-21

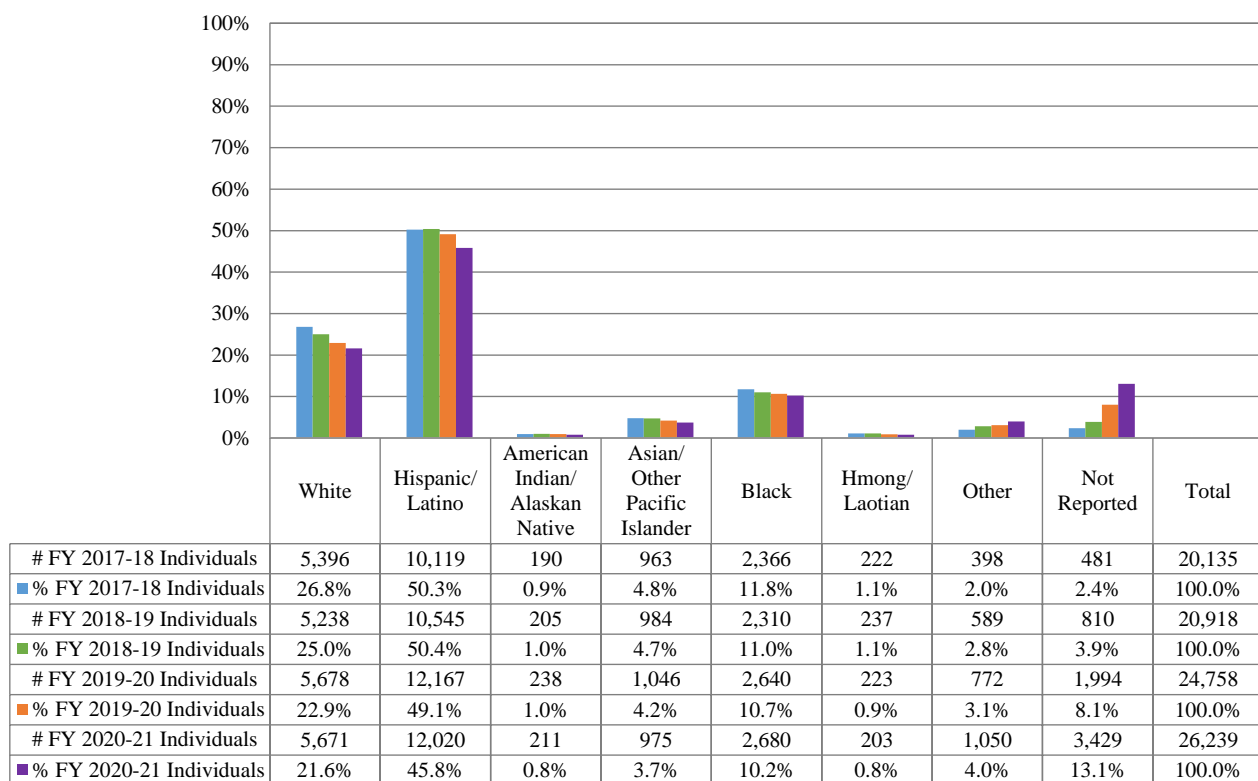
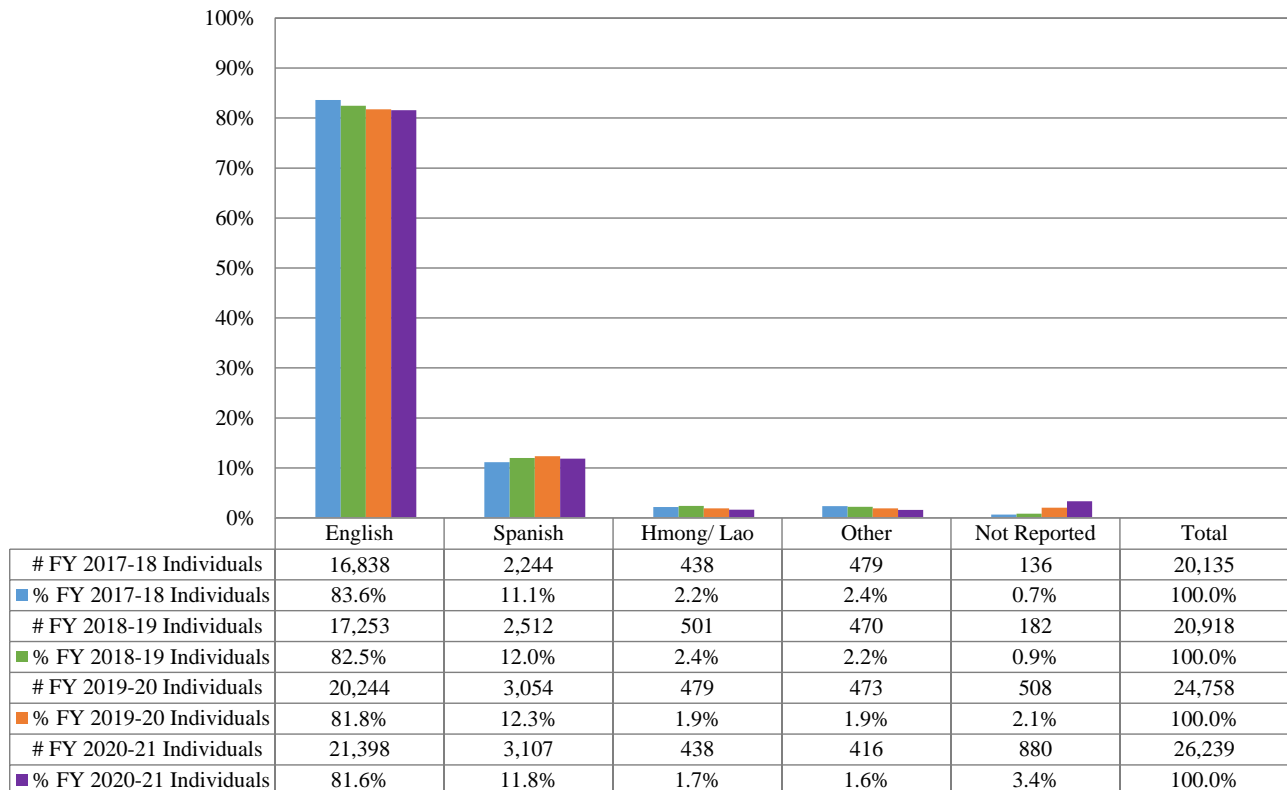


Figure 11 shows the number and percent of individuals who received one or more mental health outpatient services for four years (FY 2017/18 to FY 2020/21) by primary language. This data shows that in FY 2020/21, 81.6% of individuals served reported English, 11.8% reported Spanish, 1.7% reported Hmong/Laotian, and 1.6% reported Other Languages. There were 880 that did not report a primary language (3.4%).

**Figure 11**  
**Fresno County Mental Health Outpatient Services**  
*Number and Percent of Individuals Served, by Primary Language*  
FY 2017-18 to FY 2020-21



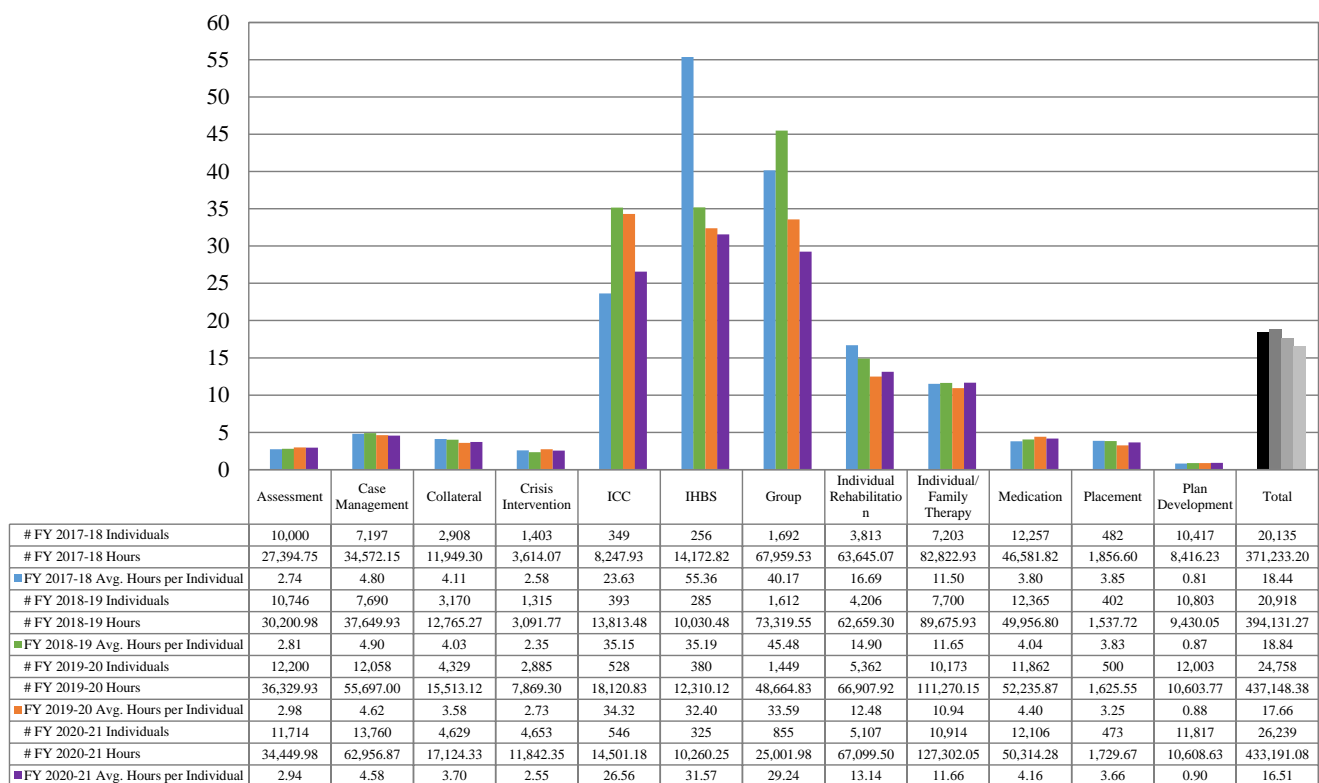
**NOTE:** *This data identifies the need to train staff on collecting data on Primary Language. It would also be helpful to collect information on Preferred Language to help identify the need for trained interpreters to deliver services in the person's preferred language.*

## 2. Utilization of Mental Health Outpatient Services

Figure 12 shows the total number of hours, per year, the number of individuals served; and the hours per individual served, by type of mental health service. This data is shown for four years, FY 2017/18 to FY 2020/21. This Avatar data shows that the 26,239 individuals served in FY 2020/21 received a total of 433,191 hours of mental health services in the year. This calculates into an average of 16.51 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. Not all individuals received all services. The number of individuals varies by type of service.

In FY 2020/21, individuals who received an assessment averaged 2.94 hours of assessment in the year; case management averaged 4.58 hours; collateral averaged 3.70; crisis intervention averaged 2.55 hours; Intensive Care Coordination (ICC) averaged 26.56 hours; Intensive Home Based Services (IHBS) averaged 31.57 hours; group averaged 29.24 hours; individual rehab averaged 13.14 hours; individual/family therapy averaged 11.66 hours; medication management averaged 4.16 hours; placement averaged 3.66 hours; and plan development averaged 0.90 hours.

**Figure 12**  
**Fresno County Mental Health Services**  
**Total Mental Health Hours, Individuals Served, and Hours per Individual Served**  
**per Year, by Service Type**  
**Mental Health Individuals Served Reported to Avatar**  
**FY 2017-18 to FY 2020-21**



### 3. Analysis of the Mental Health Population Assessment and Utilization Data, and Conclusions Drawn

The FY 2020/21 data was only recently available and analyzed. The CHC will review the Mental Health population data and develop recommendations in the next six (6) months. This review will allow the CHC to better understand the service utilization data and make recommendations for enhancing services.

#### 4. SUD Demographics (Outpatient Services)

Figures 13 through 18 show service utilization data in FY 2020/21. 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 program is shown only for one year: FY 2020/21. 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 2020/21. The data shows services delivered between July 1, 2020 and June 30, 2021.

Figure 13 shows the number and percent of individuals who received outpatient services by age group for FY 2020/21. This Avatar data shows an unduplicated count of individuals served by age group. Each individual received one or more services between July 1, 2020 and June 30, 2021.

Of the 4,202 (unduplicated) people in FY 2020/21:

- 1.8% were ages 0-15
- 14.2% were ages 16-25
- 74.5% were ages 26-59
- 9.5% were ages 60+

**Figure 13**  
**Fresno County Substance Use Disorder Outpatient Services**  
*Number and Percent of Individuals Served, by Age*  
FY 2020-21

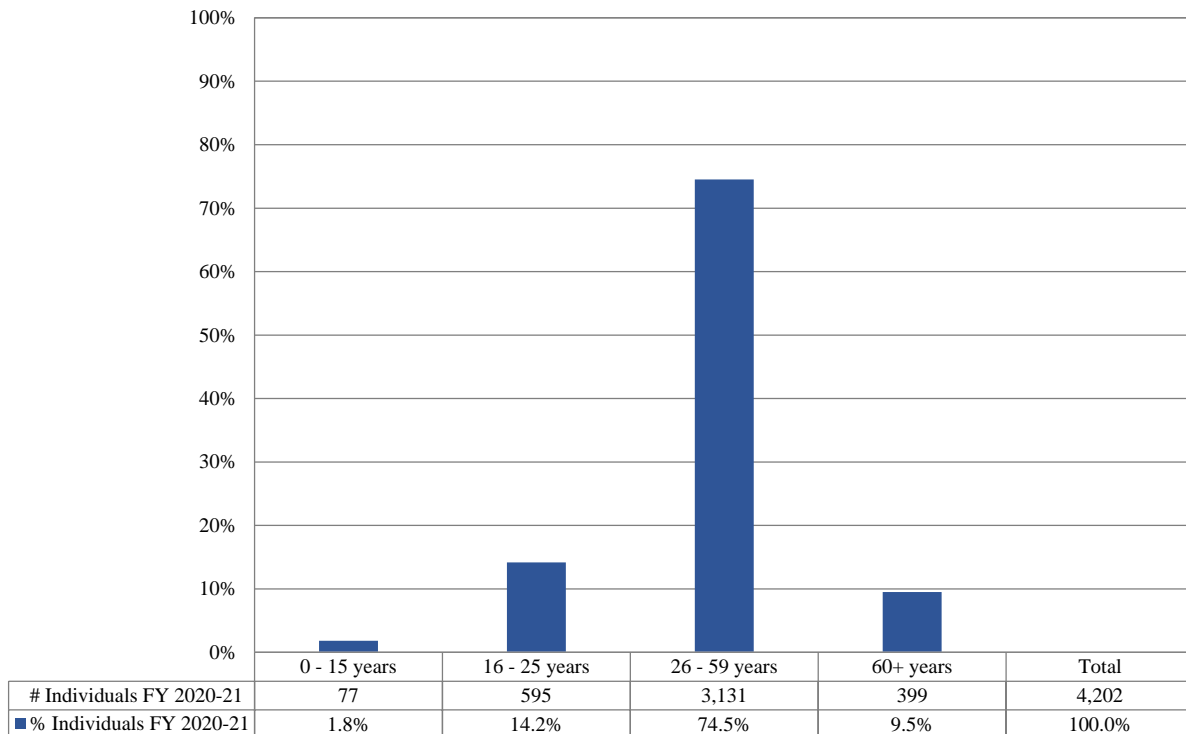


Figure 14 shows the number and percent of individuals who received one or more SUD outpatient service in FY 2020/21, by gender. This data was collected from SAIS. This data shows that for the 4,202 individuals served from July 1, 2020 through June 30, 2021, 59.7% were male and 40.3% were female.

**Figure 14**  
**Fresno County Substance Use Disorder Outpatient Services**  
*Number and Percent of Individuals Served, by Gender*  
FY 2020-21

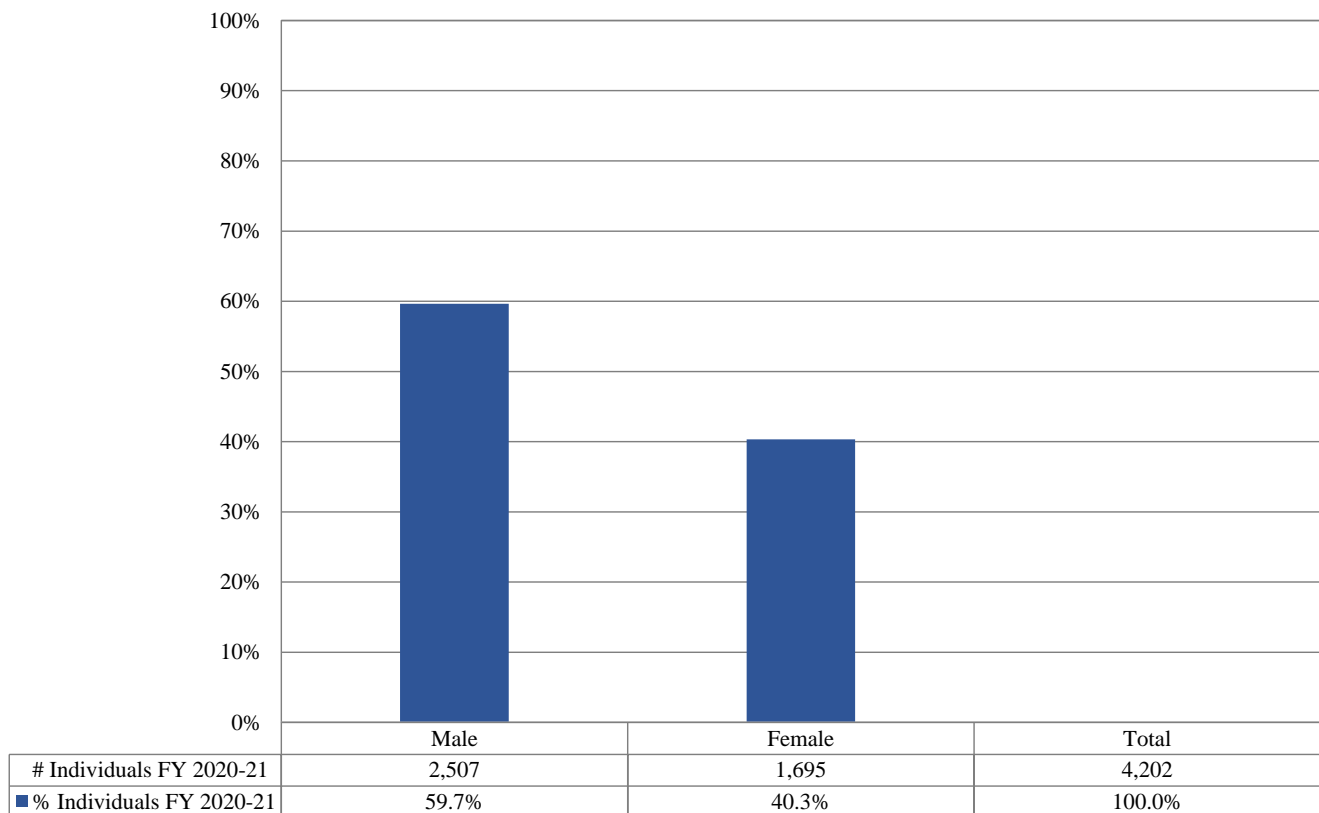
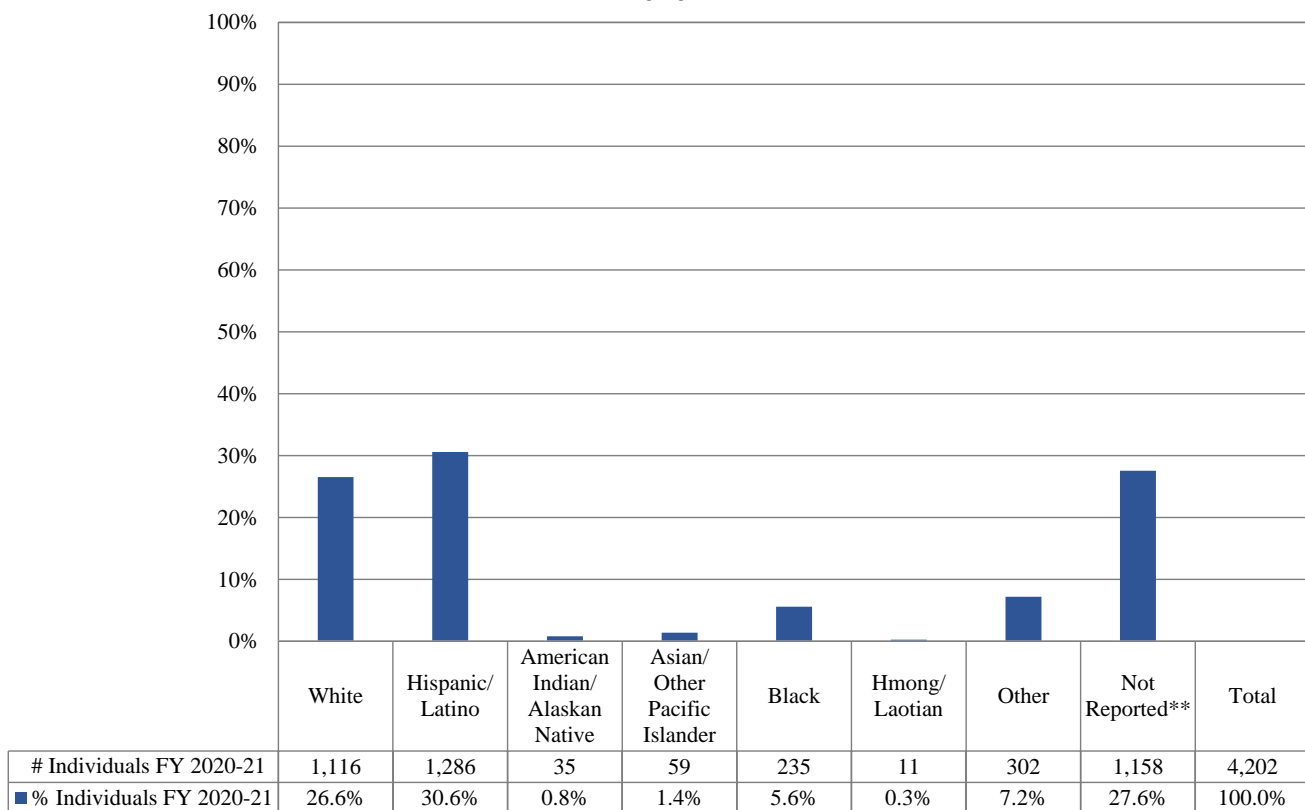


Figure 15 shows the number and percent of individuals who received one or more SUD outpatient service in FY 2020/21, by race/ethnicity. This data shows that from July 1, 2020 through June 30, 2021, of the 4,202 individuals receiving SUD services, 26.6% are White, 30.6% are Hispanic/Latino, 0.8% are American Indian/Alaskan Native, 1.4% are Asian/Other Pacific Islander, 5.6% are Black, 0.3% are Hmong/Laotian, 7.2% Other, and 24.6% (1,158) were not reported.

There were a high number of persons with Race/Ethnicity did not report because Avatar did not collect Race/Ethnicity for a few months of the year.

**Figure 15**  
**Fresno County Substance Use Disorder Outpatient Services**  
*Number and Percent of Individuals Served, by Race/Ethnicity*  
FY 2020-21



\*\* Race/Ethnicity was not collected in Avatar for part of the year.

Figure 16 shows the number and percent of individuals who received one or more SUD outpatient service in FY 2020/21, by primary language. This data shows that 85.1% of individuals served speak English, 10% speak Spanish, 0.8% speak Hmong or Lao, 0.9% reported that they speak a different language, and 3.2% were Not Reported from July 1, 2020 through June 30, 2021.

**Figure 16**  
**Fresno County Substance Use Disorder Outpatient Services**  
*Number and Percent of Individuals Served, by Primary Language*  
FY 2020-21

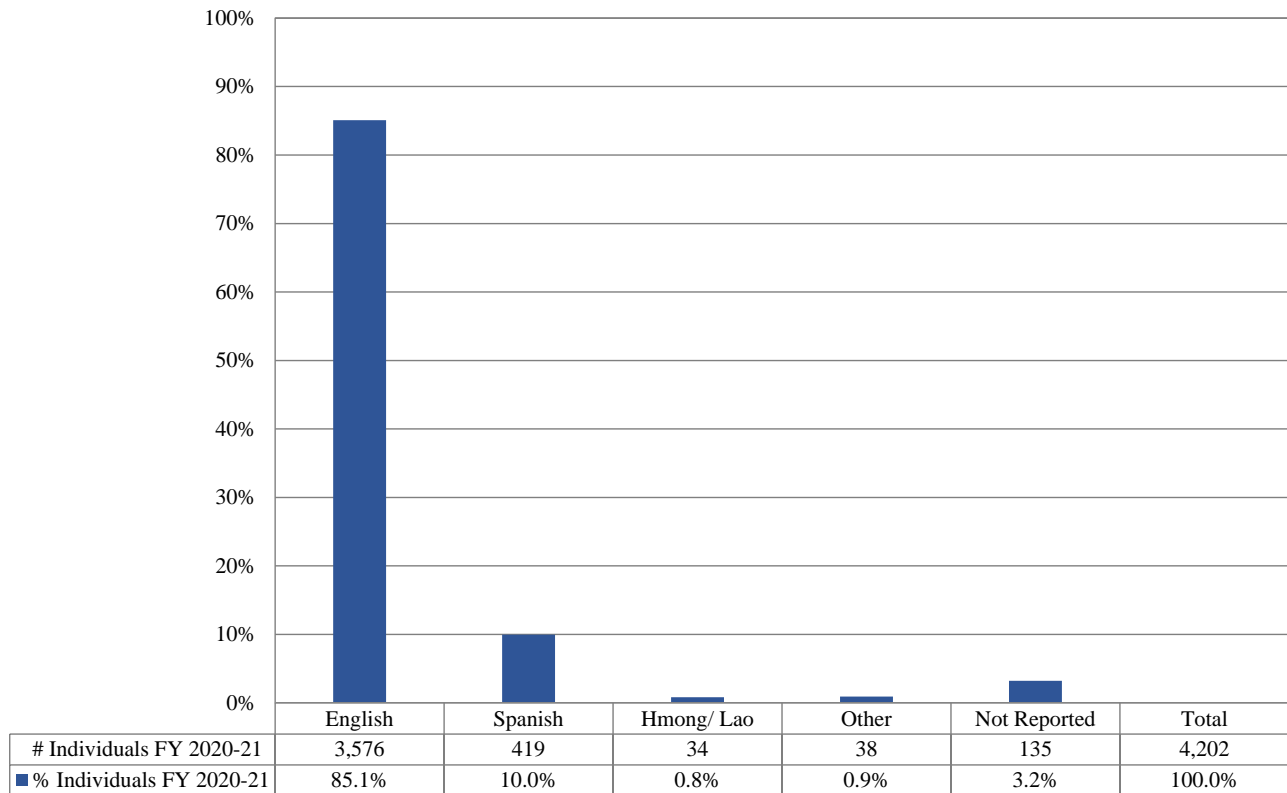
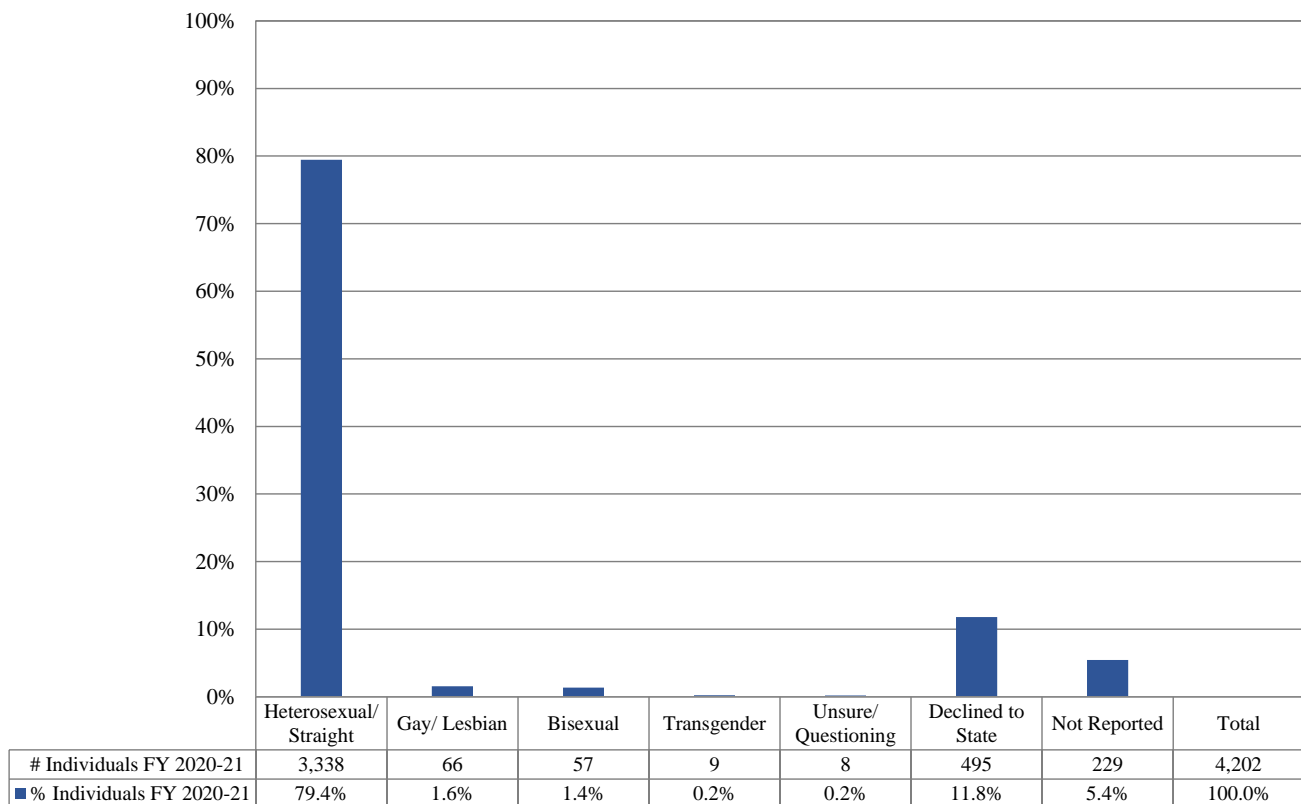




Figure 17 shows the number and percent of individuals who received one or more SUD outpatient service in FY 2020/21, by sexual identity. This data shows that from July 1, 2020 through June 30, 2021, 79.4% of individuals served reported they identified as Heterosexual/Straight, 1.6% identified as Gay or Lesbian, 1.4% identified as Bisexual, 0.2% identified as Transgender, 0.2% identified as Unsure/Questioning, and 11.8% Declined to State. 5.4% were not reported (229).

**Figure 17**  
**Fresno County Substance Use Disorder Outpatient Services**  
*Number and Percent of Individuals Served, by Sexual Identity*  
FY 2020-21



## 5. Utilization of SUD Outpatient Services

The following data shows substance use disorder (SUD) outpatient services by type of service. There are three types of services: Outpatient Services, which provides up to six hours of services per week and is primarily delivered in group services; Intensive Outpatient Services, which provides at least nine (9) hours of services per week and is primarily delivered in group services; Narcotic Treatment Program (NTP) services which are primarily delivered as an individual contact. The number of persons served in each program component in FY 2020/21 are shown below.

NOTE: Approximately 71 people received both Outpatient and NTP services. Some providers may not be reporting data in Avatar, so this number may underrepresent the total number of people who are not received services in both systems.

- **Total SUD Outpatient Services N=4,202**
- **Narcotic Treatment Program (NTP) Services N=1,980**

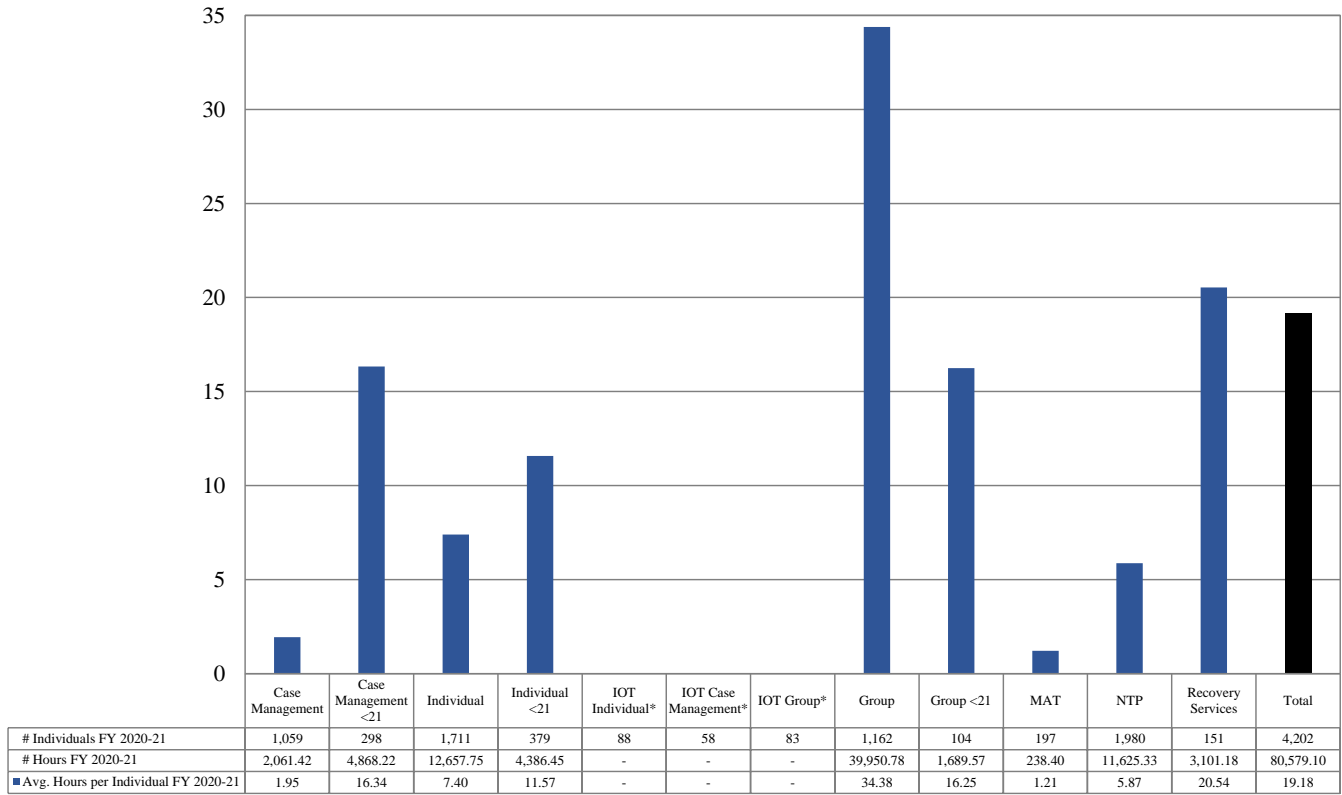
Figure 18 shows the total number of individuals that received SUD outpatient services, the total hours of outpatient services delivered by type of SUD outpatient service for FY 2020/21, and the average hours of outpatient services per individual.

This graph shows data from the FY 2020/21. There were 4,202 individuals that received a total of 80,579 hours of SUD outpatient services. This data calculates into an average of 19.18 hours per individual for the fiscal year.

This data also shows the number of individuals, total hours, and average hours per person, for each type of service (Case Management (ages 21+); Case Management (< 21 years); Individual Outpatient (ages 21+); Individual Outpatient (<21); Group (ages 21+); Group (<21); Medication Assisted Treatment (MAT); NTP; and Recovery Services. The hours for Intensive Outpatient Treatment (IOT) were not available when this report was developed, so the graph only shows the number of persons that receive IOT services.

The average hours per client data shows: case management for adults averaged 1.95 hours; case management youth was 16.34 hours; individual therapy for adults, 7.4 hours; individual therapy for youth, 11.57 hours; group services for adults, 34.38 hours; group services for youth, 16.25; MAT, 1.21 hours; NTP, 5.87 hours; and Recovery Services, 20.54 hours.

**Figure 18**  
**Fresno County Substance Use Disorder Outpatient Services**  
***Total Substance Use Hours, Individuals Served, and Hours per Individual Served***  
***by Service Type***  
**FY 2020-21**



\* IOT hours are not available for this CRP.

## 6. SUD Demographics (Residential)

Figure 19 shows the number and percent of individuals who received substance use disorder residential treatment services by age group for FY 2020/21. This data is calculated from Avatar data. This Avatar data shows an **unduplicated** count of individuals served by age group for the fiscal year. Each individual that received one or more services in FY 2020/21 is counted once.

Of the 959 (unduplicated) people that received residential treatment in FY 2020/21:

- 2% were ages youth ages <21 years
- 94.7% were ages 21-59; and
- 3.3% were ages 60+.

**Figure 19**  
**Fresno County Substance Use Disorder Residential Treatment**  
*Number and Percent of Individuals Served, by Age*  
FY 2020-21

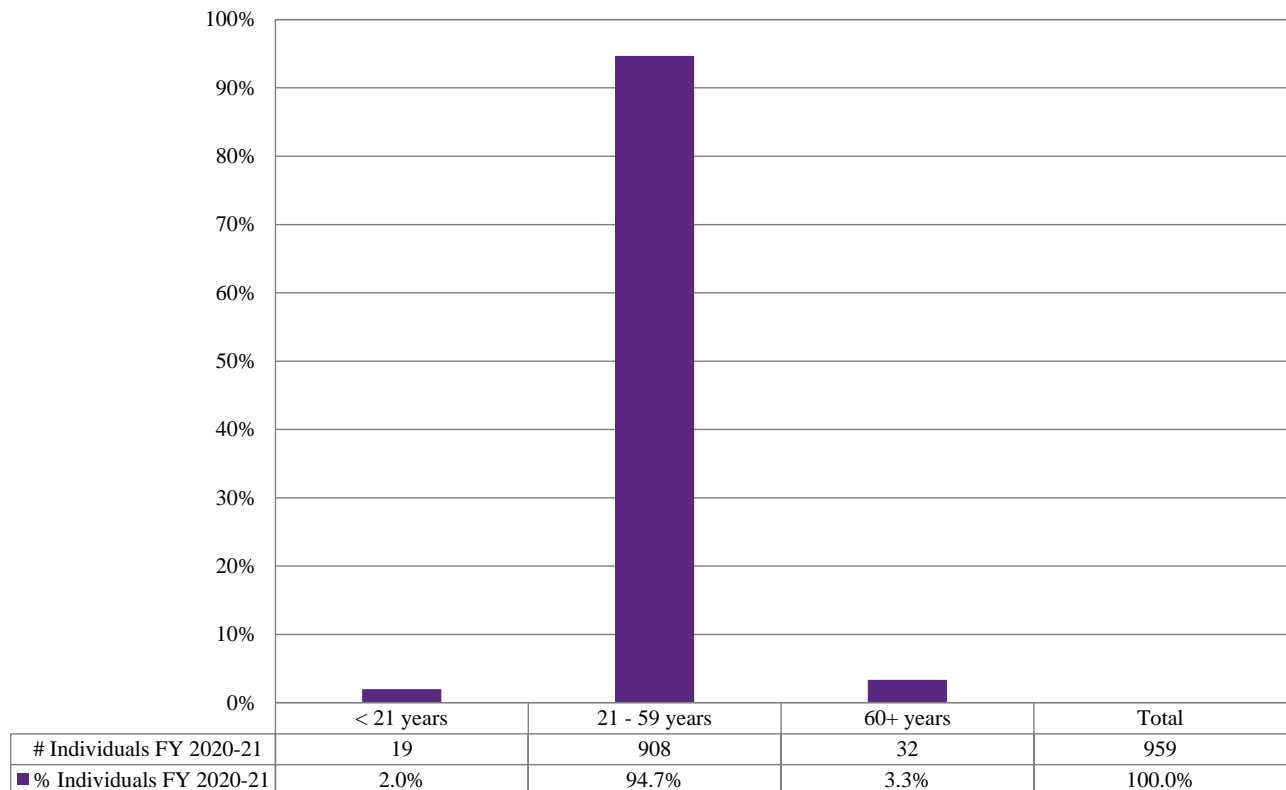


Figure 20 shows the number and percent of individuals who received one or more SUD residential treatment service for FY 2020/21. This data is calculated from Avatar data. This Avatar data shows an **unduplicated** count of individuals served by gender for the FY 2020/21. Each individual that received one or more services in FY 2020/21 is counted once. This data shows that for the 959 individuals served in FY 2020/21, 51.7% were males and 48.2% were females. There was one (1) person who reported Transgender.

**Figure 20**  
**Fresno County Substance Use Disorder Residential Treatment**  
*Number and Percent of Individuals Served, by Gender*  
FY 2020-21

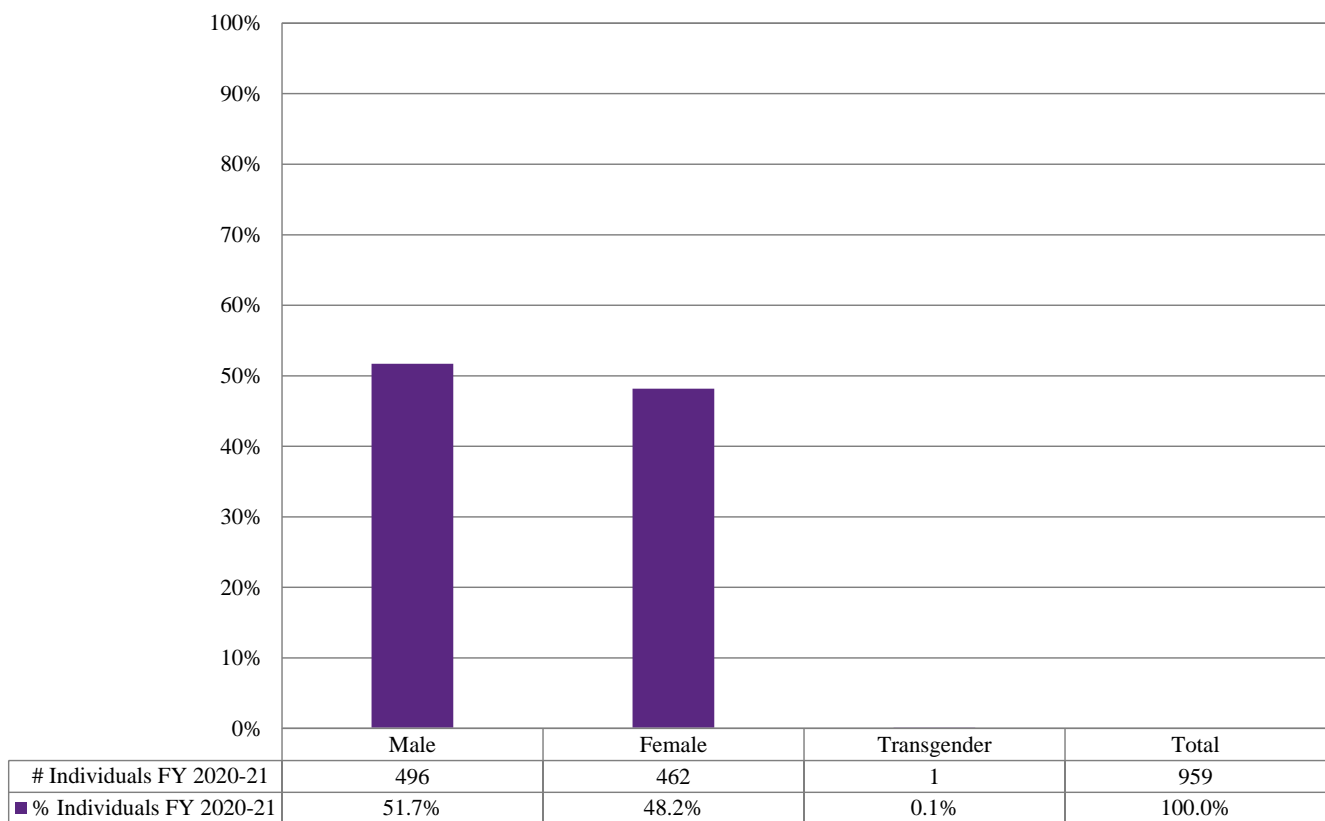
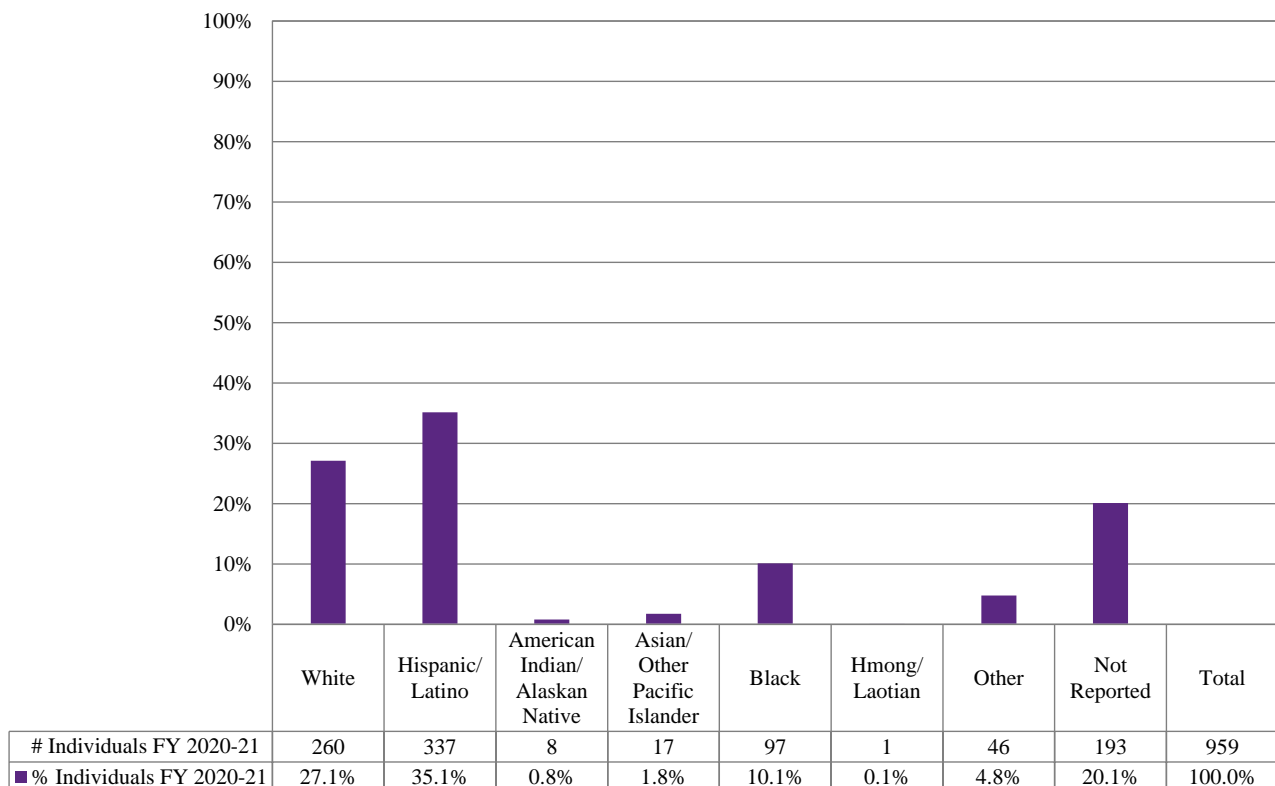


Figure 21 shows the number and percent of individuals who received one or more SUD residential treatment service by race/ethnicity for FY 2020/21. This data is calculated from Avatar data. This Avatar data shows an **unduplicated** count of individuals served by race/ethnicity for FY 2020/21. Each individual received one or more residential treatment service in FY 2020/21.

This data shows that for FY 2020/21, of the 959 individuals receiving SUD residential treatment services, 27.1% are White; 35.1% are Hispanic/Latino; 0.8% are American Indian/Alaskan Native; 1.8% are Asian/Other Pacific Islander; 10.1% are Black; 4.8% Other; and 20.1% (193) were not reported.

**Figure 21**  
**Fresno County Substance Use Disorder Residential Treatment**  
*Number and Percent of Individuals Served, by Race/Ethnicity\*\**  
FY 2020-21



\*\* Race/Ethnicity was not collected in Avatar for a portion of the fiscal year.

Figure 22 shows the number and percent of individuals who received one or more SUD residential treatment service by Primary Language for the FY 2020/21. Data is shown for FY 2020/21. This data is calculated from Avatar data. This Avatar data shows an **unduplicated** count of individuals served by Primary Language for FY 2020/21. Each individual that received one or more services between July 1, 2020 through June 30, 2021 is counted once.

This data shows that 87.8% of individuals served speak English; 8.7% speak Spanish, 0.2% speak Hmong/Lao; 0.3% reported that they speak a different language; and 3.0% were Not Reported.

**Figure 22**  
**Fresno County Substance Use Disorder Residential Treatment**  
**Number and Percent of Individuals Served, by Primary Language**  
**FY 2020-21**

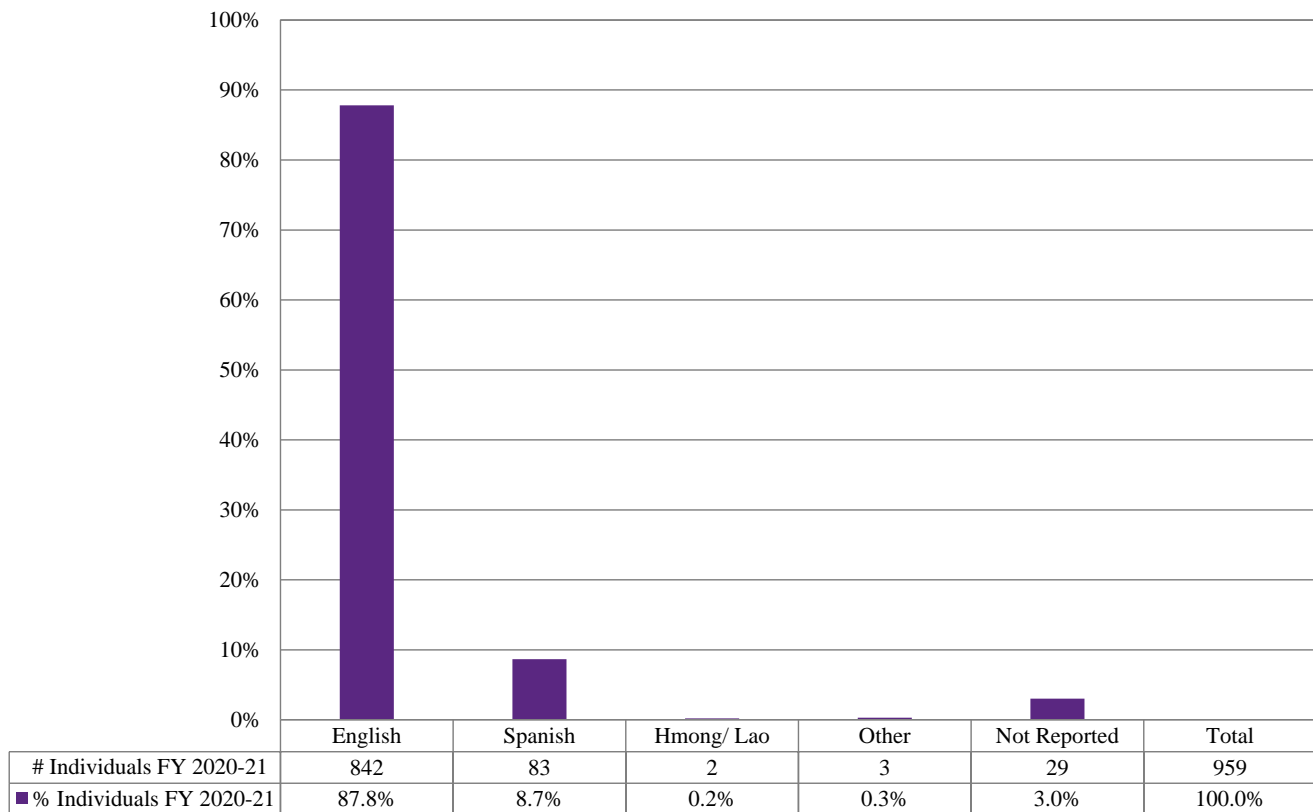
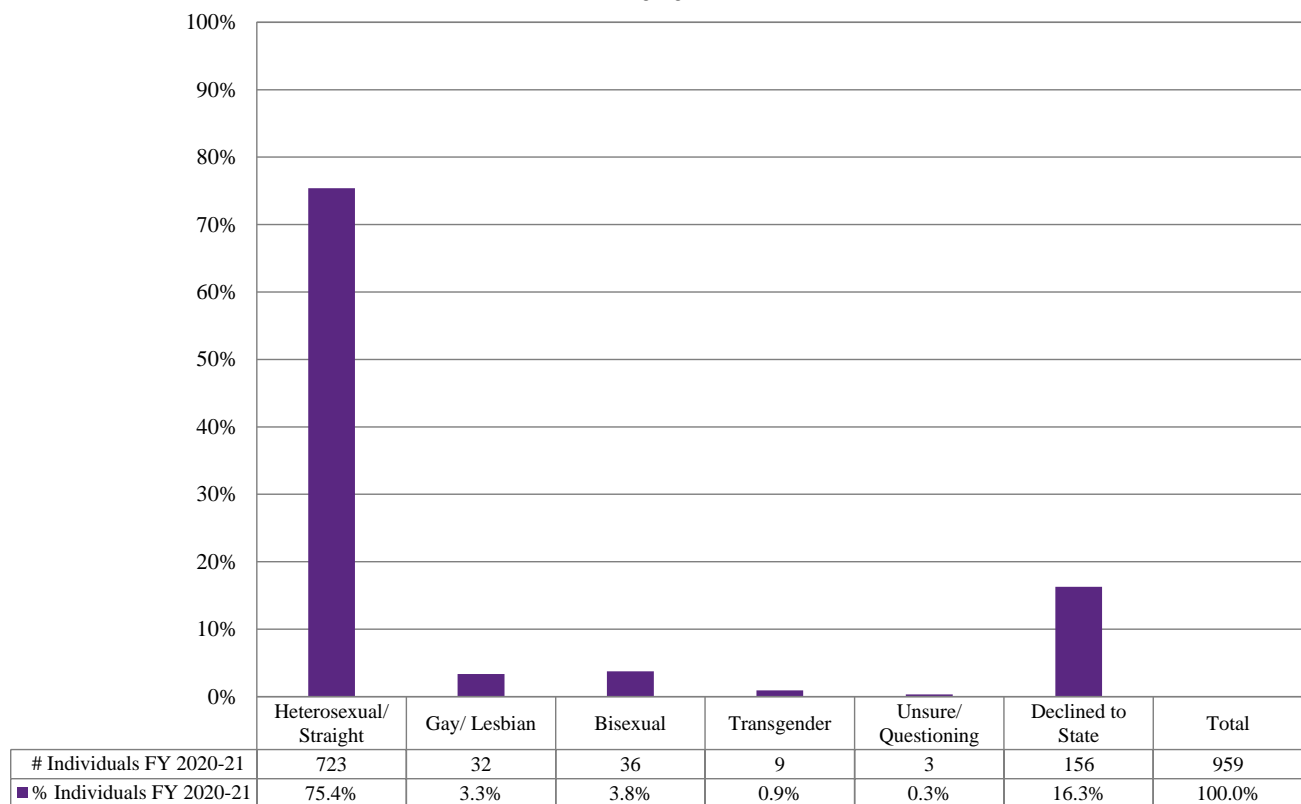


Figure 23 shows the number and percent of individuals who received one or more SUD residential treatment service by Sexual Identity for FY 2020/21. This data is calculated from Avatar data. This Avatar data shows an **unduplicated** count of individuals that received SUD residential services by Sexual Identity. Each individual received one or more services for FY 2020/21.

This data shows that 75.4% of individuals served identified as Heterosexual/ Straight; 3.3% identified as Gay or Lesbian; 3.8% identified as Bisexual; 0.9% identified as Transgender; 0.3% identified as Unsure/Questioning, and 16.3% Declined to Answer.

**Figure 23**  
**Fresno County Substance Use Disorder Residential Treatment**  
*Number and Percent of Individuals Served, by Sexual Identity*  
FY 2020-21





## 7. Utilization of SUD Residential Treatment Services

Figure 24 shows the number and percent of days that substance use disorder individuals served accessed 3.1 residential services, 3.5 residential services, and withdrawal management services in FY 2020/21. There were 42,119 total days of services delivered to substance use disorder individuals, with 22,130 days of residential 3.1 (52.5%), 19,012 days of 3.5 residential (45.1%), and 977 days of withdrawal management (2.3%).

**Figure 24**  
**Fresno County Substance Use Disorder Residential Treatment**  
*Number and Percent of Days*  
FY 2020-21

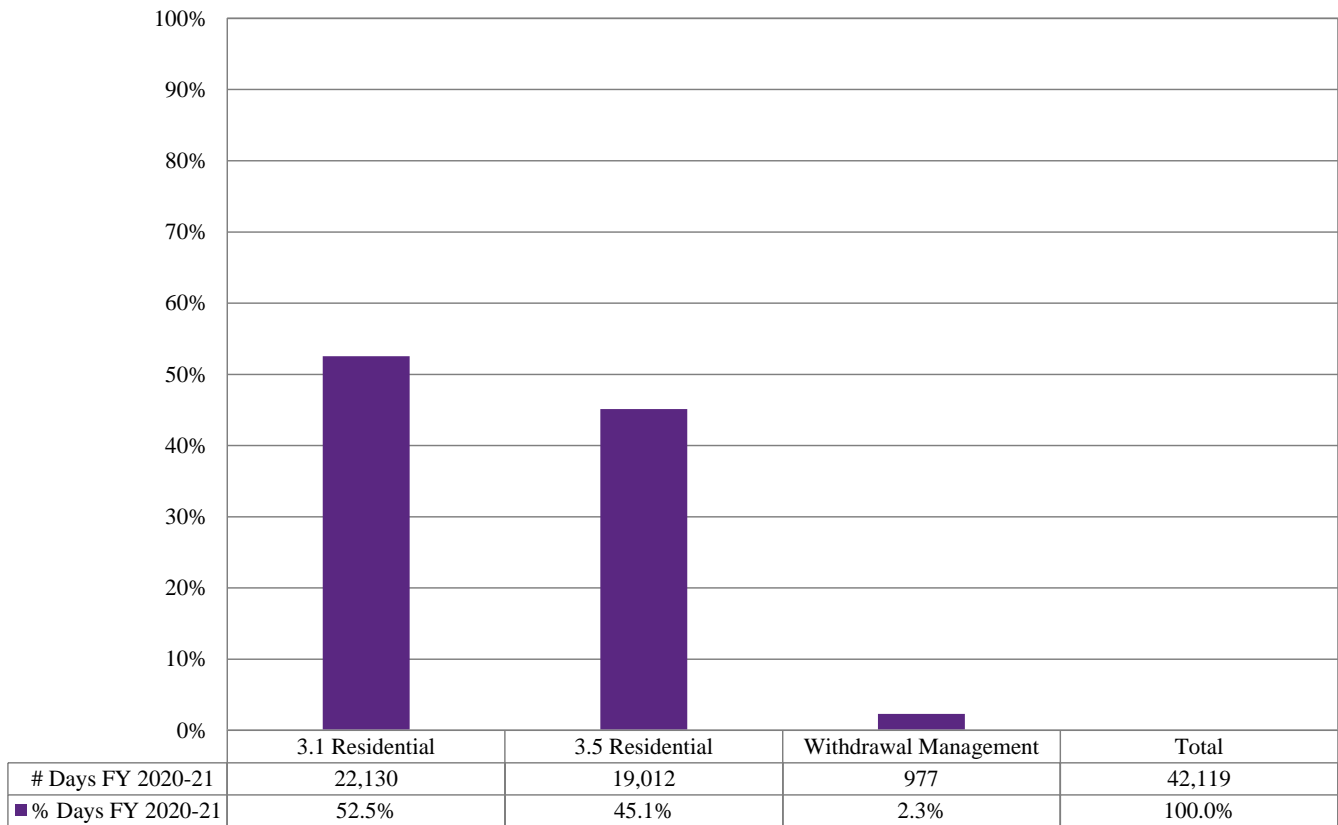


Figure 25 shows the number and percent of individuals served who received 3.1 residential services, 3.5 residential services, and withdrawal management services for FY 2020/21. Data is shown for each individual that received one or more service in FY 2020/21. There were 959 individuals who receive SUD residential services, with 529 individuals that received 3.1 residential (55.2%), 414 individuals that received 3.5 residential (43.2%), and 148 individuals that received withdrawal management services (15.4%).

**Figure 25**  
**Fresno County Substance Use Disorder Residential Treatment**  
***Number and Percent of Individuals Served***  
FY 2020-21

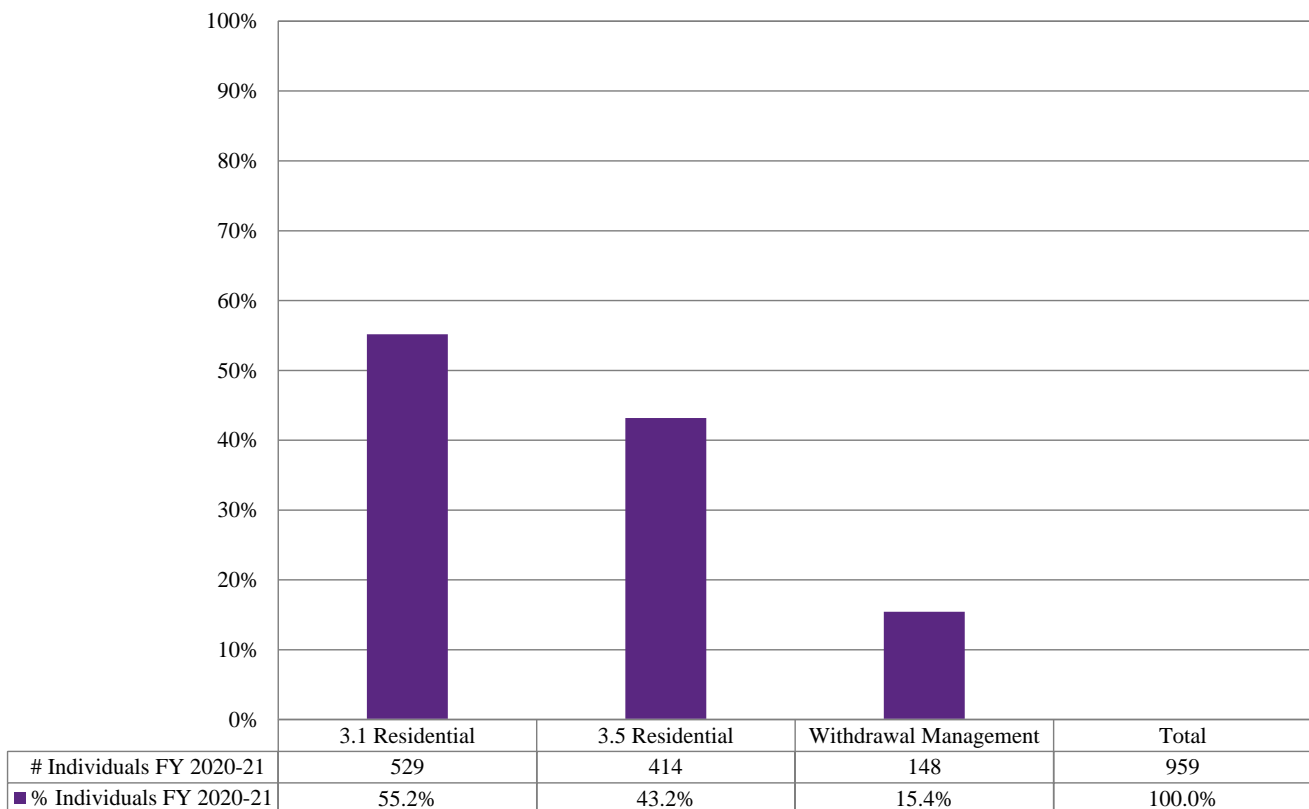
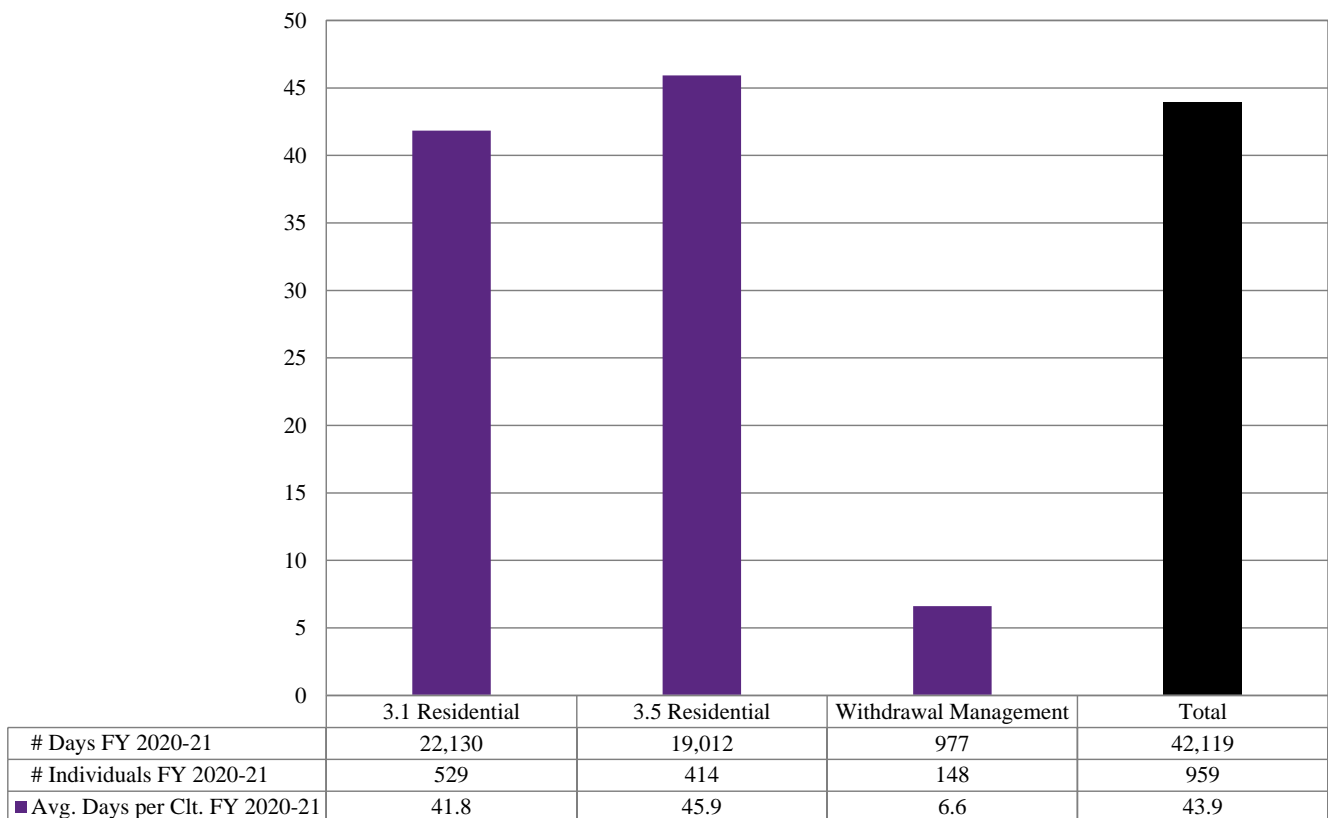


Figure 26 shows the number and percent of days, individuals served, and average days per individual served in residential treatment services for FY 2020/21. There were 959 individuals served. These individuals received a total of 42,119 days of service, which calculates to an average of 43.9 days per client. There were 529 individuals that received 22,130 days of 3.1 residential services (41.8 days per individual); 414 individuals that received 19,012 days of 3.5 residential service (45.9 days per individual); and 148 individuals that received 977 days of withdrawal management services (6.6 days per person).

**Figure 26**  
**Fresno County Substance Use Disorder Residential Treatment**  
***Number and Percent of Days, Individuals Served, and Average Days per Individual Served***  
**FY 2020-21**



## 8. Analysis of the Population Assessment and Utilization Data, and Conclusions Drawn

The FY 2020/21 data was only recently available and analyzed. The CHC will review the SUD population data and develop recommendations in the next six months. This will allow the CHC to better understand the service utilization data and make recommendations for enhancing services.

### **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***

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. The DBH will continue to identify opportunities to expand the workforce to meet the needs of our cultural communities. The Central Regional Workforce Education and Training (WET) plan partnership is seeking to expand efforts to increase bilingual and bicultural persons into the BHSOC.

DBH also 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, including developing Wellness and Recovery Plans (WRAP) to support recovery.

DBH also has a full range of services for children, transition age youth, adults, and older adults. We 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.

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
- Identify opportunities to hire bilingual, bicultural case managers and rehab specialists, as well as persons with lived experience and family members
- Analyze 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
- 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 with 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 treatment plans written in the individual's preferred language, whenever possible
- Provide training to staff to deliver innovative, evidence-based, 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.

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. 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](http://www.DBHespanol.com) and is working on a similar Hmong page.

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 regularly updated and posted on the DBH website.

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 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 (Avatar), 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 departments, 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 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.

The New 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 client and/or family member during services.

**Objective:** In FY 2019/20, BHSOC is updating the process for assessing both county staff, and organization provider's staff, regarding ethnicity and culturally sensitivity, by function. 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 Culturally Humility Committee (CHC) is collecting information from Human Resources on an aggregate basis, to provide race/ethnicity summary data on DBH staff who are in direct service provider classifications. This information will be available on a summary level basis to show the number of direct service staff that interact with individuals served. In addition, this information will also be reported for all other staff by race/ethnicity. In conjunction, the CHC will be collecting aggregate information from the DBH Workforce Language and Bilingual Pay Survey to provide summary data on DBH direct service staff to show the number of direct services staff that speak, read, and write fluently in a language other than English; the number who receive bilingual pay; and how many are interested in becoming bilingual proficient in their second language. This information will help determine estimates of need to match with individuals receiving services to assess the need for hiring additional staff to meet the needs of different cultures and preferred language. Each person's ability to write in their language will also be documented, to understand the capacity to write Treatment Plans in the person's

preferred language. The CHC will review this information and recommend strategies for addressing any identified issues.

***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 related to cultural issues. The QIC reviews all issues and determines if the resolution was culturally appropriate. The QIC and CHC will work together to identify additional issues and objectives to help improve services during the coming year. The QIC and CHC will share data, whenever feasible, to provide a consistent foundation of information across the service system.

## **IV. STAFF AND SERVICE PROVIDER ASSESSMENT**

### ***A. Current Staff Composition***

#### **1. Ethnicity by Function**

The Cultural Humility Committee (CHC) 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. The 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.

#### **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 2019/20, the Language subcommittee has continued its work to examine the designation and certification of bilingual staff. DBH has 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.

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 Language Subcommittee has also recommended starting a Language Services Committee, to provide support to persons who serve as interpreters. This committee would 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 Services Committee will help provide consistency of interpreting across both interpreters and staff who use interpreters. In addition, a dictionary of key terms will be developed and posted on the website to be shared across the county.

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 to support the Language Services 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 reviewing translated materials for accuracy.



### **3. Staff and Volunteer Cultural Humility Survey**

In an effort to assess the cultural responsiveness of our workforce, we asked staff and volunteers to complete the Staff and Volunteer Cultural Humility Survey in March 2021. The complete results are shown in Attachment E.

There were 494 staff who completed the survey. Of these individuals, 41% were county staff, 57% were contract provider staff, and less than 2% were volunteers. 57% were direct service/clinical/case management staff, 16% were administration/clerical staff who do *not* routinely interact with persons served, 12% were administration/clerical staff who *do* routinely interact with persons served, and 15% were management staff. The survey in the coming year will be expanded to help identify those who are working as peers or persons with lived experience.

Of the individuals who completed the survey, the breakdown of staff by department/program is as follows: 25% from Children's Mental Health, 31% from Contracted Providers, 14% from the Adult System of Care, 9% from Administration, 3% from Finance/Accounting/Business Office, 6% from Managed Care, 3% from ISDS/Quality Improvement/Medical Records, 1% from Compliance, 6% from Public Health, and 2% from 'Other.'

Of these survey respondents, 50% were Hispanic, 25% were White, 16% were Asian, 5% were Black, 1% were Native Hawaiian or Other Pacific Islanders, 1% were American Indian/Alaska Native, 1% were Middle Eastern, and 1% identified as 'Other.' Seventy-four percent (74%) of staff identify as Female, 25% identify as Male, 1% identify as Genderqueer, 0.2% identify as Transgender, and 0.2% identify as 'Other.' For sexual orientation, 91% of staff identified as Heterosexual, 4% as Gay or Lesbian, 3% as Bisexual, 1% as Queer, 1% identify as Questioning, and 0.5% as 'Other.'

Forty-six (46%) were bilingual, with 71% speaking Spanish, 18% speaking Hmong, 4% speaking Punjabi, and 12% speaking another language. Staff may speak more than one language other than English. Of the staff who identified as bilingual, 61% acted as an interpreter as a part of their job function, and 26% received bilingual pay.

Seven percent (7%) of staff reported that they had a disability. Fifty-nine percent (59%) of staff identified as a person with lived Mental Health experience, and 77% reported having a family member with lived Mental Health experience. Fourteen percent (14%) of staff identified as a person with lived substance use disorder experience, and 53% 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 those questions where the responses were “**Rarely or Never**” or “**Did Not Occur to Me.**” Those will be briefly outlined below.

**Across all staff:**

*I have developed skills to utilize an interpreter effectively.*

- Rarely or Never (27%)
- Did not Occur to Me (9%)

*I attempt to learn a few key words in the client’s primary language (e.g., “Hello, Goodbye, Thank you,” etc.)*

- Rarely or Never (18%)
- Did not Occur to Me (5%)

*I develop materials in a manner that can be easily understood by clients and family members.*

- Rarely or Never (14%)
- Did not Occur to Me (4%)

*I intervene, in an appropriate manner, when I observe other staff exhibit behaviors that show cultural insensitivity or prejudice.*

- Rarely or Never (14%)
- Did not Occur to Me (5%)

**Across staff who are White:**

*I have developed skills to utilize an interpreter effectively.*

- Rarely or Never (23%)
- Did not Occur to Me (3%)

*I attempt to learn a few key words in the client’s primary language (e.g., “Hello, Goodbye, Thank you,” etc.).*

- Rarely or Never (22%)
- Did not Occur to Me (3%)

*I develop materials in a manner that can be easily understood by clients and family members.*

- Rarely or Never (13%)
- Did not Occur to Me (3%)

**Across staff who are Hispanic:**

*I have developed skills to utilize an interpreter effectively.*

- *Rarely or Never (33%)*
- *Did not Occur to Me (12%)*

*I intervene, in an appropriate manner, when I observe other staff exhibit behaviors that show cultural insensitivity or prejudice.*

- *Rarely or Never (16%)*
- *Did not Occur to Me (6%)*

*I attempt to learn a few key words in the client's primary language (e.g., "Hello, Goodbye, Thank you," etc.).*

- *Rarely or Never (16%)*
- *Did not Occur to Me (4%)*

**Across all other staff ethnicities:**

*I have developed skills to utilize an interpreter effectively.*

- *Rarely or Never (22%)*
- *Did not Occur to Me (8%)*

These results indicate a need for further staff training, especially for utilizing an interpreter. This provider training would help people who utilize an interpreter to understand how to speak slowly, with frequent pauses, so the interpreter can translate each sentence accurately. In addition, it is important for the provider to maintain eye contact with the individual served, rather than with the person interpreting. Learning the optimal seating location during a treatment session assists this goal, by having the interpreter sit behind the individual served, rather than side-by-side. By sitting behind the individual served, the provider delivering treatment can look directly at the individual and maintain eye contact, while speaking directly to the individual. The interpreter is simply the 'voice' of the individual and the provider.

***B. Analyze Staff Disparities and Related Objectives***

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

## **V. CLIENT 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 Cultural Humility Survey and Family/Caregiver Cultural Humility Survey in January 2021. In total, 1,368 surveys were completed by individuals served and family member/caregivers. The complete results for both surveys are shown in Attachments F and G.

### ***B. Client Cultural Humility Survey Results***

For the 1,019 individuals served who completed the Client Cultural Humility Survey, 33% were children and TAY ages 12 – 25; 59% were adults ages 26 – 59, and 8% were older adults, ages 60 and over. Fifty percent (50%) of survey respondents reported their race/ethnicity as Hispanic/Latino; 20% as White; 11% as Black; 13% as Asian; 3% as American Indian or Alaska Native; and 0.2% as Native Hawaiian or Other Pacific Islander. Three percent (3%) of survey respondents reported their race/ethnicity as ‘Other.’

Eighty-three percent (83%) of survey respondents’ primary language is English. Ten percent (10%) reported their primary language as Spanish; 6% as Hmong; 0.4% as Punjabi; and 1% as ‘Other.’

For sexual orientation, 82% of respondents identified as Heterosexual/Straight; 9% Bisexual; 3% Gay or Lesbian; 1% Questioning; 0.6% Queer; and 5% as ‘Other.’ Forty-six percent (46%) of survey respondents identified as Female; 50% Male; 1% Transgender; 1% Questioning; 1% Genderqueer; and 1% ‘Other.’ Ninety-six percent (96%) of respondents reported not being involved with the military. Fifty-three percent (53%) 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 “**Disagree.**” Those will be briefly outlined below.

#### **Across all Respondents:**

*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. (8%)*

*Some of the treatment staff are from my racial or ethnic group. (9%)*

*The facility has pictures or reading material that show people from my racial or ethnic group. (11%)*

### ***C. Family/Caregiver Cultural Humility Survey Results***

For the 349 individuals who completed the Family/Caregiver Cultural Humility Survey, 25% were children ages 0 – 11, 30% were TAY ages 12 – 25, 33% were adults ages 26 – 59, and 12% were older adults, ages 60 and over. Forty-eight percent (48%) of survey respondents reported their race/ethnicity as Hispanic/Latino; 24% as White; 9% as Black; 16% as Asian; and 1% as American Indian or Alaska Native. Two percent (2%) of survey respondents reported their race/ethnicity as ‘Other.’

Seventy-three percent (73%) of survey respondents’ primary language is English. Fourteen percent (14%) reported their primary language as Spanish; 12% as Hmong; 0.3% as Punjabi; and 1% as ‘Other.’

For sexual orientation, 91% of respondents identified as Heterosexual/Straight; 3% Bisexual; 2% Gay or Lesbian; 3% Questioning; and 1% as ‘Other.’ Fifty-one percent (51%) of survey respondents identified as Female; 47% Male; 1% Transgender; 1% Questioning; and 0.3% ‘Other.’ Ninety-nine percent (99%) of respondents reported not being involved with the military. Forty-six percent (46%) 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 “**Disagree.**” Those will be briefly outlined below.

#### **Across all Respondents:**

*Some of the treatment staff are from my family member’s racial or ethnic group. (6%)*

*The facility has pictures or reading material that show people from my racial or ethnic group. (7%)*

### ***D. Analyze Disparities and Related Objectives***

Survey results will be analyzed and shared with the CHC to help identify new strategies and goals.

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

Both the Client Cultural Humility Survey and Family/Caregiver Cultural Humility Survey were translated into the two threshold languages for Fresno County, Spanish and Hmong. The CHC identified the need to improve the quality these translated surveys, to ensure that the translations are accurate and culturally sensitive. In FY 2019/20, the Language Committee obtained feedback from a group of bilingual staff and consumers to review the accuracy of the Spanish and Hmong translations of the Client and Family/Caregiver Cultural Humility Survey. The recommendations made by these individuals were incorporated into the 2021 Client and Family/Caregiver Cultural Humility Survey.

## **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. In addition, BHSOC will require county staff and contracted direct service providers to complete a minimum of eight (8) hours of additional cultural competency training per fiscal year.

### ***A. Rationale for the Cultural Competency Trainings***

Racial and ethnic disparities in BHSOC services had 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 Native American, 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 CHC will discuss and recommend opportunities for identifying additional trainings.

### ***B. Training Participation***

This section describes cultural responsiveness and humility trainings for staff and providers, including training in the use of interpreters, in FY 2020/21.

Fresno County has funded a Mental Wealth Series, which is a community mental health literacy within local African American Faith groups, as a way to build up mental health literacy, and will be tied to some future initiatives.

Also note in the coming year there is work planned for several sessions of #Out4MentalHealth. Working to develop several internal DEI Champions who will then train in DEI concepts and then work to help implement those practices and infuse it in our organization's culture. Fresno County will be one of three counties that will be part of the learning pilot of the Solano County projected called the Interdisciplinary Collaboration Cultural Transformation Model.

DBH is also in the process to develop a Fresno-Centric LGBTQ-BIPOC training to help improve equity and responsiveness of services for those intersectionalities.

Trainings are also being explored in a collaborative effort with two other counties for training in provider equitable and responsive care to Indigenous communities from Southern Mexico and Central America.

***C. Core Cultural Competency Trainings in FY 2020/21***

<b>Title of Training / Event / Conference</b>	<b>Number of Participants</b>
Health Equity & Multicultural Diversity Training	337
Introduction & Implementation of Cultural Responsiveness (IICR)	192
Behavioral Health Interpreter Training (BHIT) Interpreter Trainings	9
Behavioral Health Interpreter Training (BHIT) Providers Trainings	55
Using Communication Strategies to Bridge Cultural Divides (Relias)	139
Your Role in Workplace Diversity (Relias)	64

***D. Additional Cultural Competency Trainings in FY 2020/21***

<b>Title of Training / Event / Conference</b>	<b>Number of Participants</b>
Best Practices for Working with LGBTQ Children and Youth	5
Bridging the Diversity Gap (Relias)	360
Cultural Competence (Relias)	53
A Culture-Centered Approach to Recovery (Relias)	1
Behavioral Health Services and the LGBTQ+ Community (Relias)	37
Building a Multicultural Care Environment (Relias)	1
Cultural Competence and Sensitivity in the LGBTQ Community - California (Relias)	2
Diversity, Equity, Inclusion, Training (DEIT)	94
How Culture Impacts Communication (Relias)	2

<b>Title of Training / Event / Conference</b>	<b>Number of Participants</b>
Substance Use Disorder Treatment and the LGBTQ Community - Retired 10/2/2021 (Relias)	1
The Role of the Behavioral Health Interpreter (Relias)	1
Working More Effectively with the LGBTQ+ Community (Relias)	1
2020 PSI - Postpartum Support International – Virtual Conference	3
Gender Spectrum Professionals’ Symposium	1
NCCHC Correctional Mental Health Care Conference	3
10th Annual Evidence-Based Practices Symposium (CIBHS) Building a Life Beyond Homelessness	9
CIT2020: A Virtual Conference	5
Relias Impact Nation 2020	2
16th Annual TCOM Conference	2
California Pan-Ethnic Health Network Voices for Change: Revolutionizing Health Equity (conference)	3
Virtual Maternal Mental Health FORUM (conference)	1
53rd Annual Conference American Association of Suicidology AAS21	1
2021 California Health Equity Summit (CIBHS)	2
Listening, Learning, and Leading: Anti-Racism and the California Crisis Care Continuum” Conference	1

\*Adèle James Consulting designed and facilitated a two-part CLAS Standards Training for Fresno DBH staff in May and June 2020. The training was facilitated in four cohorts using Zoom, and each cohort attended two separate trainings. The training goals included the following: 1. To improve individuals served services and outcomes by identifying and implementing culturally responsive practices & procedures; 2. To increase awareness and understanding of how cultural identity can influence work with staff, individuals served, and families; and 3. To align DBH staff practices with the CLAS Standards to improve services and outcomes for individuals served. The approach to the trainings emphasized use of real-world examples, self-directed learning, and problem solving. Adèle also provided the training for REIA. The REIA cohort is now made of three groups with approximately 15-18 persons who



are working on using the REIA to address policies, contacting, program design, workforce practices, etc.

## **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 Cultural Humility Committee (CHC) will continue to meet monthly to continually identify opportunities to promote the delivery of culturally responsive services.

A Plan Do Study Act (PDSA) method is 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.

## Attachment 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.



[www.ThinkCulturalHealth.hhs.gov](http://www.ThinkCulturalHealth.hhs.gov)



## Attachment 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)

<b>CLAS Standard</b>	<b>CCPR Criteria</b>	<b>Framework Guiding Principles</b>
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)
<b>Engagement, Continuous Improvement and Accountability</b>		
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)

<b>CLAS Standard</b>	<b>CCPR Criteria</b>	<b>Framework Guiding Principles</b>
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: 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)

## 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)       | • DBH Director             | • Staff Development          |
| • Co-Chair (DSC)    | • DBH Deputy Director      | • Admin-HR                   |
| • Division Managers | • DBH Medical Staff        | • Compliance                 |
| • QI Staff          | • Sub-Committee Personnel  | • DBH Clinical Program Staff |
| • Stakeholders      | • DBH Contracted Providers | • 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 opportunities 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 recommendations 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

## **Fresno County Department of Behavioral Health**

### **Cultural Humility Committee (CHC) Charter**

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



## Attachment 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 occurring.  
*"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 isn't 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 welcoming 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 aggressor's 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 affect 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.

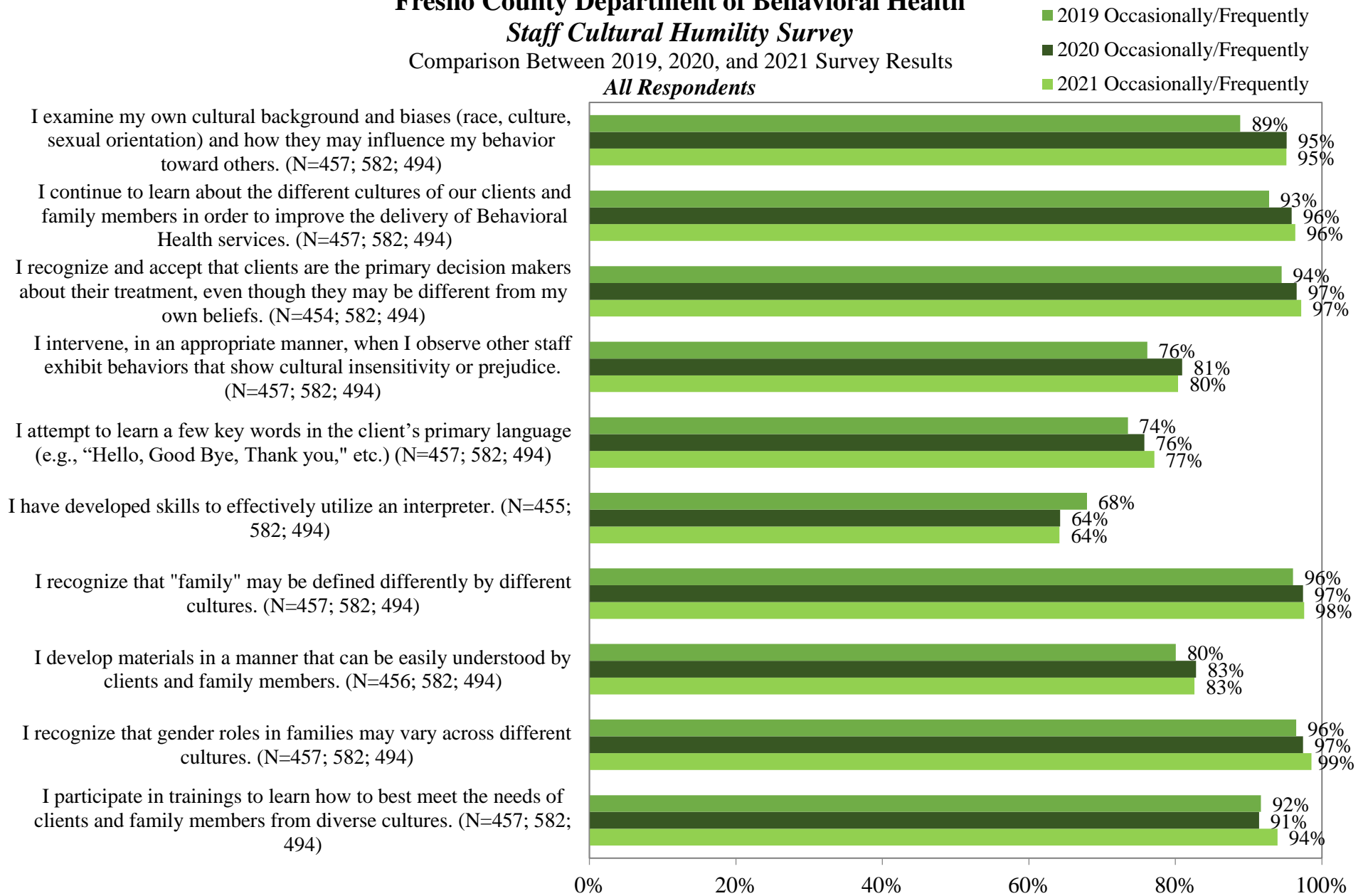


## **Attachment E: Staff and Volunteer Cultural Humility Survey Results**

## Fresno County Department of Behavioral Health Staff Cultural Humility Survey

Comparison Between 2019, 2020, and 2021 Survey Results

*All Respondents*

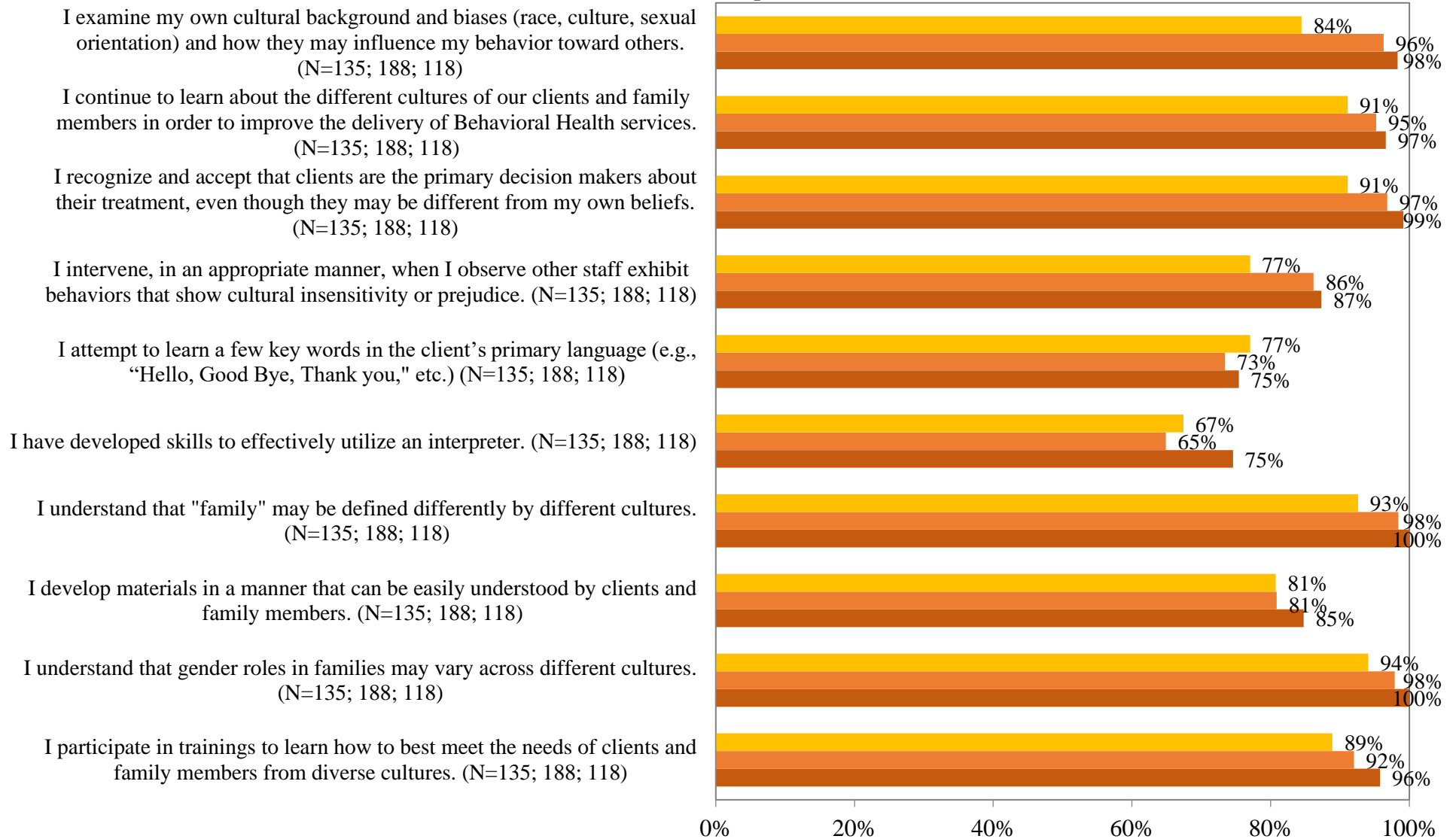


# Fresno County Department of Behavioral Health Staff Cultural Humility Survey

Comparison Between 2019, 2020, and 2021 Survey Results

## Caucasian Respondents

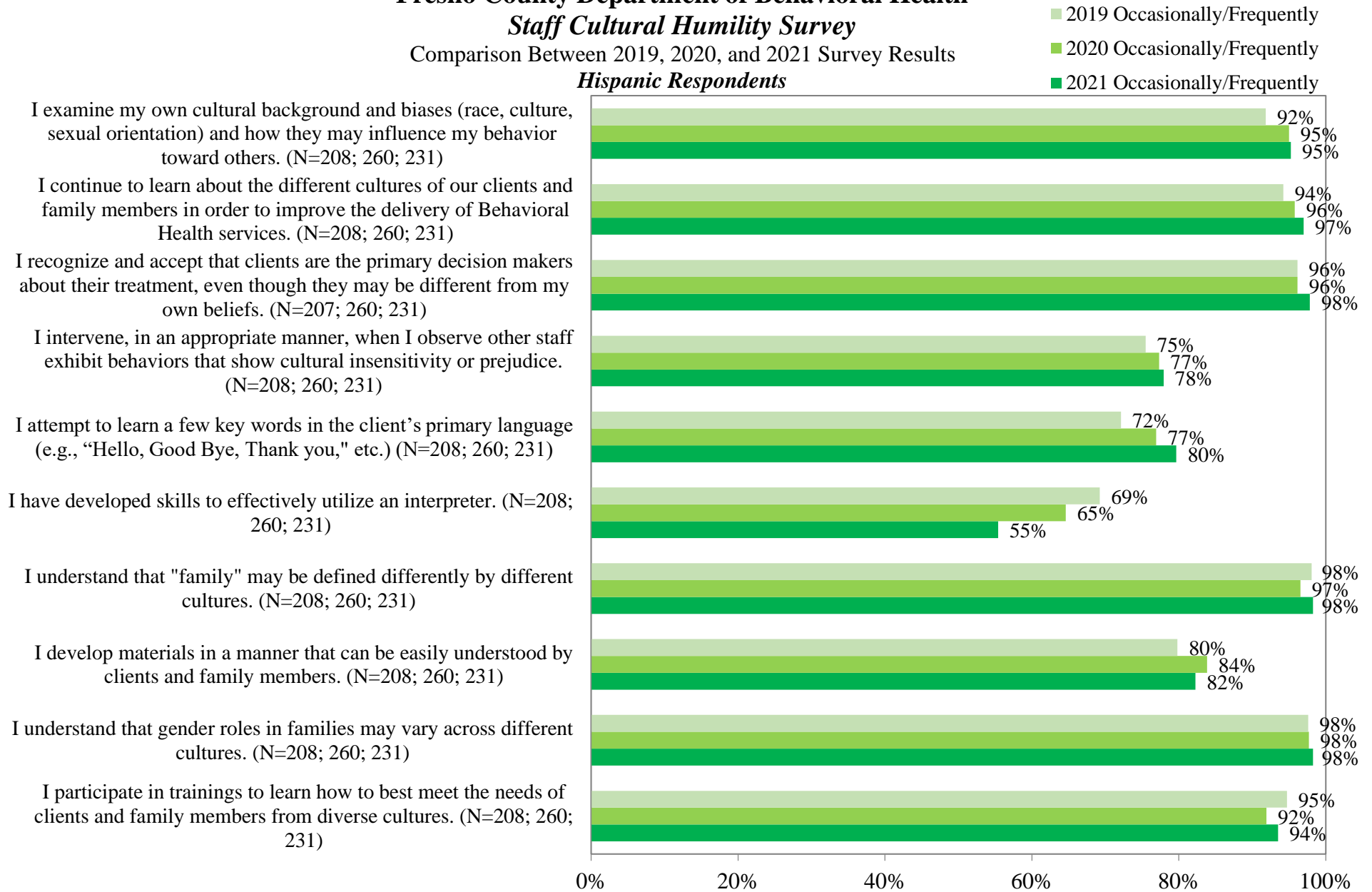
■ 2019 Occasionally/Frequently  
■ 2020 Occasionally/Frequently  
■ 2021 Occasionally/Frequently



# Fresno County Department of Behavioral Health Staff Cultural Humility Survey

Comparison Between 2019, 2020, and 2021 Survey Results

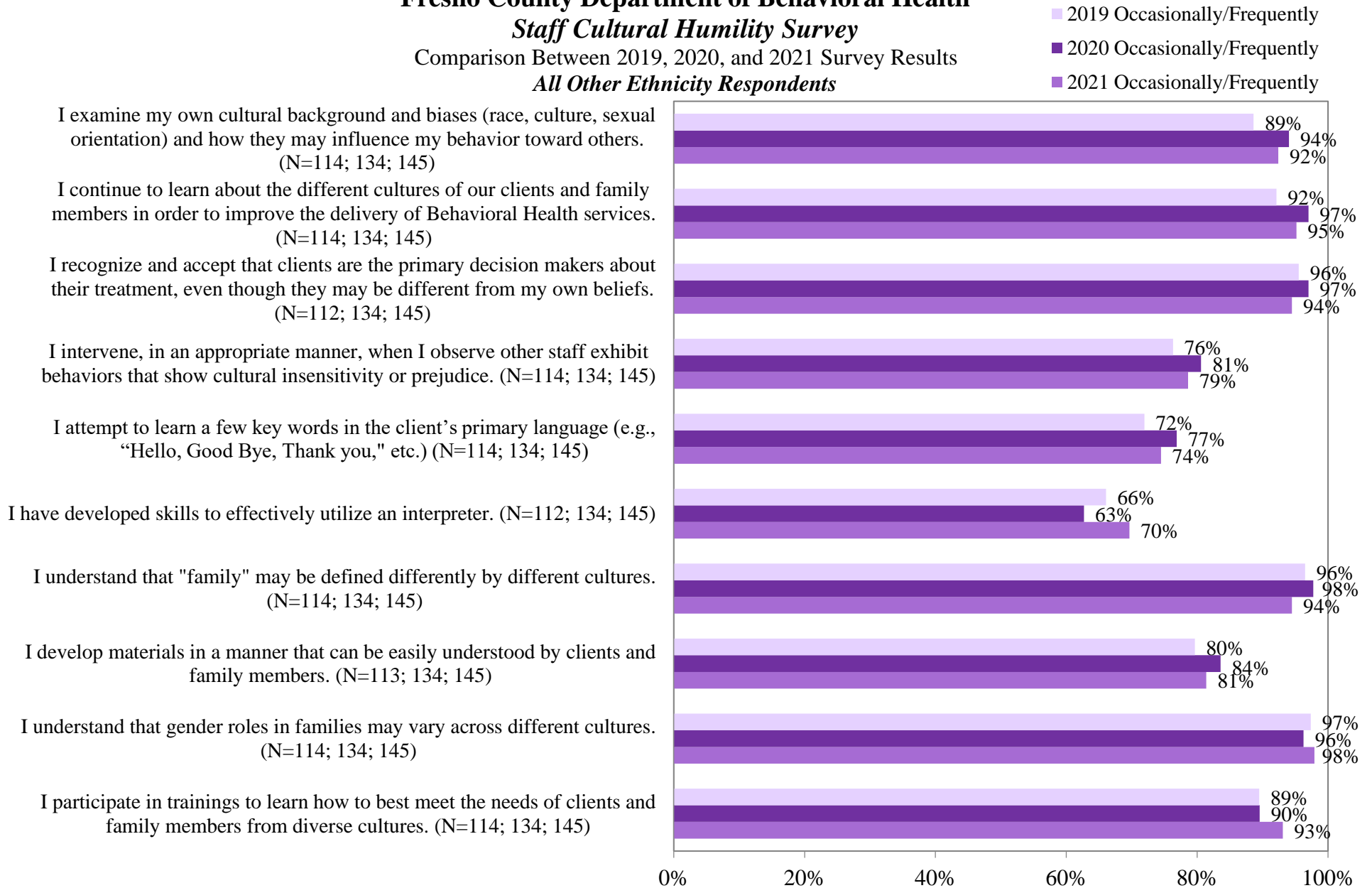
## Hispanic Respondents



# **Fresno County Department of Behavioral Health** **Staff Cultural Humility Survey**

Comparison Between 2019, 2020, and 2021 Survey Results

## ***All Other Ethnicity Respondents***



# Fresno County Department of Behavioral Health

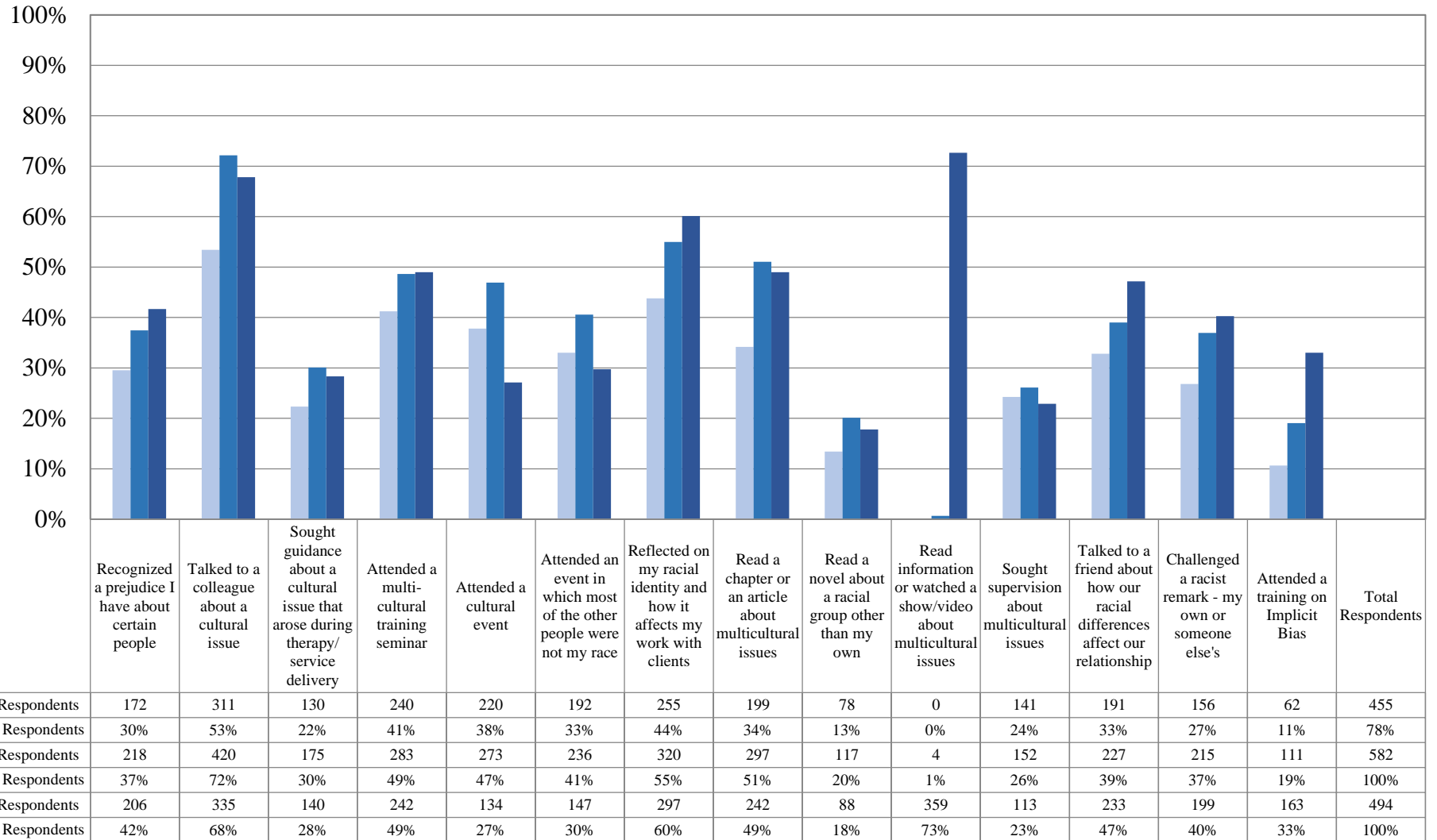
## Staff Cultural Humility Survey

Comparison Between 2019, 2020, and 2021 Survey Results

*Participation in Professional Development Activities (Past Six Months)*

**2019 All Respondents (N=455)    2020 All Respondents (N=582)    2021 All Respondents (N=494)**

*(Respondents may choose multiple answers.)*

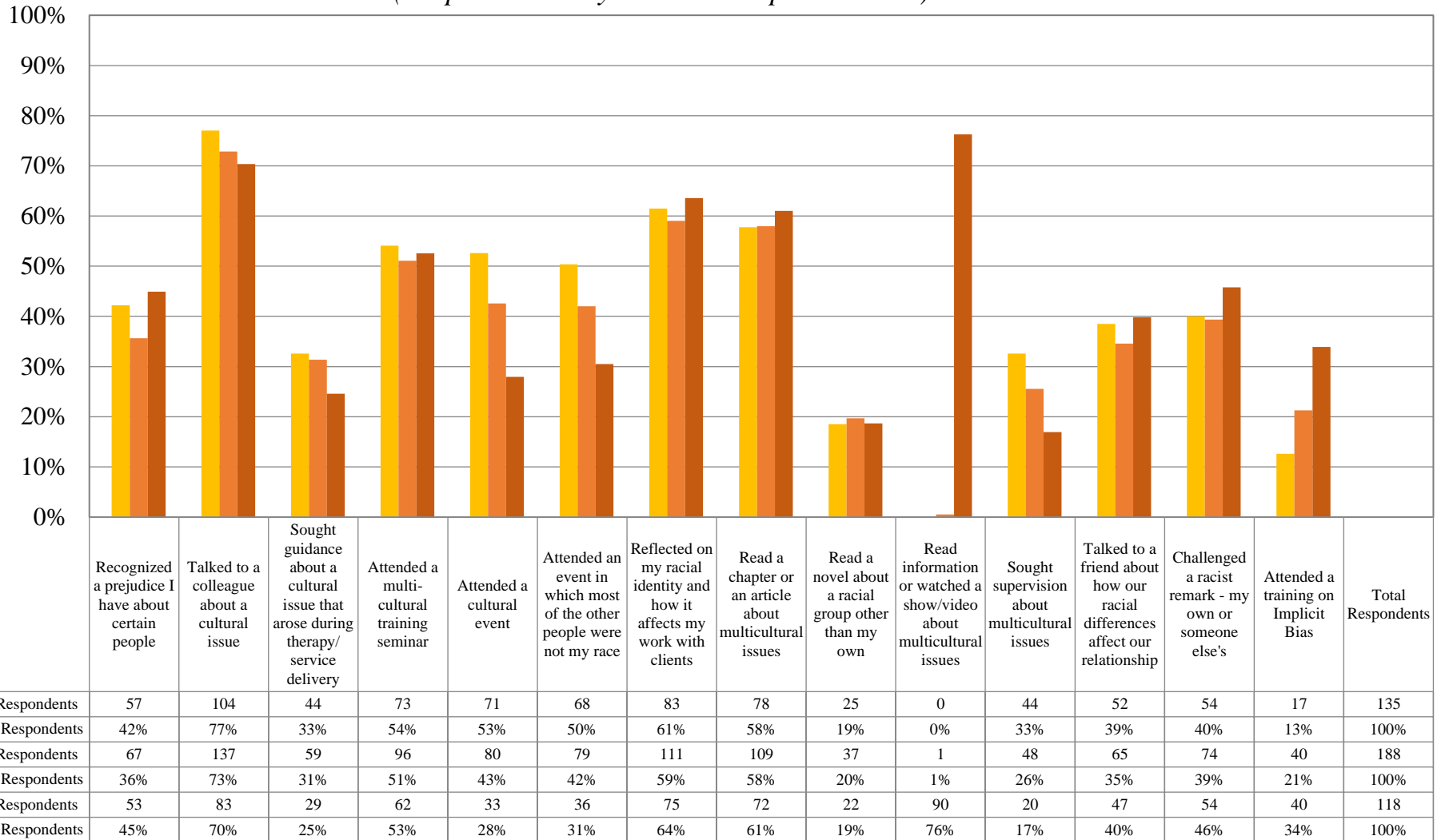


**Fresno County Department of Behavioral Health**  
**Staff Cultural Humility Survey**

Comparison Between 2019, 2020, and 2021 Survey Results

*Participation in Cultural Awareness Activities (Past Six Months)*

**2019 Caucasian Respondents (N=135)    2020 Caucasian Respondents (N=188)    2021 Caucasian Respondents (N=118)**  
*(Respondents may choose multiple answers.)*



# Fresno County Department of Behavioral Health

## Staff Cultural Humility Survey

Comparison Between 2019, 2020, and 2021 Survey Results

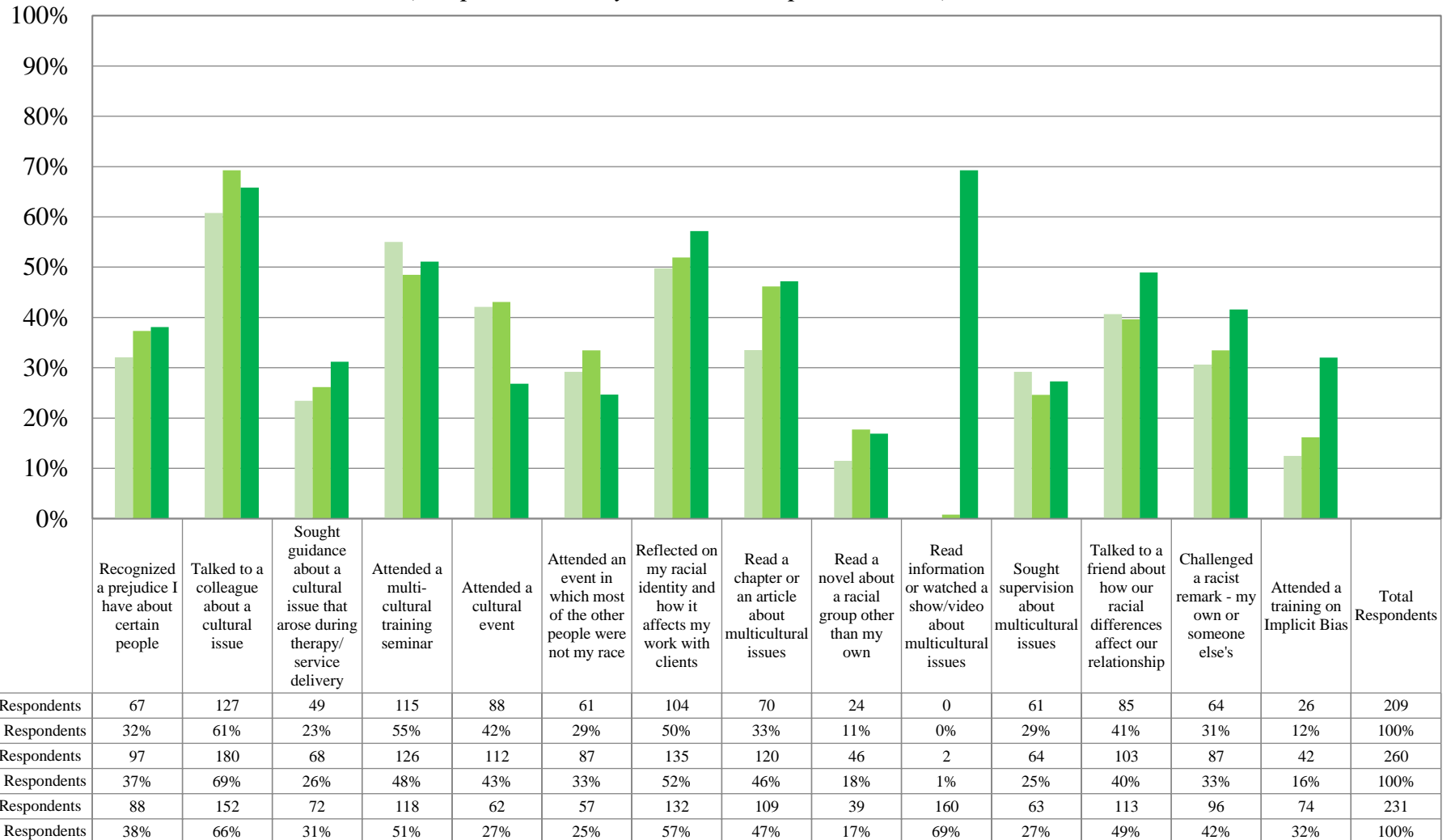
### Participation in Cultural Awareness Activities (Past Six Months)

2019 Hispanic Respondents (N=209)

2020 Hispanic Respondents (N=260)

2021 Hispanic Respondents (N=231)

(Respondents may choose multiple answers.)



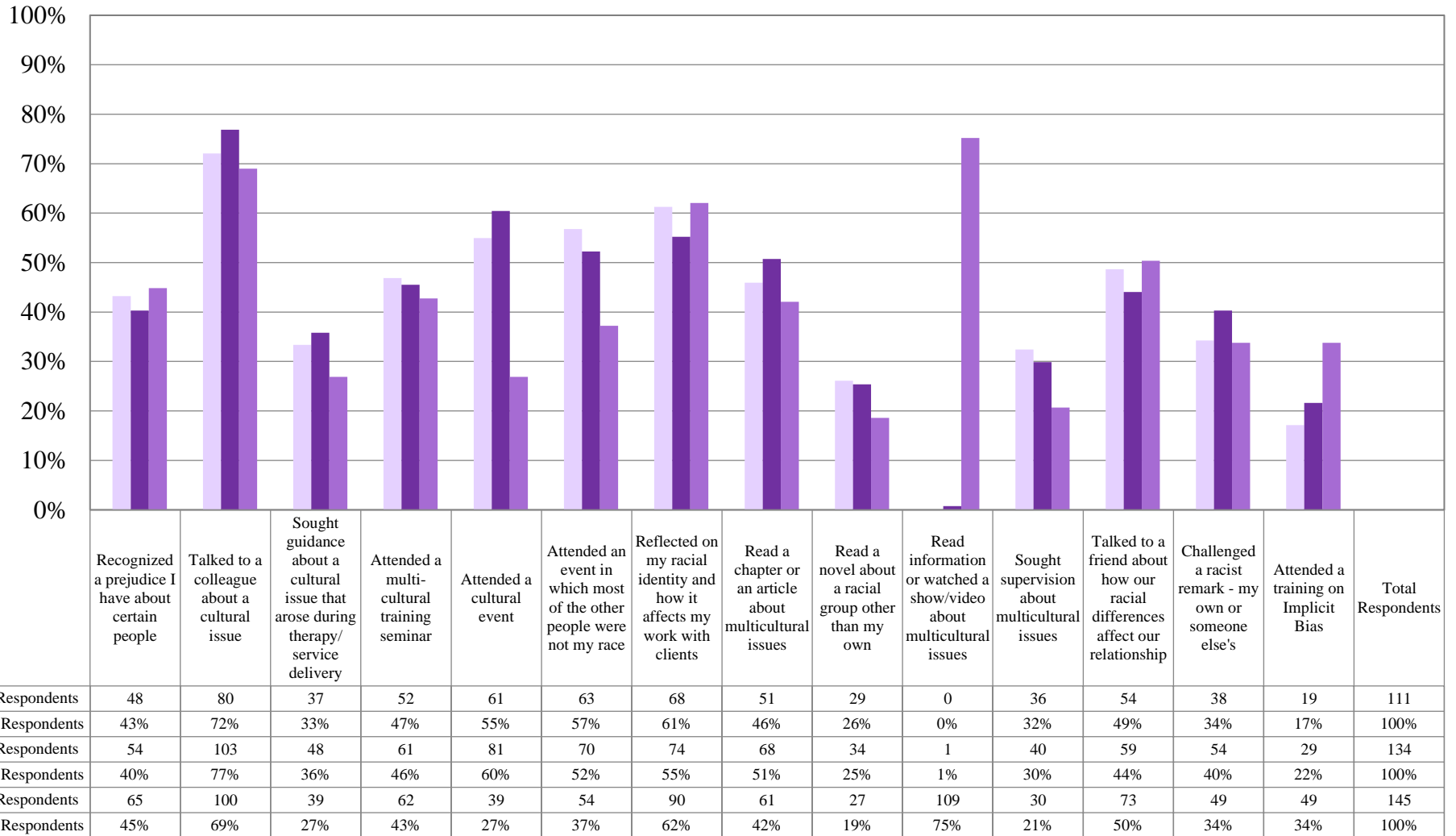


**Fresno County Department of Behavioral Health**  
**Staff Cultural Humility Survey**

Comparison Between 2019, 2020, and 2021 Survey Results

*Participation in Cultural Awareness Activities (Past Six Months)*

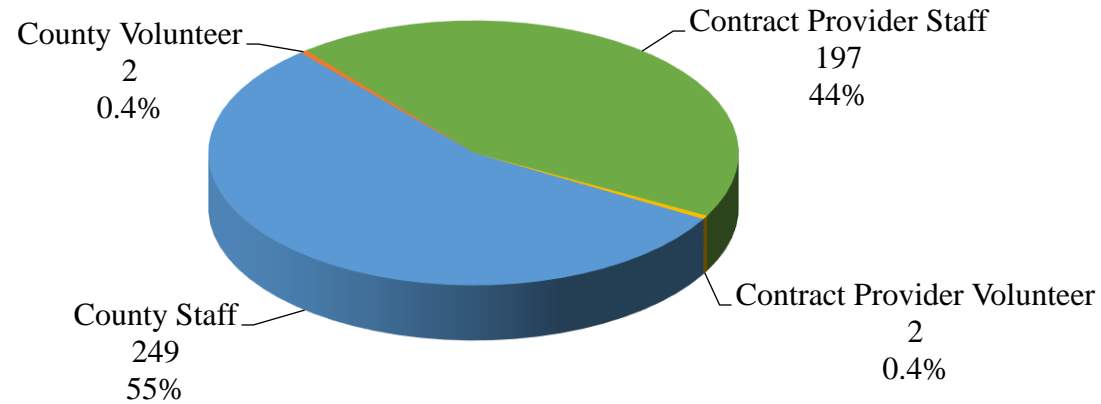
**2019 Other Ethnicity Respondents (N=111)    2020 Other Ethnicity Respondents (N=134)    2021 Other Ethnicity Respondents (N=145)**  
*(Respondents may choose multiple answers.)*



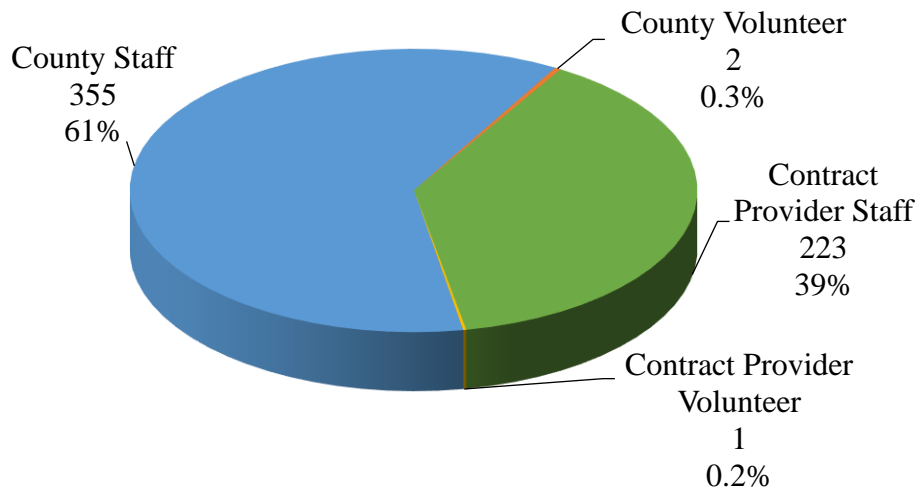
# Fresno County Department of Behavioral Health Staff Cultural Humility Survey

Comparison Between 2019, 2020, and 2021 Survey Results

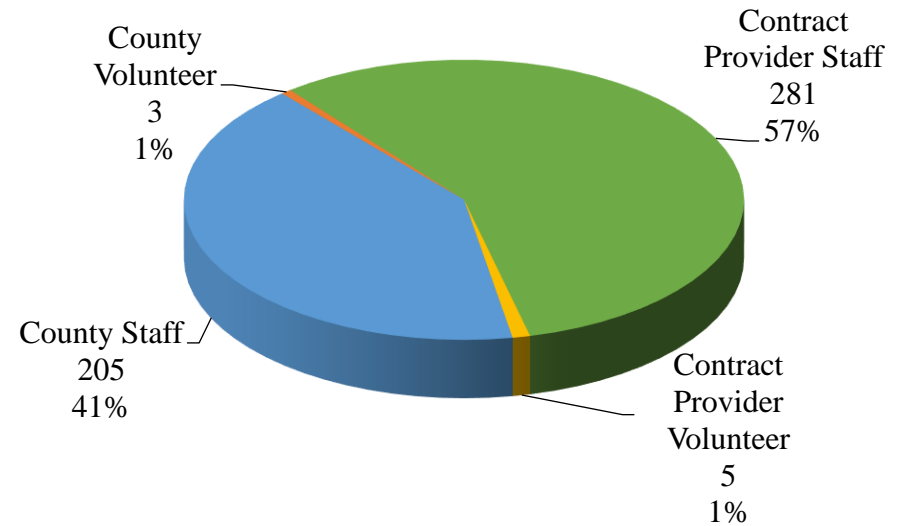
**2019 Employment Status (N=450)**



**2020 Employment Status (N=581)**

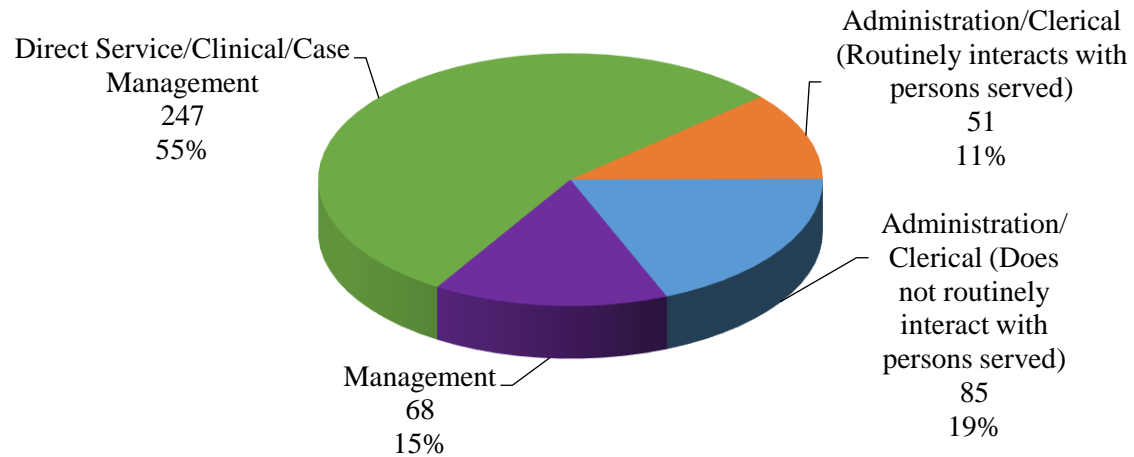


**2021 Employment Status (N=494)**

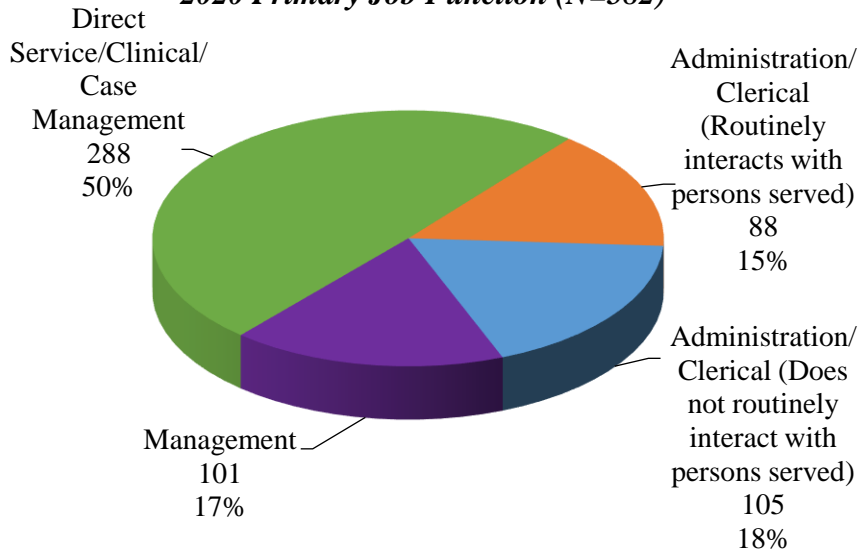


**Fresno County Department of Behavioral Health**  
**Staff Cultural Humility Survey**  
 Comparison Between 2019, 2020, and 2021 Survey Results

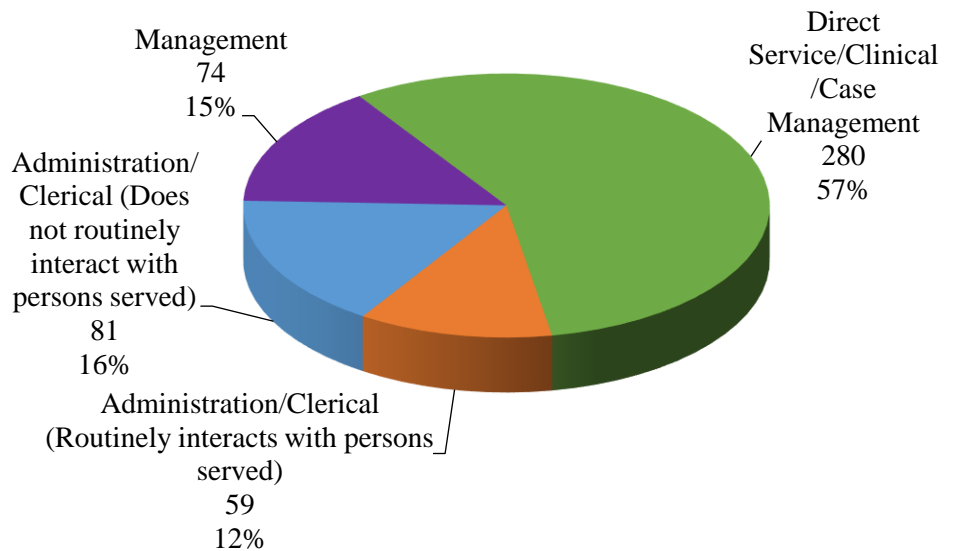
**2019 Primary Job Function (N=451)**



**2020 Primary Job Function (N=582)**

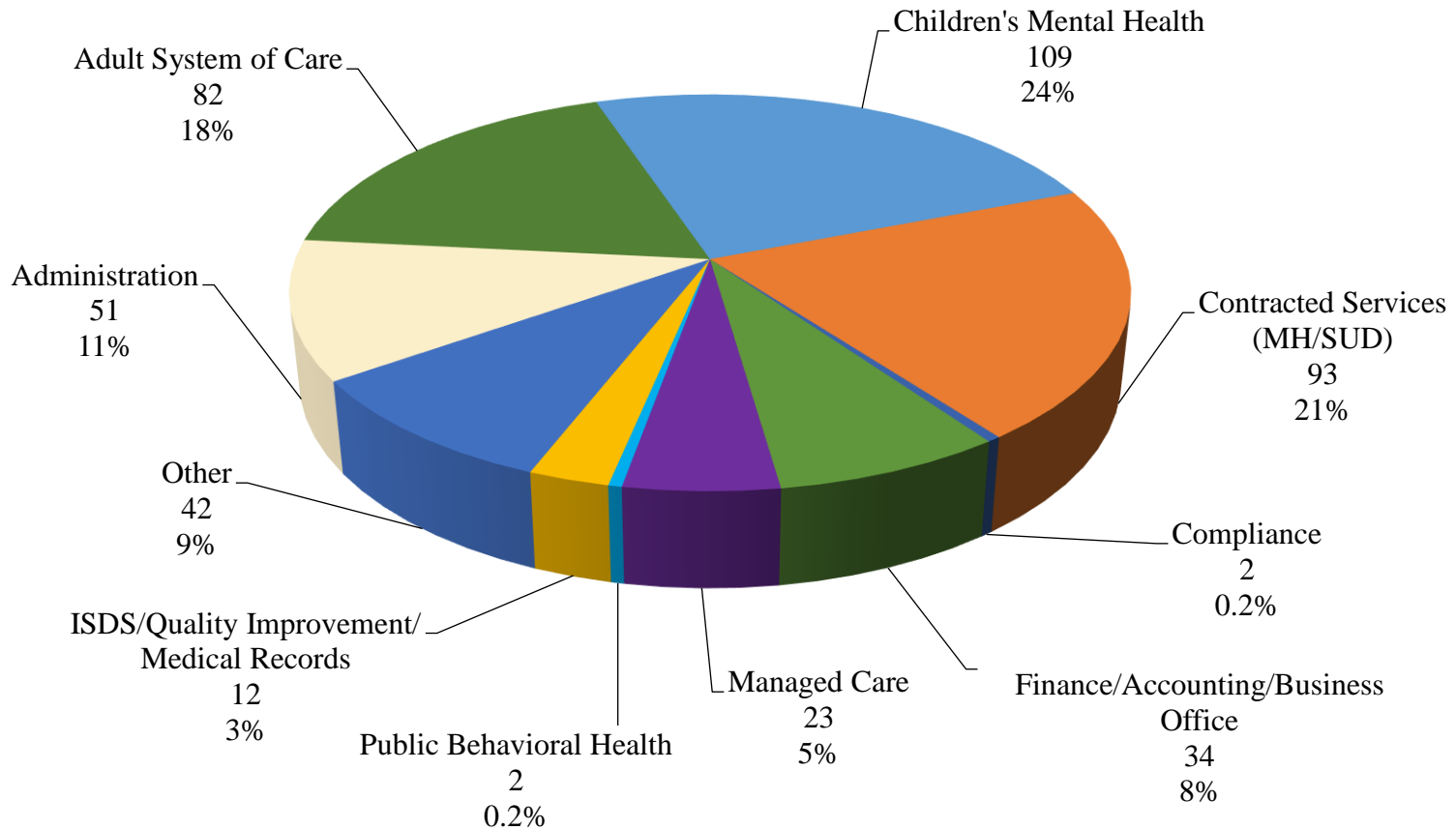


**2021 Primary Job Function (N=494)**



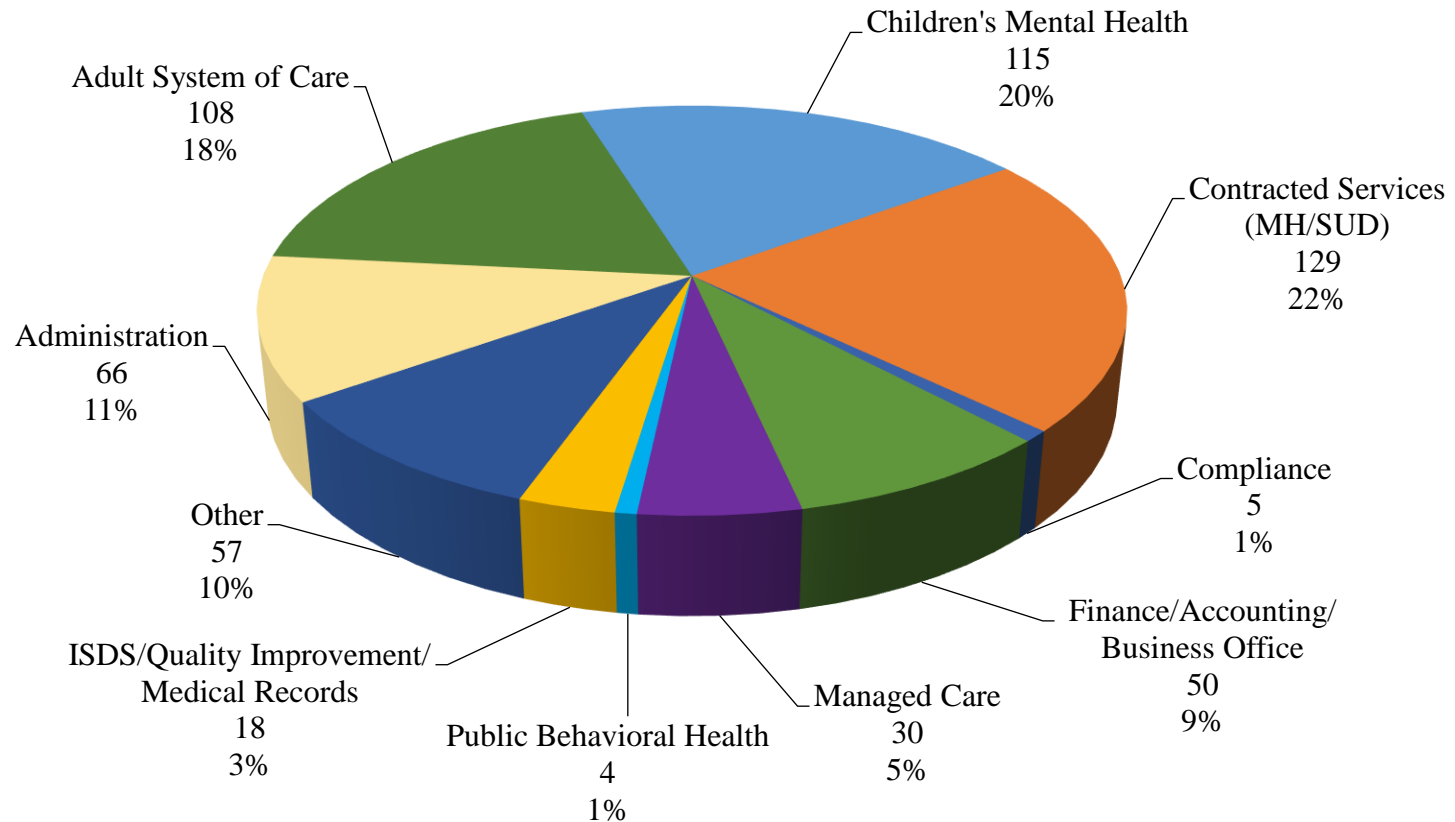
**Fresno County Department of Behavioral Health**  
***Staff Cultural Humility Survey***  
 Comparison Between 2019, 2020, and 2021 Survey Results

***2019 Department/Program (N=450)***



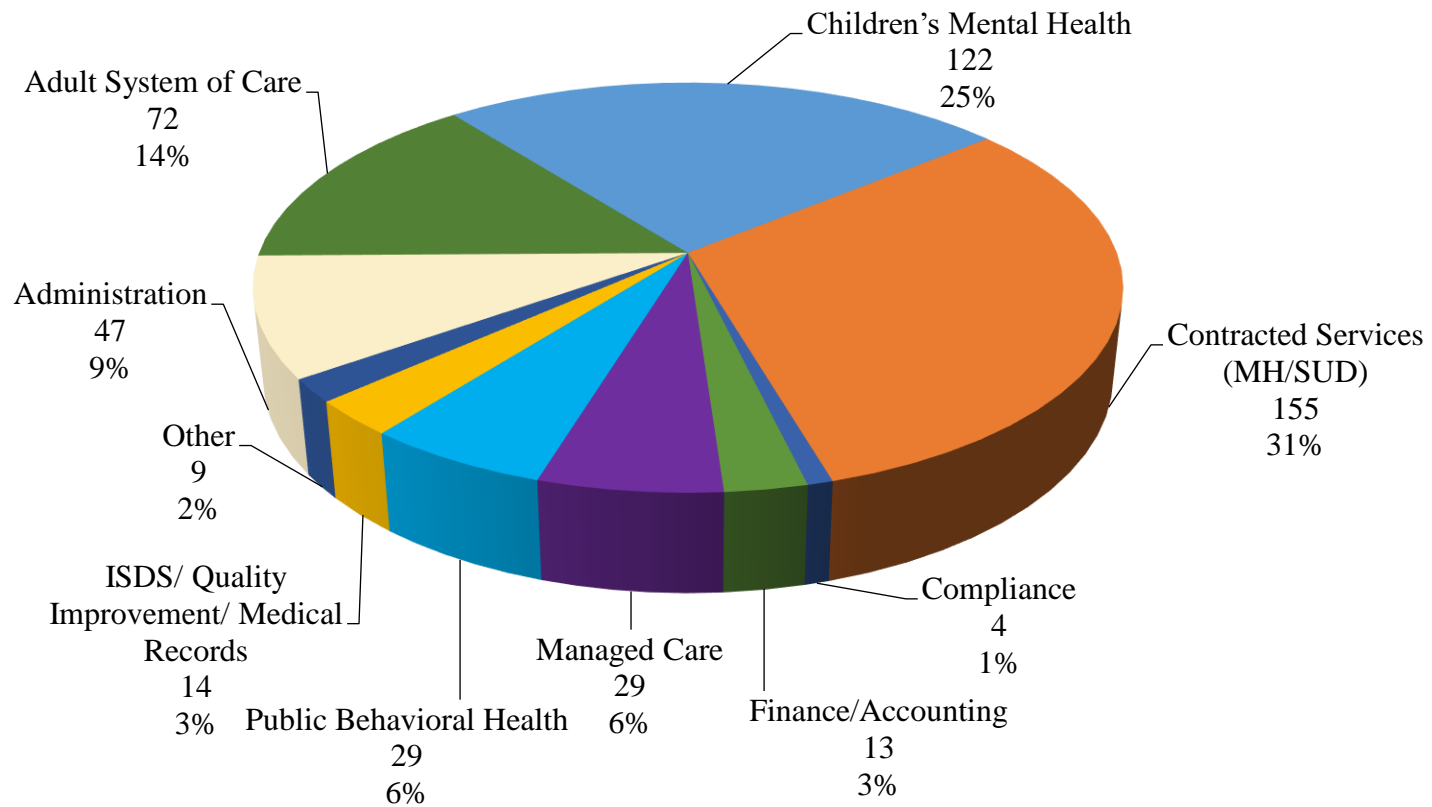
**Fresno County Department of Behavioral Health**  
***Staff Cultural Humility Survey***  
Comparison Between 2019, 2020, and 2021 Survey Results

***2020 Department/Program (N=582)***



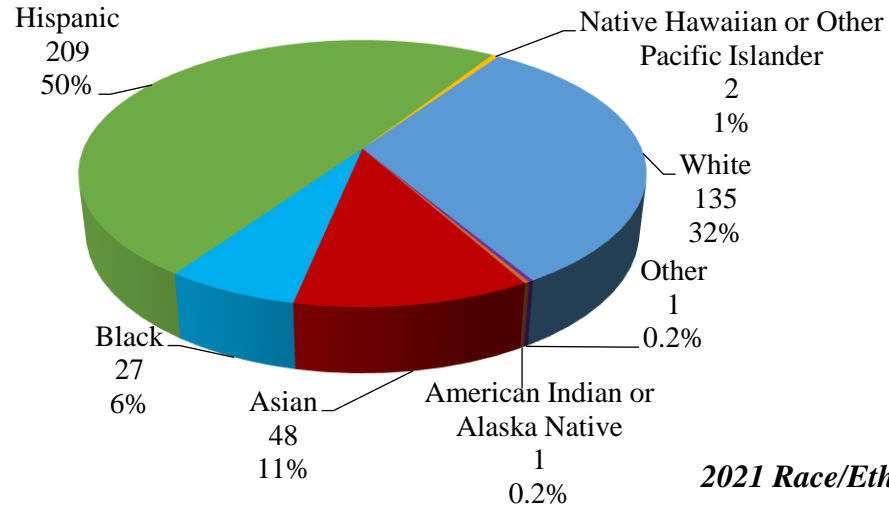
**Fresno County Department of Behavioral Health**  
***Staff Cultural Humility Survey***  
 Comparison Between 2019, 2020, and 2021 Survey Results

***2021 Department/Program (N=494)***

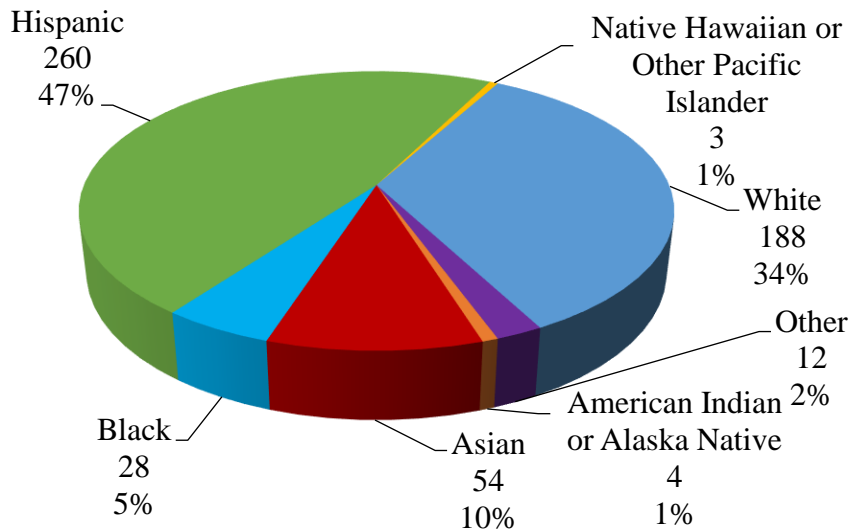


**Fresno County Department of Behavioral Health**  
**Staff Cultural Humility Survey**  
 Comparison Between 2019, 2020, and 2021 Survey Results

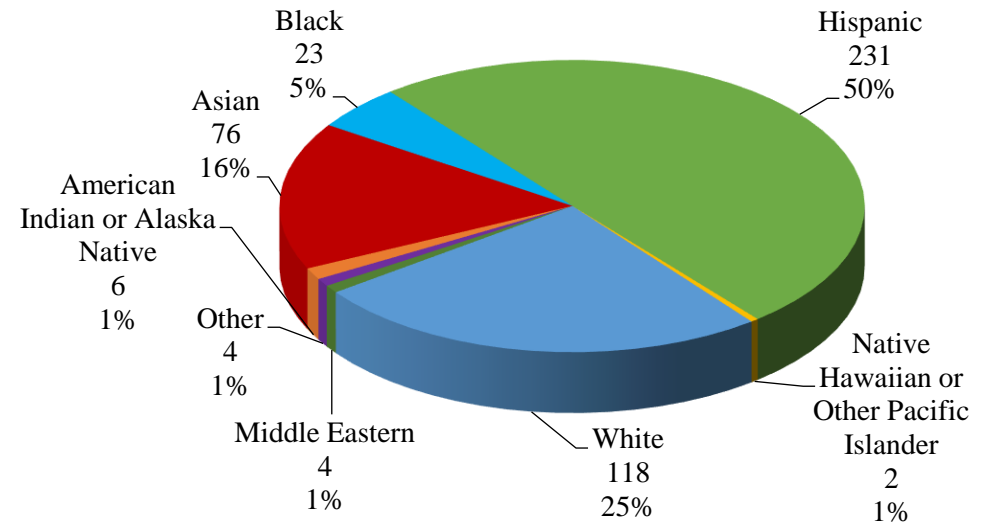
**2019 Race/Ethnicity (N=423)**



**2020 Race/Ethnicity (N=549)**

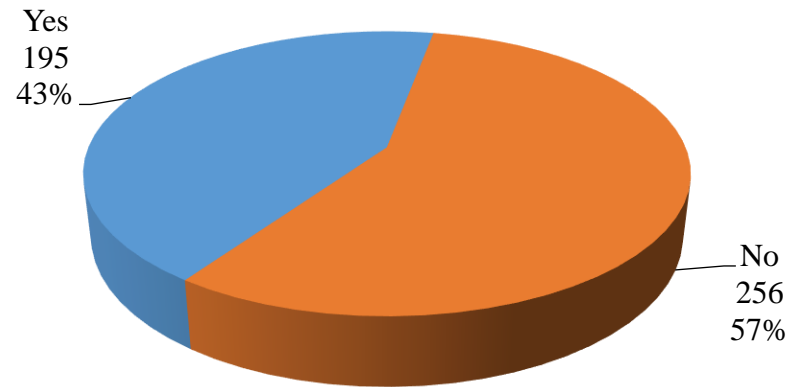


**2021 Race/Ethnicity (N=464)**

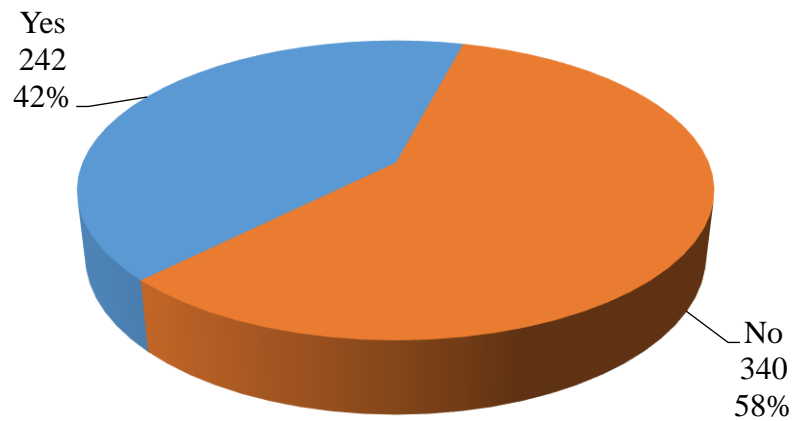


**Fresno County Department of Behavioral Health**  
***Staff Cultural Humility Survey***  
Comparison Between 2019, 2020, and 2021 Survey Results

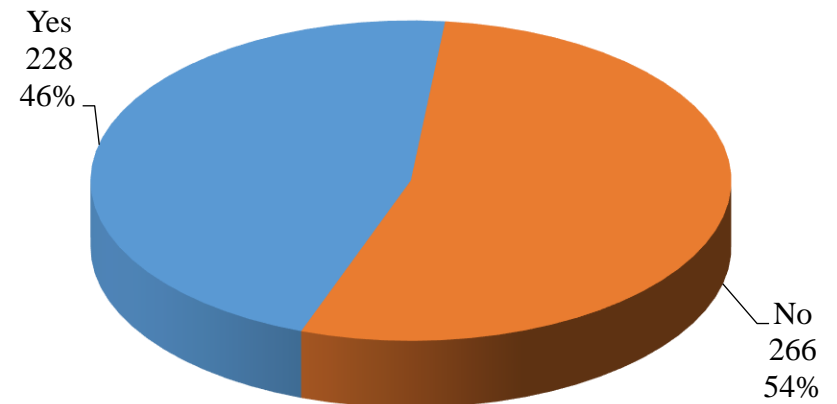
***2019 Do you consider yourself Bilingual?***  
***(N=451)***



***2020 Do you consider yourself Bilingual?***  
***(N=582)***



***2021 Do you consider yourself Bilingual?***  
***(N=494)***





**Fresno County Department of Behavioral Health**  
**Staff Cultural Humility Survey**

Comparison Between 2019, 2020, and 2021 Survey Results

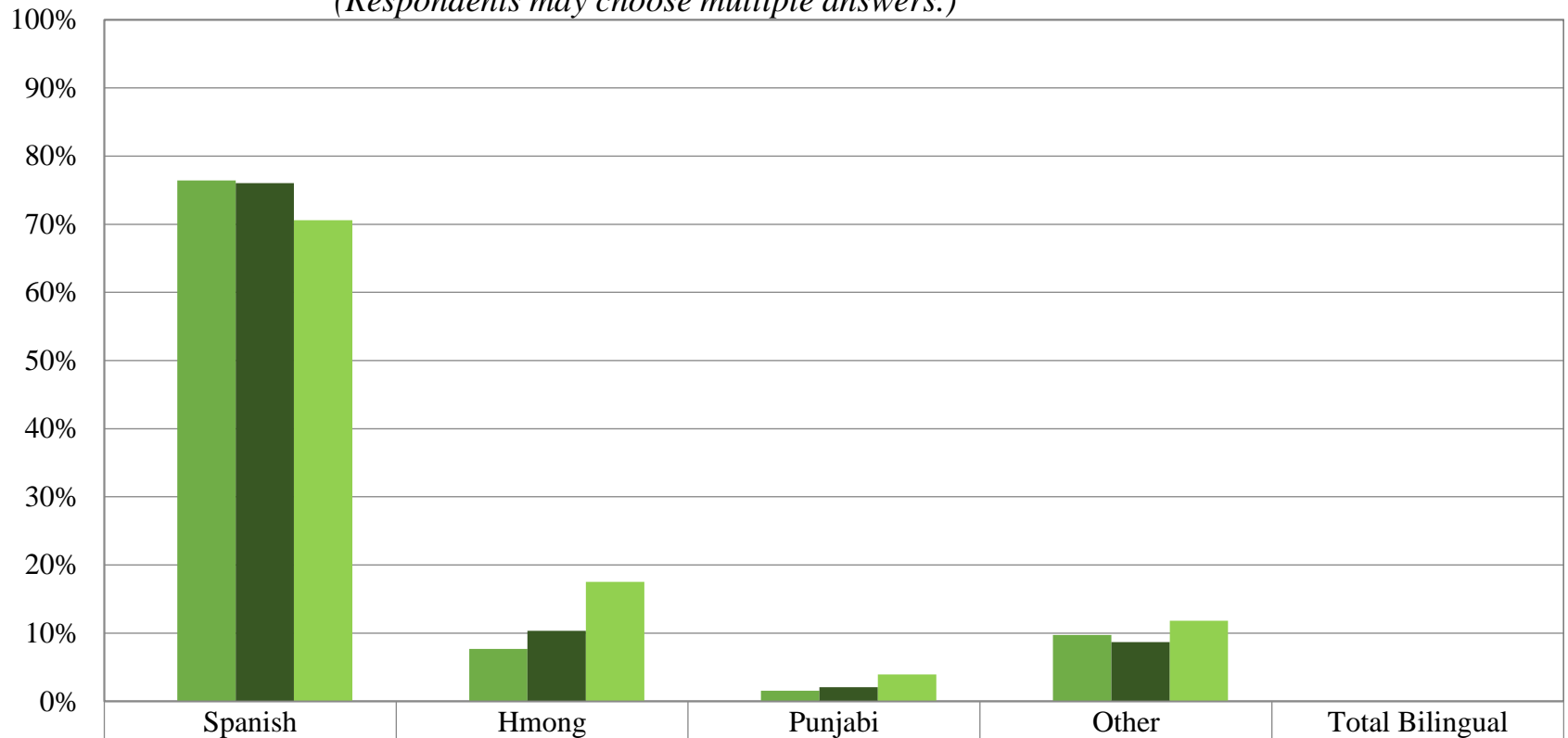
*If Bilingual, which language(s) do you speak?*

**2019 Bilingual Respondents (N=195)**

**2020 Bilingual Respondents (N=242)**

**2021 Bilingual Respondents (N=228)**

*(Respondents may choose multiple answers.)*



	Spanish	Hmong	Punjabi	Other	Total Bilingual
2019 # Respondents	149	15	3	19	195
2019 % Respondents	76%	8%	2%	10%	100%
2020 # Respondents	184	25	5	21	242
2020 % Respondents	76%	10%	2%	9%	100%
2021 # Respondents	161	40	9	27	228
2021 % Respondents	71%	18%	4%	12%	100%

**Fresno County Department of Behavioral Health**  
**Staff Cultural Humility Survey**

Comparison Between 2019, 2020, and 2021 Survey Results

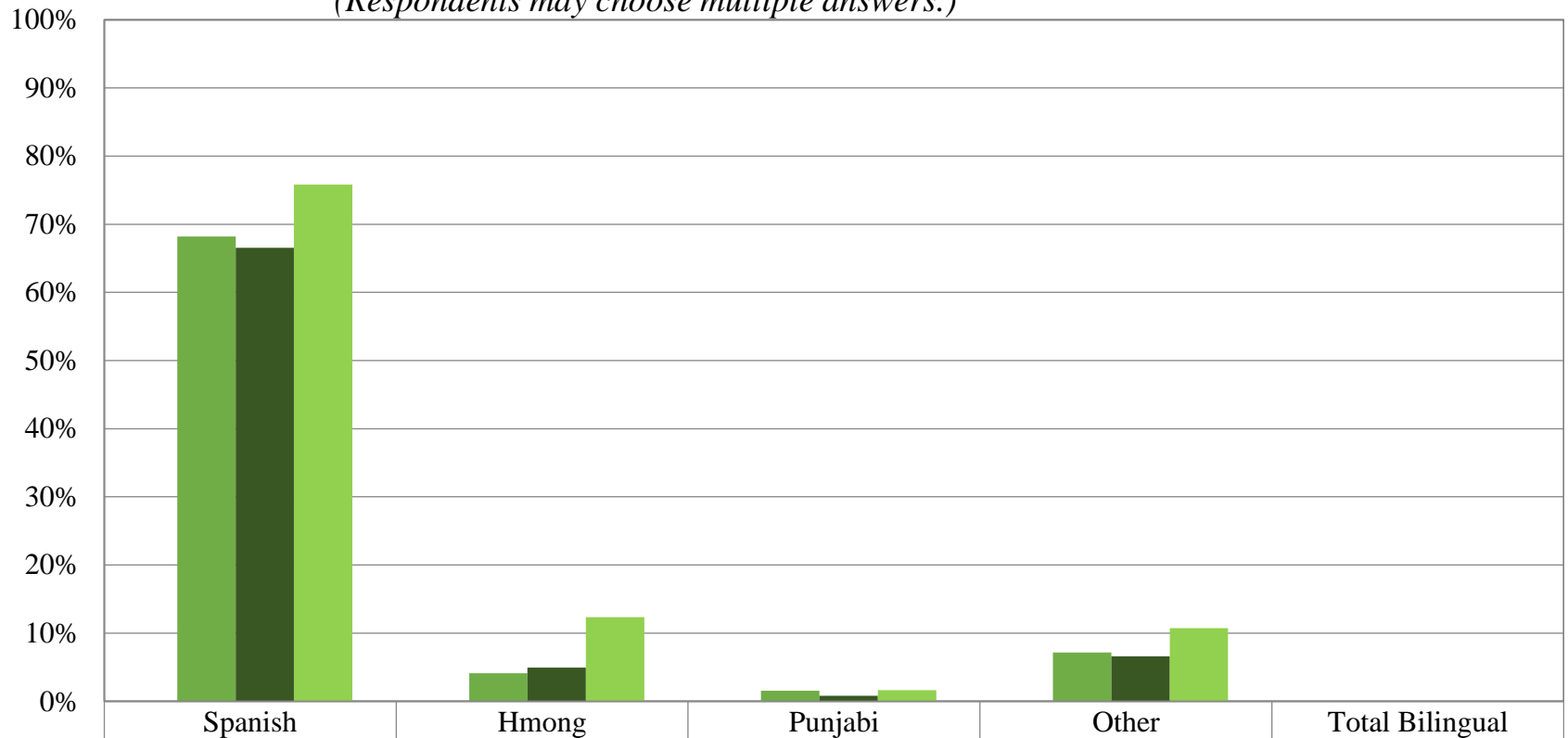
*If Bilingual, which language(s) are you proficient in reading and writing?*

**2019 Bilingual Respondents (N=195)**

**2020 Bilingual Respondents (N=242)**

**2021 Bilingual Respondents (N=228)**

*(Respondents may choose multiple answers.)*

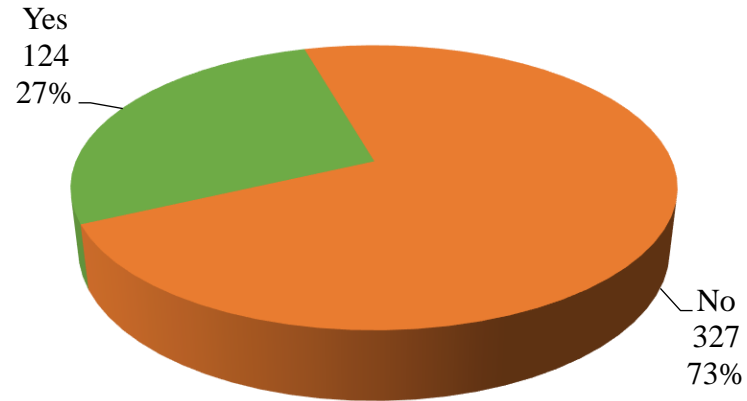


	Spanish	Hmong	Punjabi	Other	Total Bilingual
2019 # Respondents	133	8	3	14	195
2019 % Respondents	68%	4%	2%	7%	100%
2020 # Respondents	161	12	2	16	242
2020 % Respondents	67%	5%	1%	7%	100%
2021 # Respondents	141	23	3	20	228
2021 % Respondents	76%	12%	2%	11%	100%

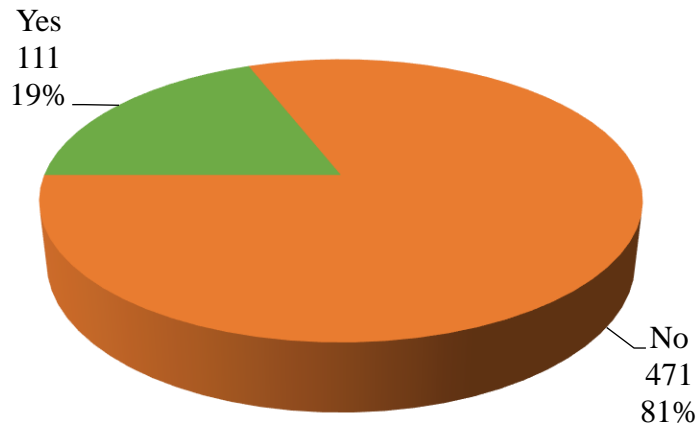
**Fresno County Department of Behavioral Health**  
***Staff Cultural Humility Survey***

Comparison Between 2019, 2020, and 2021 Survey Results

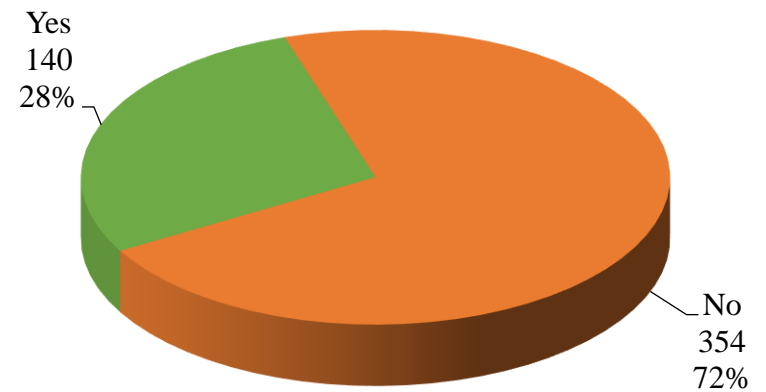
***2019 Do you act as an Interpreter as  
part of your Job Function? (N=451)***



***2020 Do you act as an Interpreter as  
part of your Job Function? (N=582)***



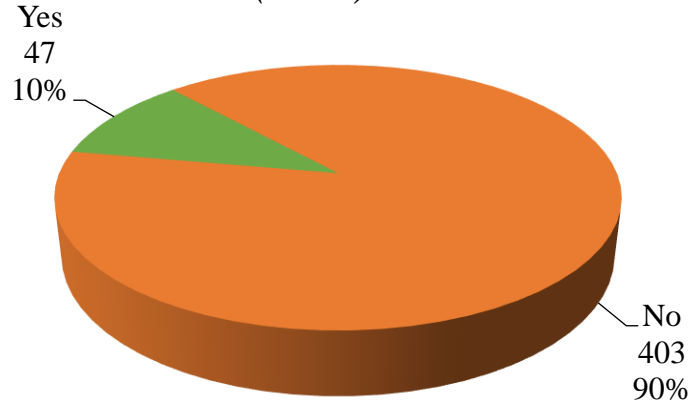
***2021 Do you act as an Interpreter as  
part of your Job Function? (N=494)***



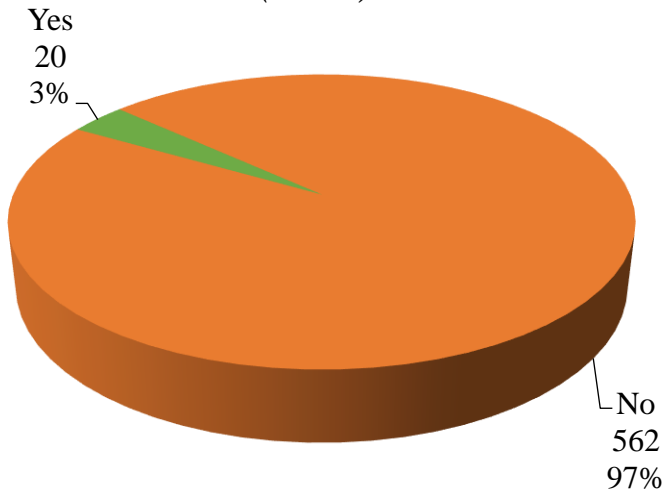
**Fresno County Department of Behavioral Health**  
***Staff Cultural Humility Survey***

Comparison Between 2019, 2020, and 2021 Survey Results

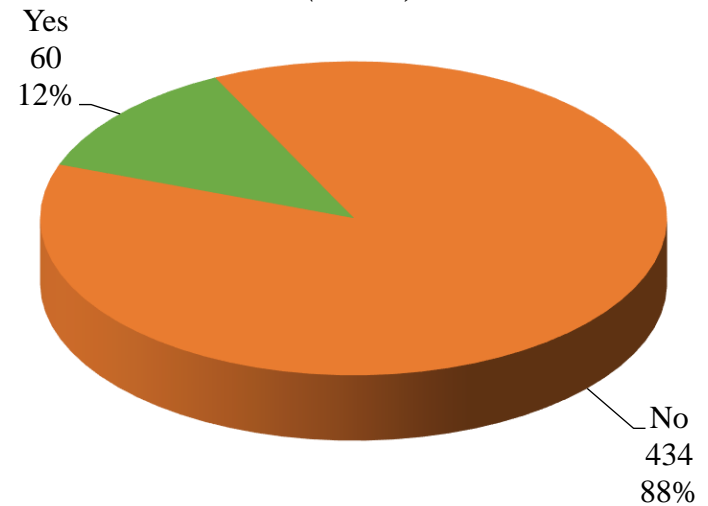
***2019 Do you receive bilingual pay?***  
***(N=450)***



***2020 Do you receive bilingual pay?***  
***(N=582)***



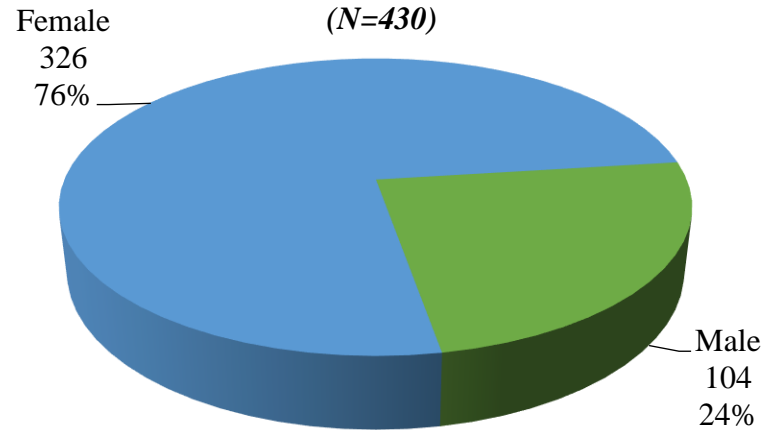
***2021 Do you receive bilingual pay?***  
***(N=494)***



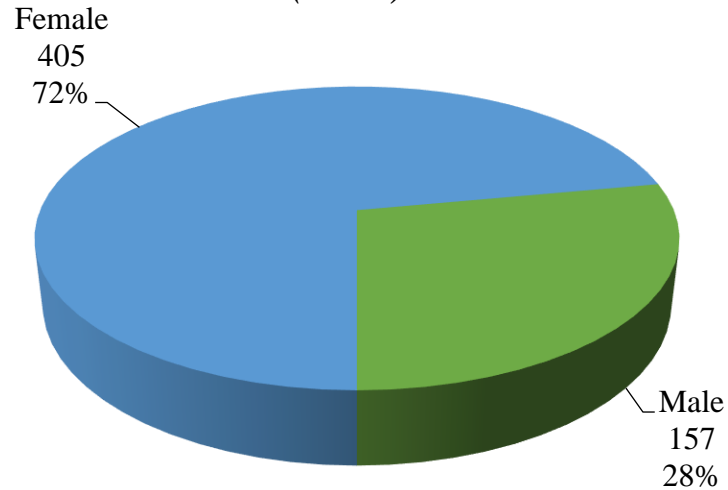
**Fresno County Department of Behavioral Health**  
***Staff Cultural Humility Survey***

Comparison Between 2019, 2020, and 2021 Survey Results

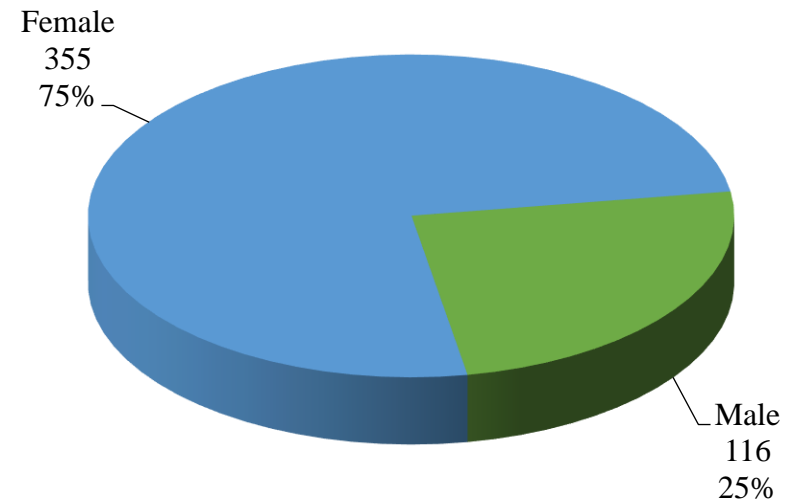
***2019 Gender Assigned at Birth***  
***(N=430)***



***2020 Gender Assigned at Birth***  
***(N=562)***

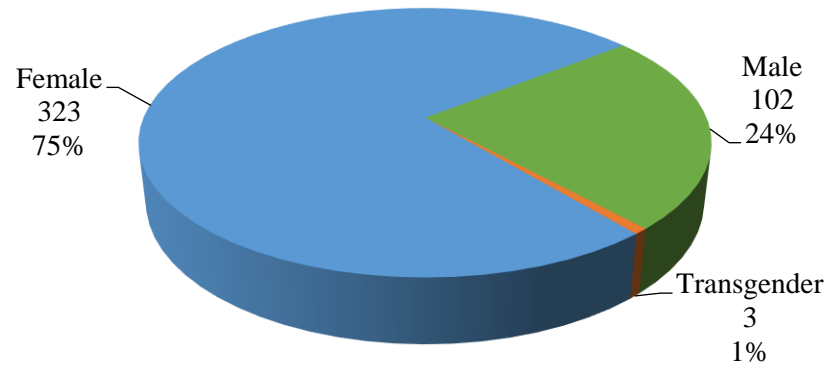


***2021 Gender Assigned at Birth***  
***(N=471)***

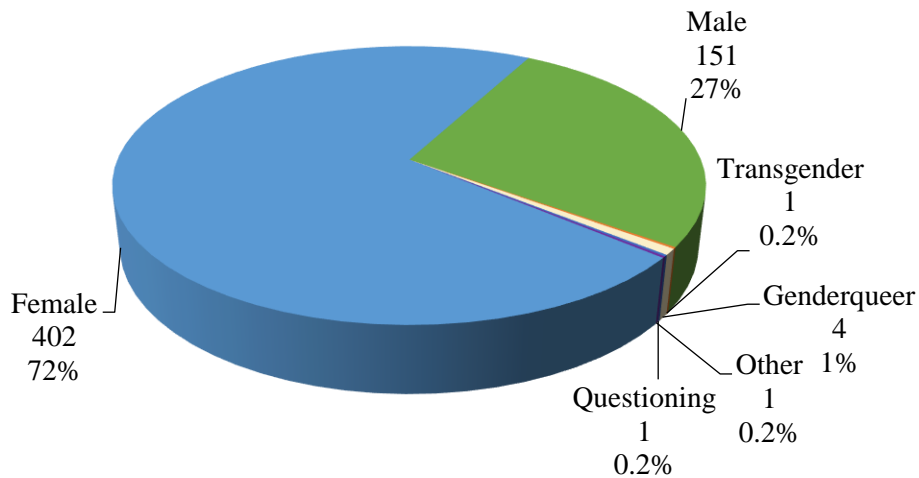


**Fresno County Department of Behavioral Health**  
***Staff Cultural Humility Survey***  
 Comparison Between 2019, 2020, and 2021 Survey Results

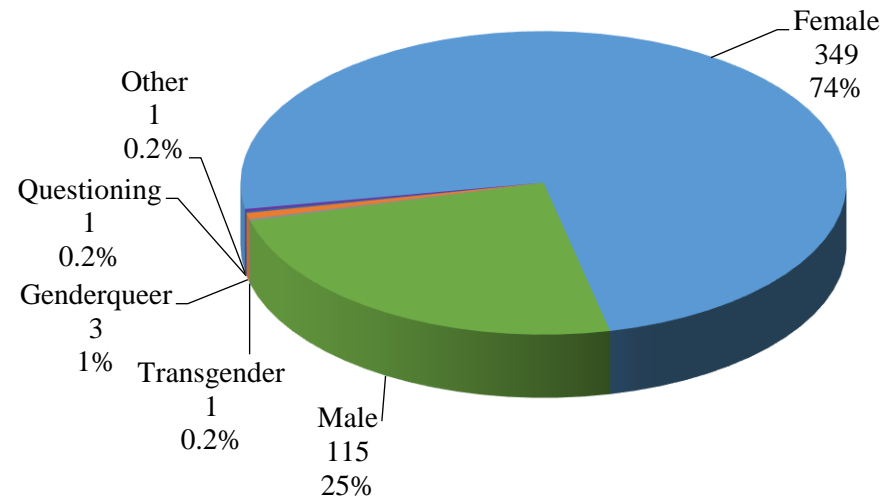
***2019 Current Gender Identity***  
***(N=428)***



***2020 Current Gender Identity***  
***(N=560)***

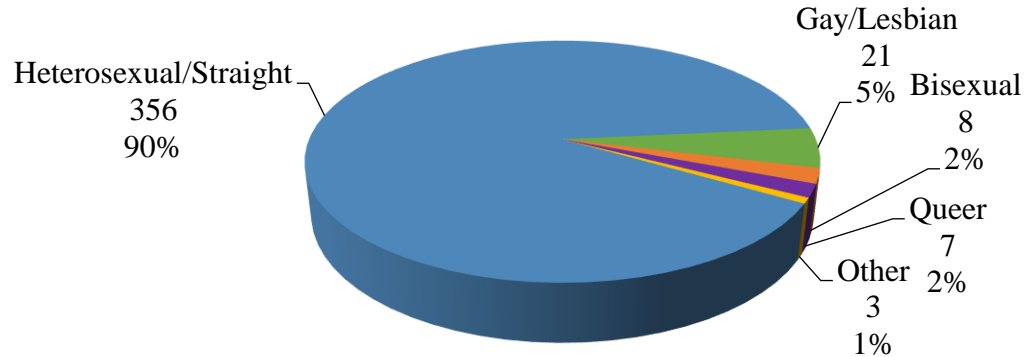


***2021 Current Gender Identity***  
***(N=470)***

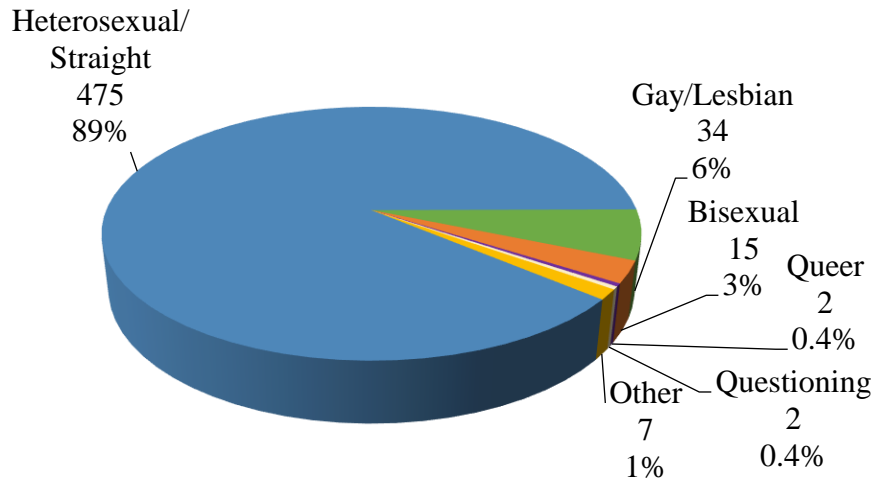


**Fresno County Department of Behavioral Health**  
**Staff Cultural Humility Survey**  
 Comparison Between 2019, 2020, and 2021 Survey Results

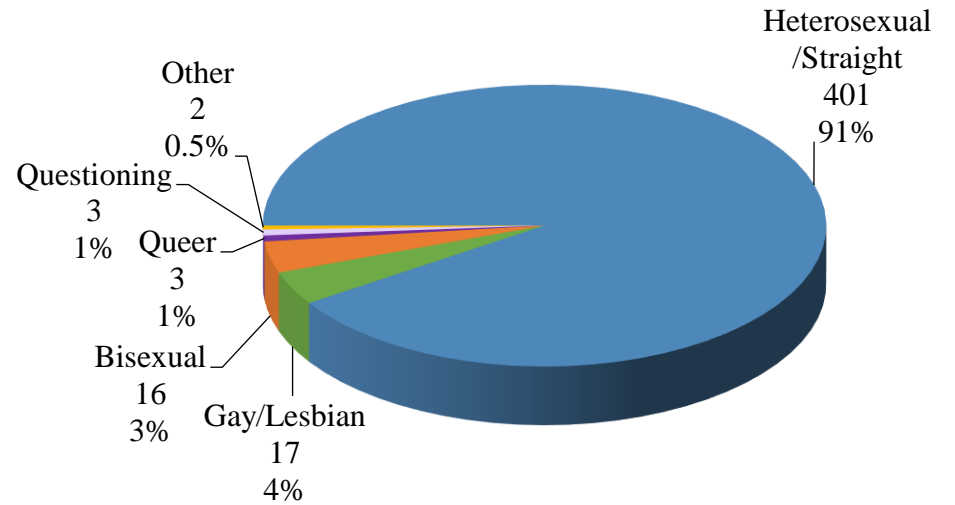
**2019 Sexual Orientation (N=395)**



**2020 Sexual Orientation (N=535)**



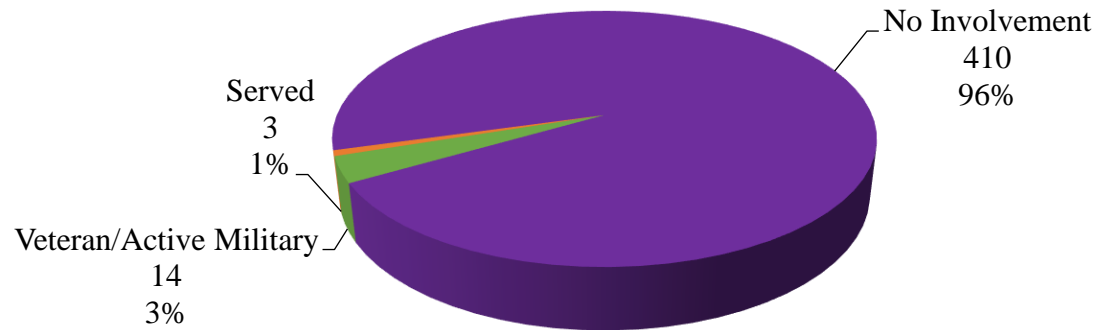
**2021 Sexual Orientation (N=442)**



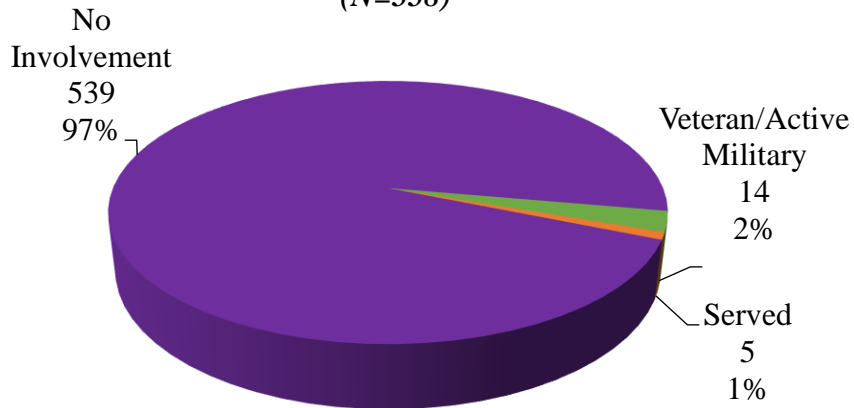
**Fresno County Department of Behavioral Health**  
**Staff Cultural Humility Survey**

Comparison Between 2019, 2020, and 2021 Survey Results

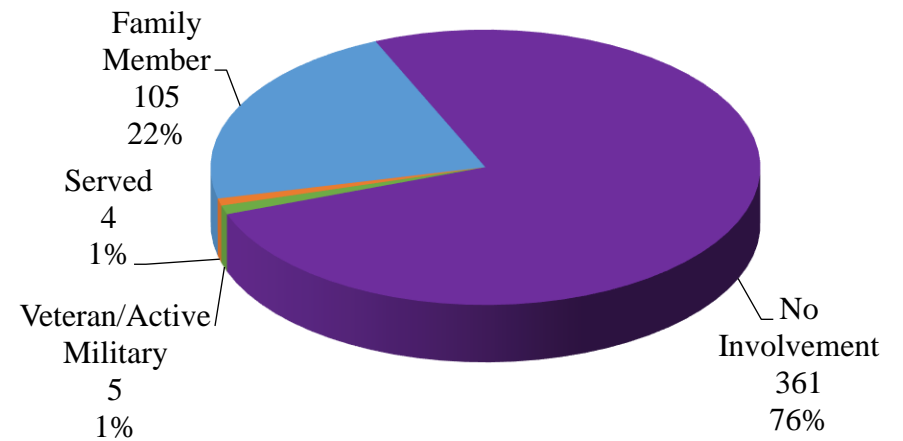
**2019 Military/Service Involvement**  
**(N=427)**



**2020 Military/Service Involvement**  
**(N=558)**



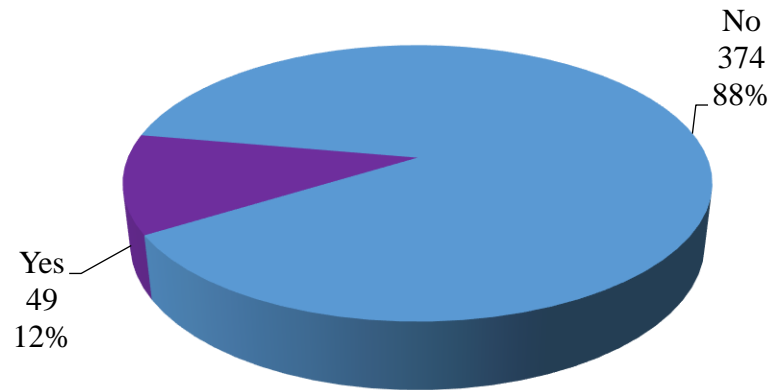
**2021 Military/Service Involvement**  
**(N=475)**



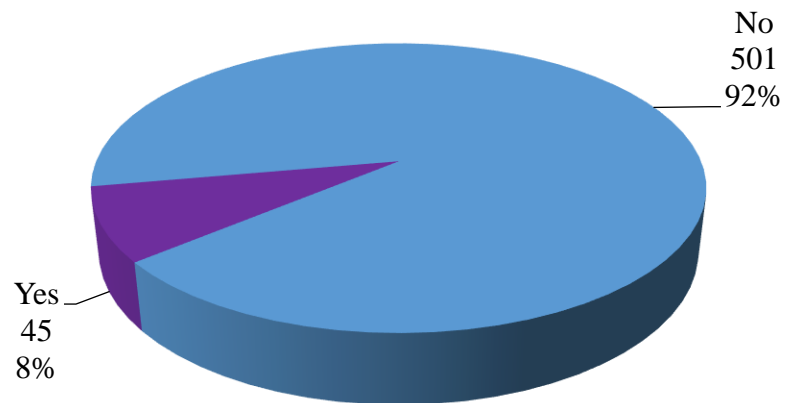


**Fresno County Department of Behavioral Health**  
***Staff Cultural Humility Survey***  
Comparison Between 2019, 2020, and 2021 Survey Results

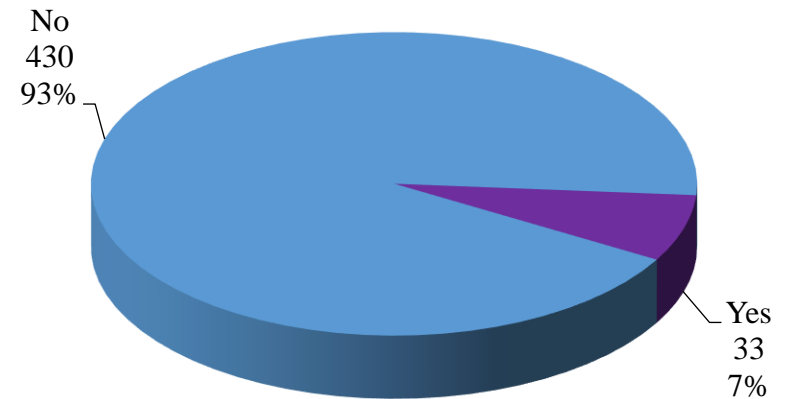
***2019 Do you have a disability? (N=423)***



***2020 Do you have a disability? (N=546)***



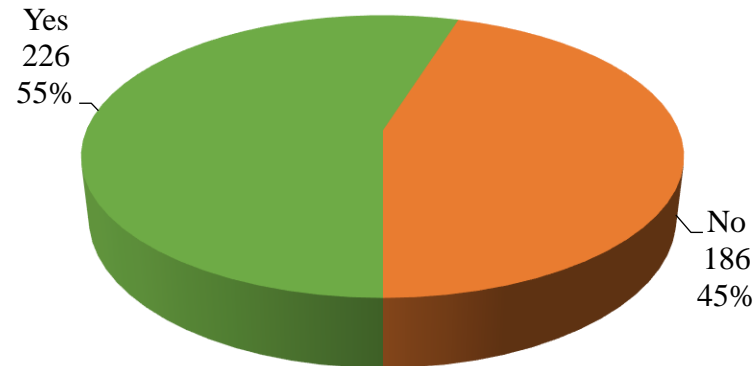
***2021 Do you have a disability? (N=463)***



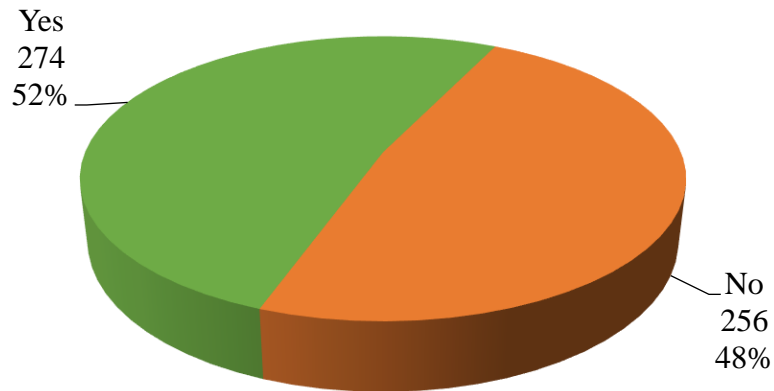
**Fresno County Department of Behavioral Health**  
***Staff Cultural Humility Survey***

Comparison Between 2019, 2020, and 2021 Survey Results

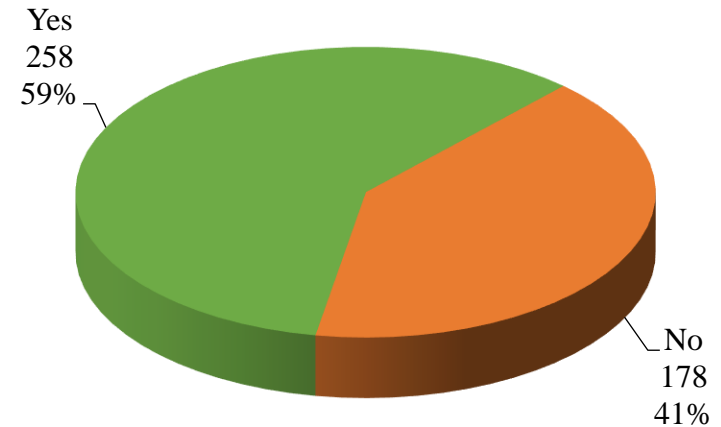
***2019 Do you consider yourself to be a person  
with lived Mental Health experience?***  
***(N=412)***



***2020 Do you consider yourself to be a  
person with lived Mental Health experience?***  
***(N=530)***



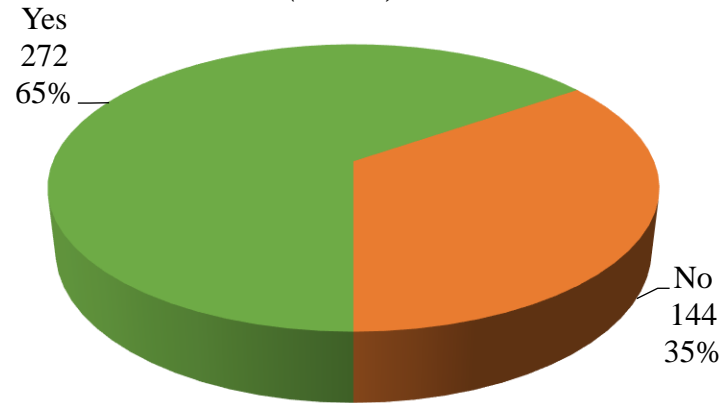
***2021 Do you consider yourself to be a  
person with lived Mental Health experience?***  
***(N=436)***



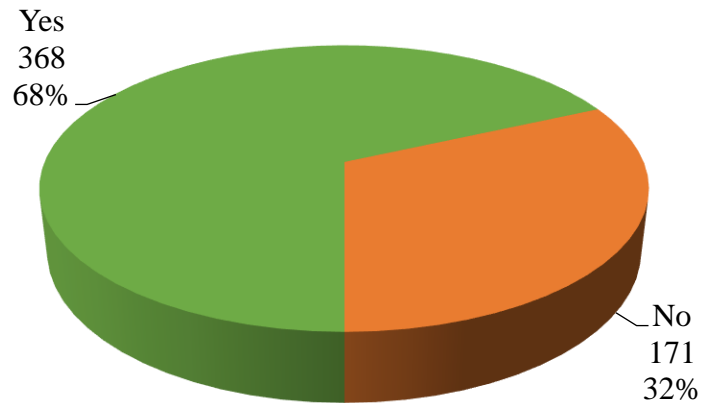
**Fresno County Department of Behavioral Health**  
***Staff Cultural Humility Survey***

Comparison Between 2019, 2020, and 2021 Survey Results

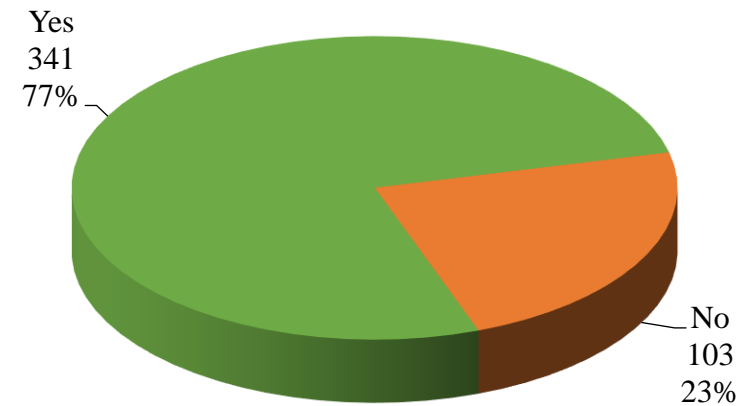
***2019 Are you a family member of a person  
with lived Mental Health experience?***  
**(N=416)**



***2020 Are you a family member of a person  
with lived Mental Health experience?***  
**(N=539)**



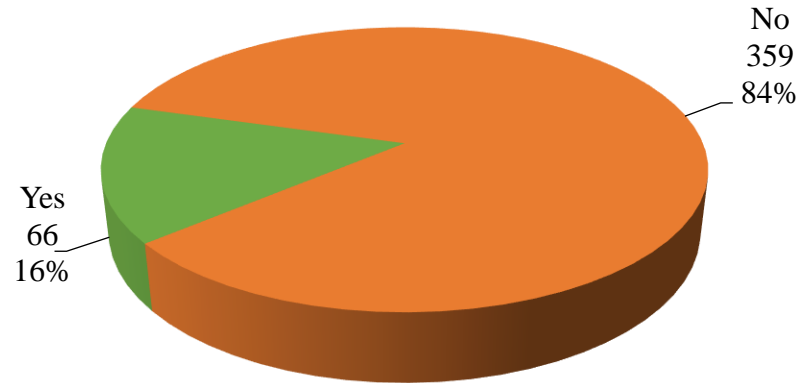
***2021 Are you a family member of a person  
with lived Mental Health experience?***  
**(N=444)**



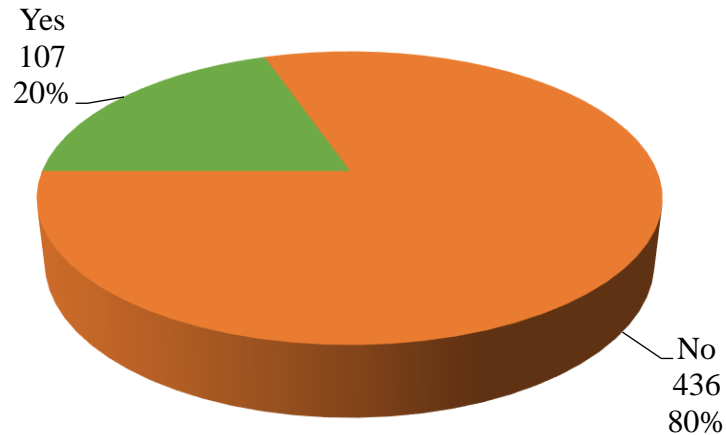
**Fresno County Department of Behavioral Health**  
***Staff Cultural Humility Survey***

Comparison Between 2019, 2020, and 2021 Survey Results

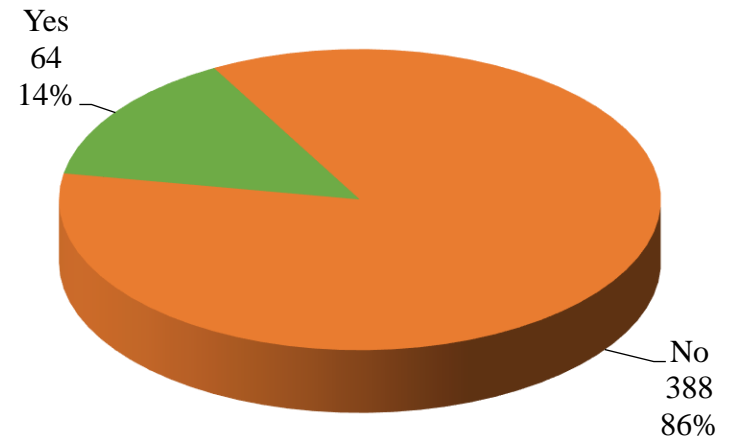
***2019 Do you consider yourself to be a person  
with lived Substance Use Disorder  
experience? (N=425)***



***2020 Do you consider yourself to be a  
person with lived Substance Use Disorder  
experience? (N=543)***



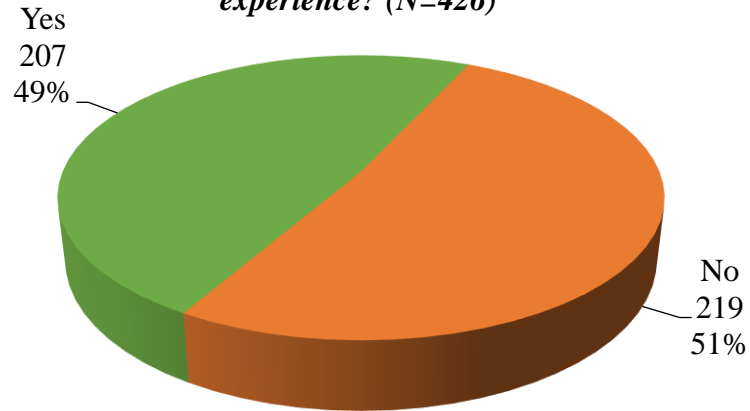
***2021 Do you consider yourself to be a  
person with lived Substance Use Disorder  
experience? (N=452)***



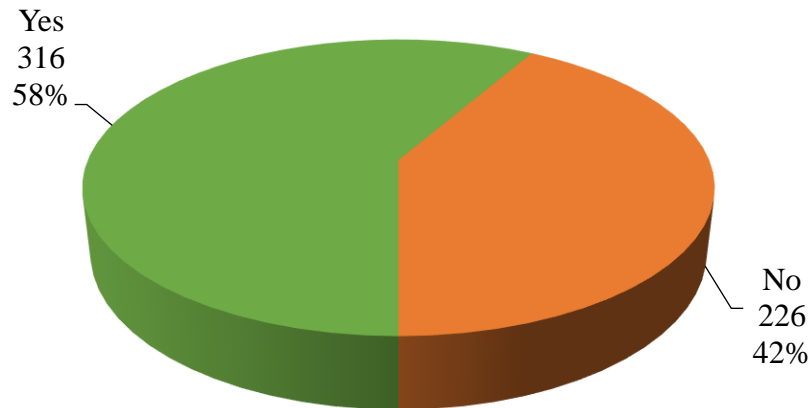
**Fresno County Department of Behavioral Health**  
***Staff Cultural Humility Survey***

Comparison Between 2019, 2020, and 2021 Survey Results

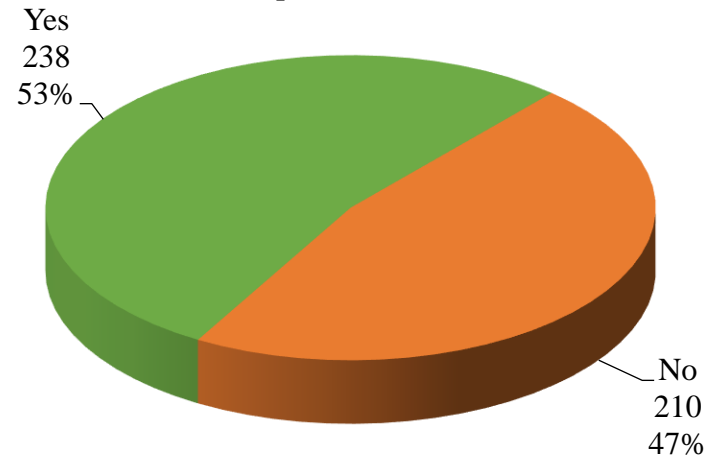
***2019 Are you a family member of a person  
with lived Substance Use Disorder  
experience? (N=426)***



***2020 Are you a family member of a person  
with lived Substance Use Disorder  
experience? (N=542)***



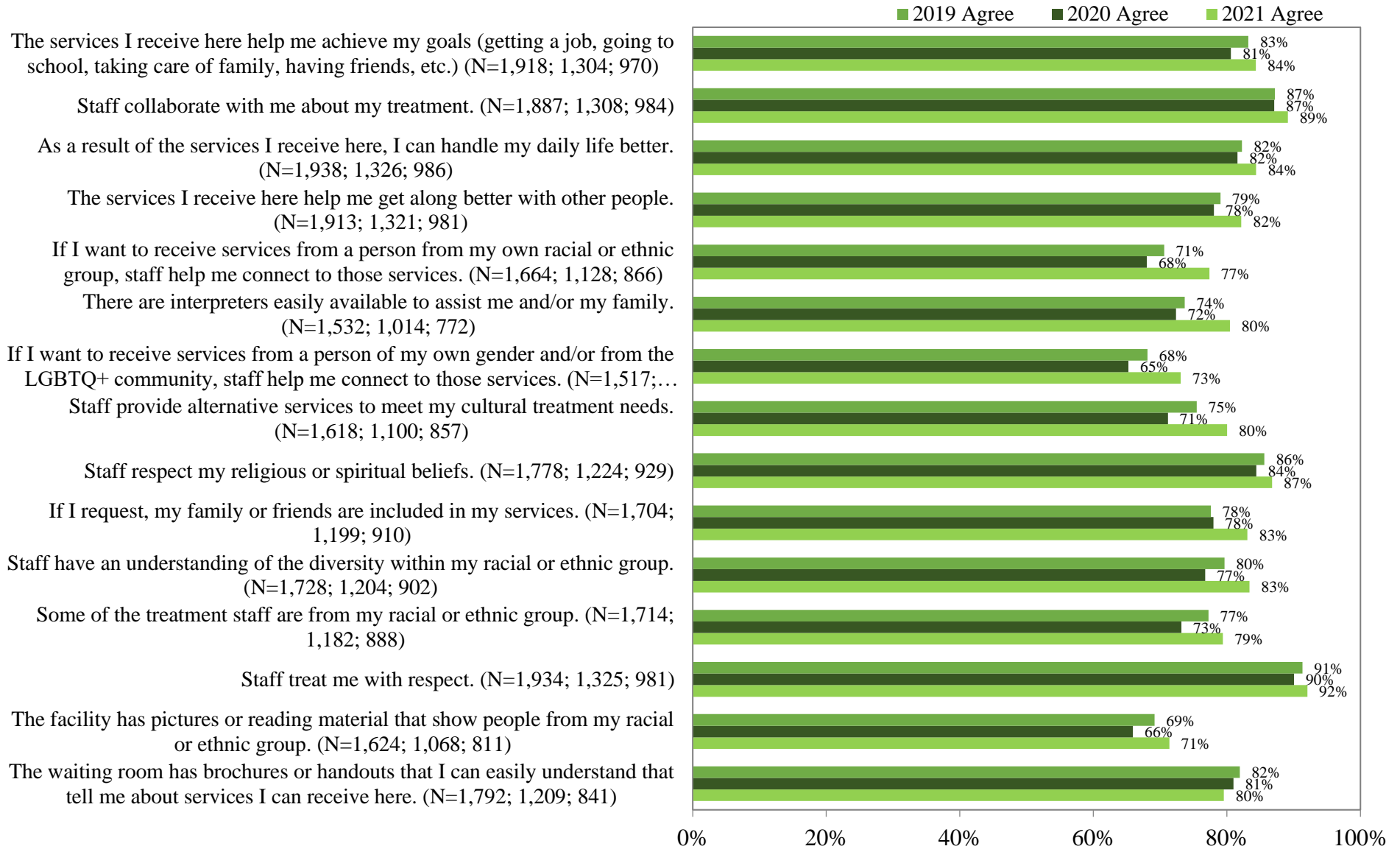
***2021 Are you a family member of a person  
with lived Substance Use Disorder  
experience? (N=448)***



## **Attachment F: Client Cultural Humility Survey Results**

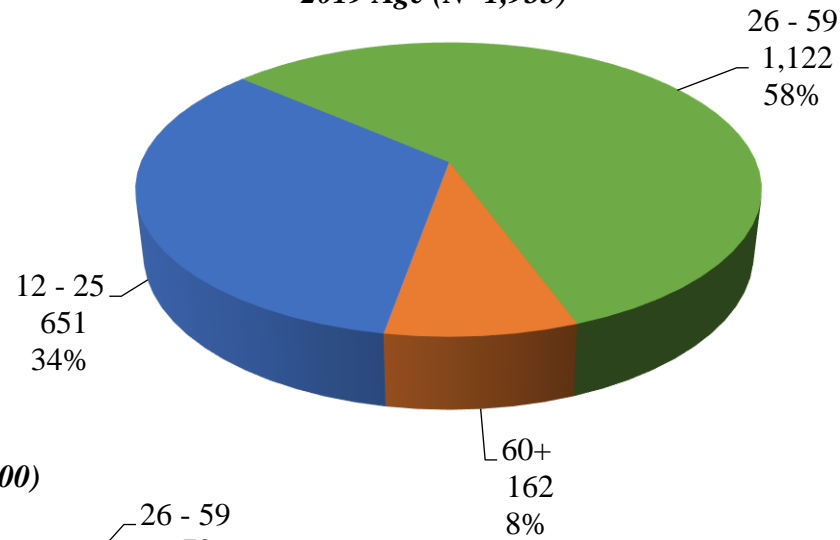
## Fresno County Department of Behavioral Health *Client Cultural Humility Survey*

Comparison Between 2019, 2020, and 2021 Survey Results

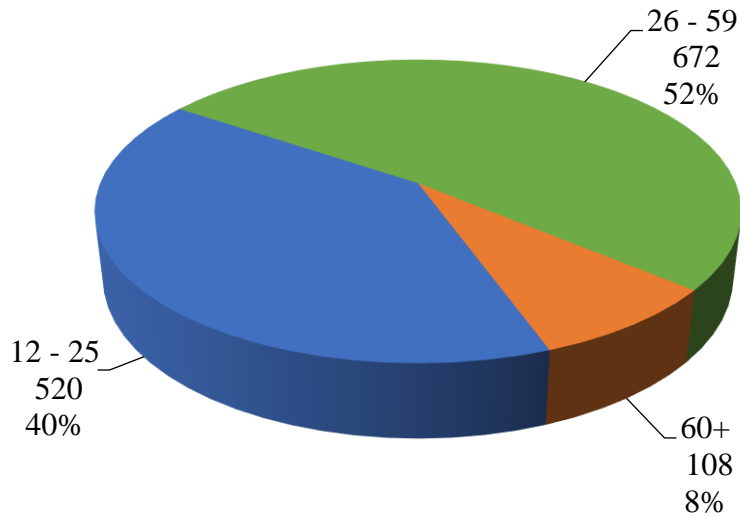


**Fresno County Department of Behavioral Health**  
***Client Cultural Humility Survey***  
 Comparison Between 2019, 2020, and 2021 Survey Results

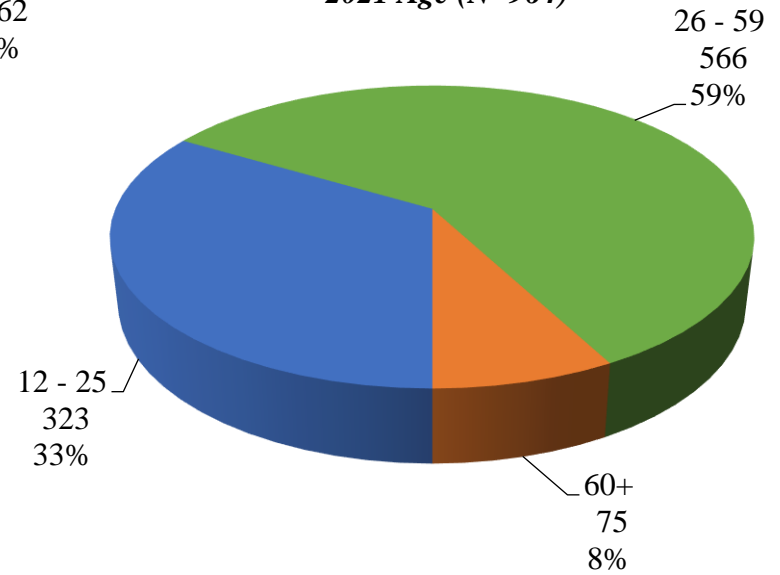
**2019 Age (N=1,935)**



**2020 Age (N=1,300)**



**2021 Age (N=964)**

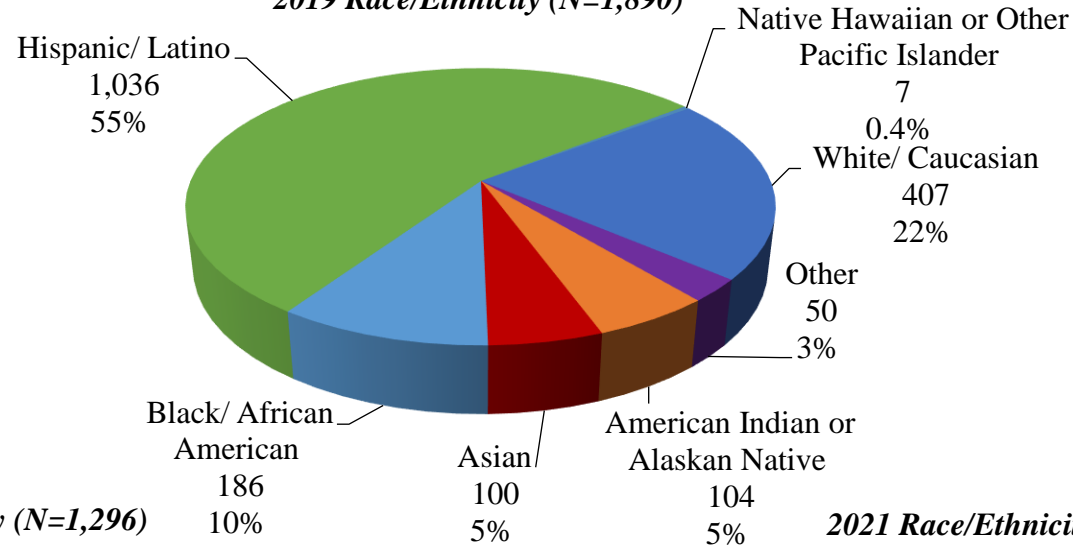




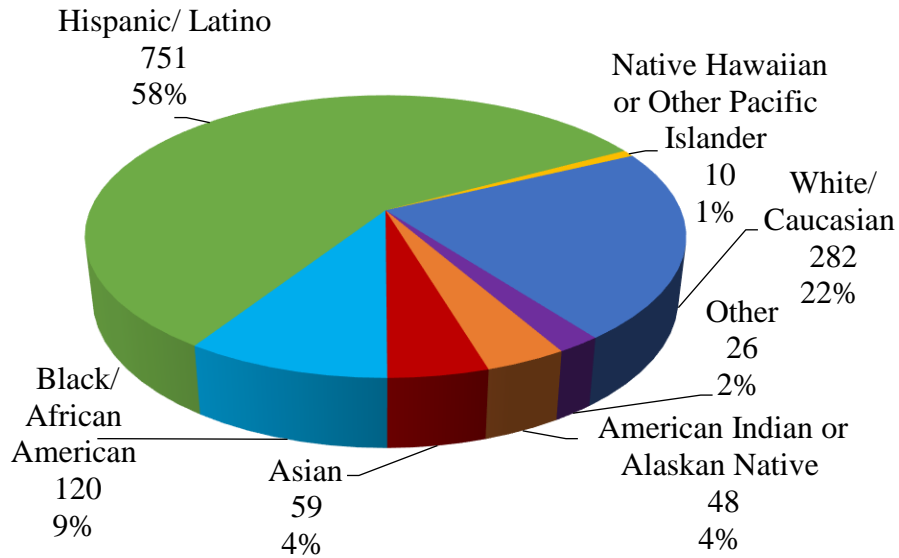
# Fresno County Department of Behavioral Health Client Cultural Humility Survey

Comparison Between 2019, 2020, and 2021 Survey Results

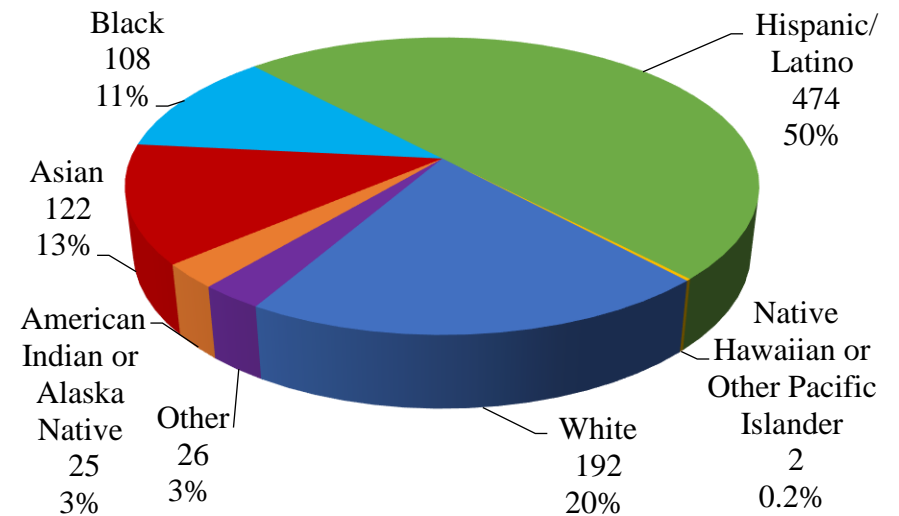
**2019 Race/Ethnicity (N=1,890)**



**2020 Race/Ethnicity (N=1,296)**



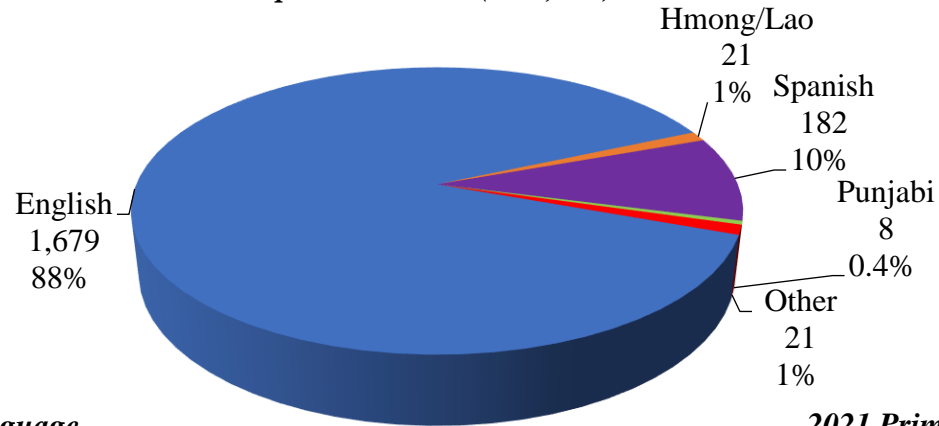
**2021 Race/Ethnicity (N=949)**



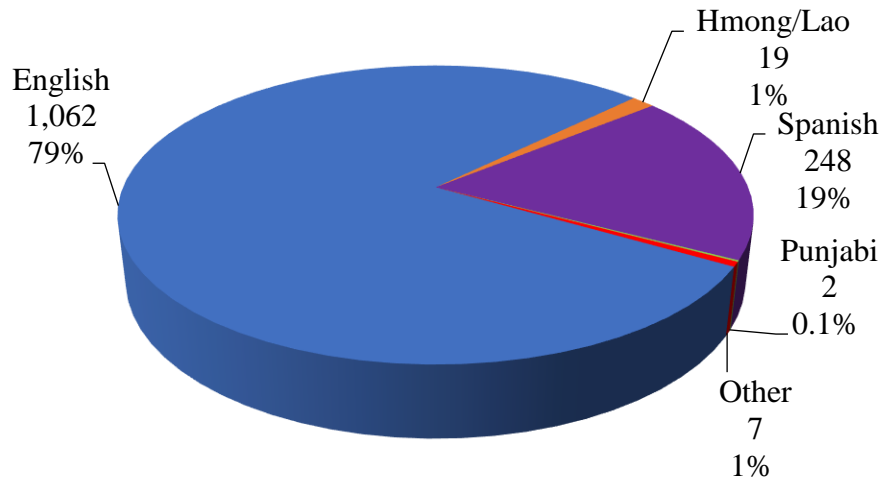
# Fresno County Department of Behavioral Health Client Cultural Humility Survey

Comparison Between 2019, 2020, and 2021 Survey Results

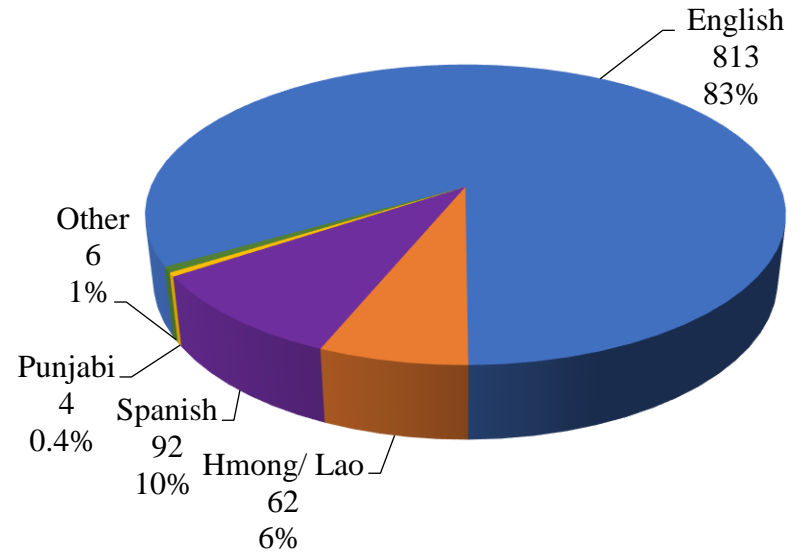
**2019 Primary Language  
Spoken at home (N=1,911)**



**2020 Primary Language  
Spoken at home (N=1,338)**

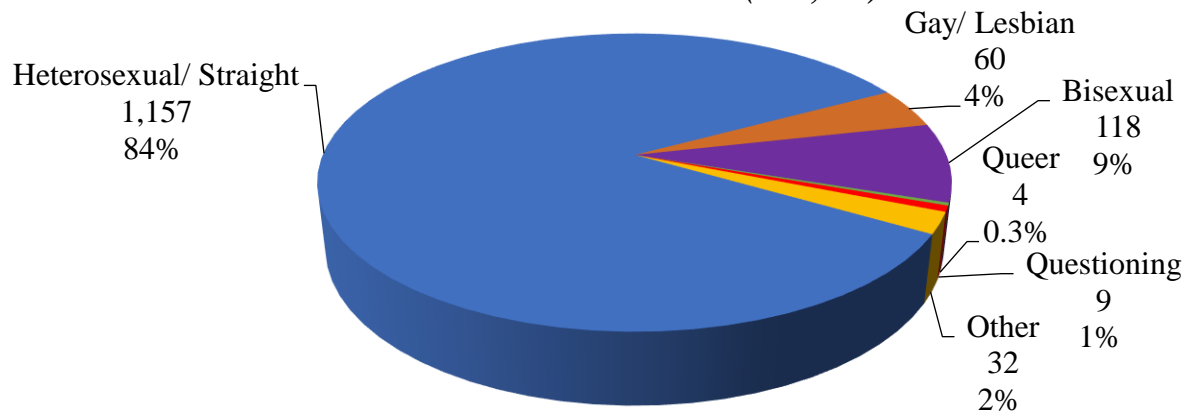


**2021 Primary Language  
Spoken at home (N=977)**

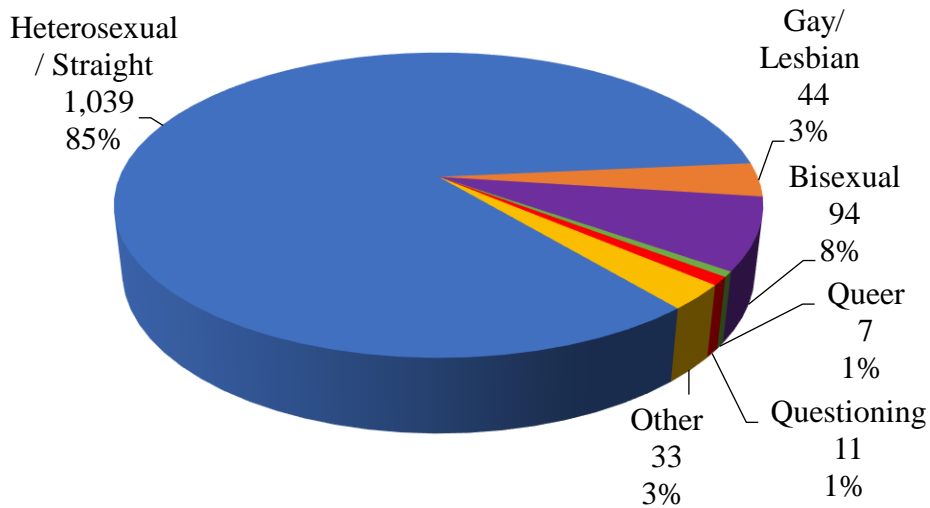


**Fresno County Department of Behavioral Health**  
***Client Cultural Humility Survey***  
 Comparison Between 2019, 2020, and 2021 Survey Results

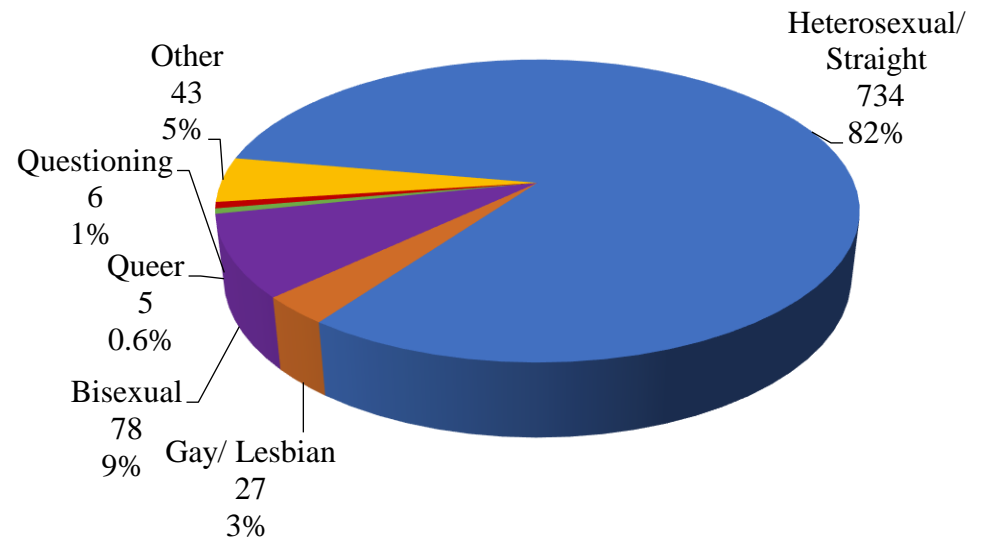
**2019 Sexual Orientation (N=1,380)**



**2020 Sexual Orientation (N=1,228)**



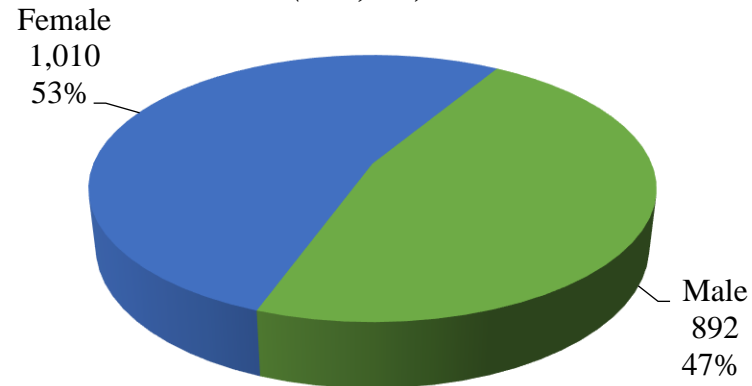
**2021 Sexual Orientation (N=893)**



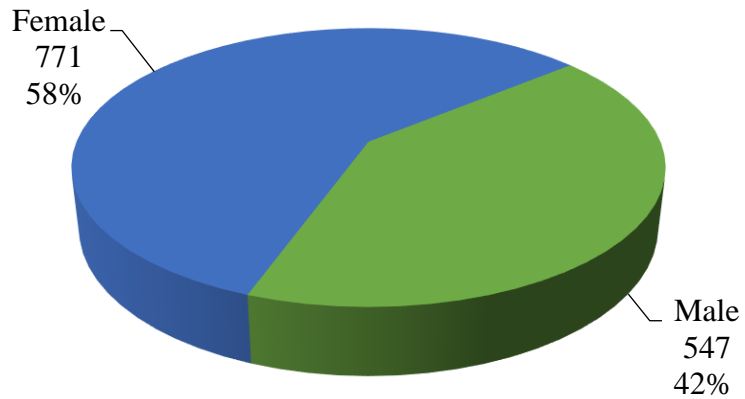
**Fresno County Department of Behavioral Health**  
***Client Cultural Humility Survey***

Comparison Between 2019, 2020, and 2021 Survey Results

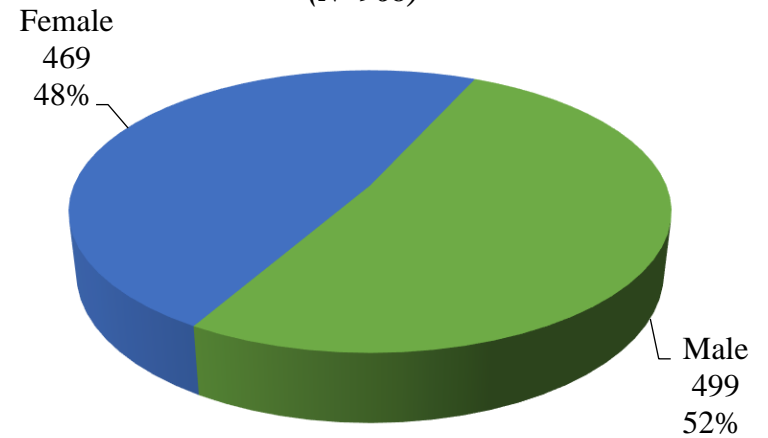
***2019 Gender Assigned at Birth***  
***(N=1,902)***



***2020 Gender Assigned at Birth***  
***(N=1,318)***



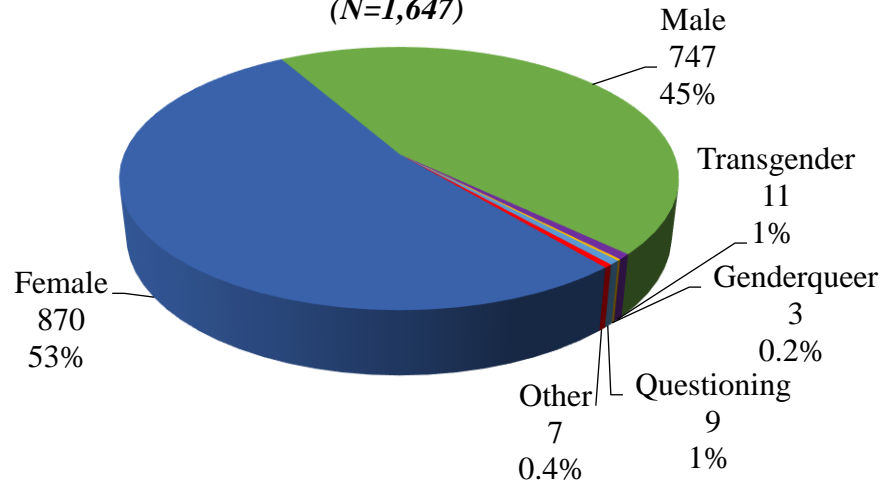
***2021 Gender Assigned at Birth***  
***(N=968)***



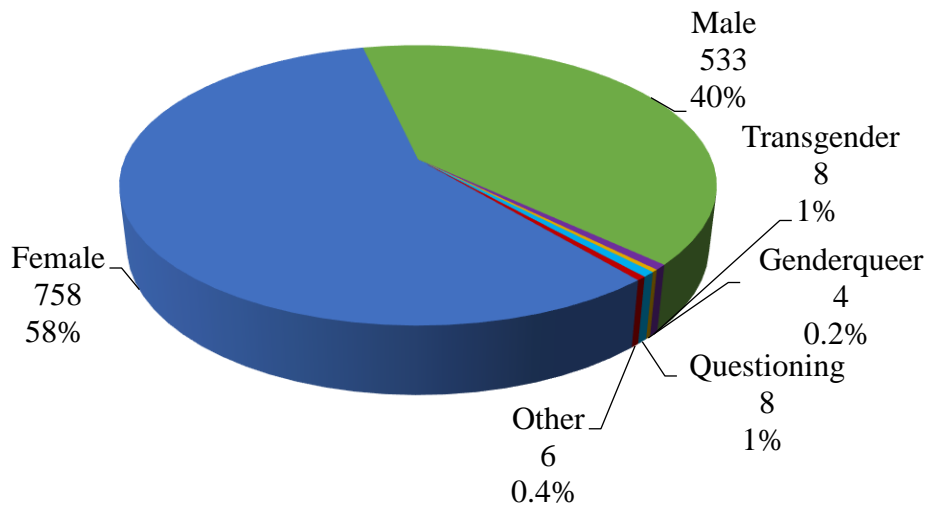
**Fresno County Department of Behavioral Health**  
***Client Cultural Humility Survey***

Comparison Between 2019, 2020, and 2021 Survey Results

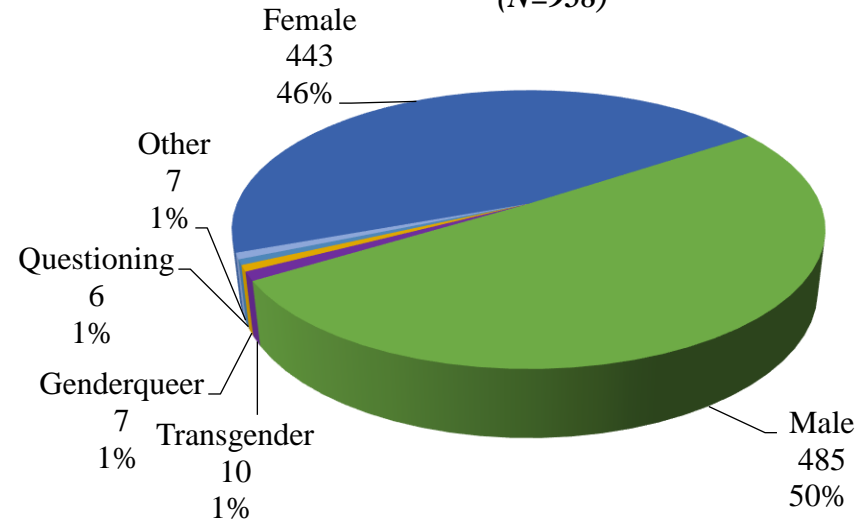
**2019 Current Gender Identity**  
**(N=1,647)**



**2020 Current Gender Identity**  
**(N=1,317)**



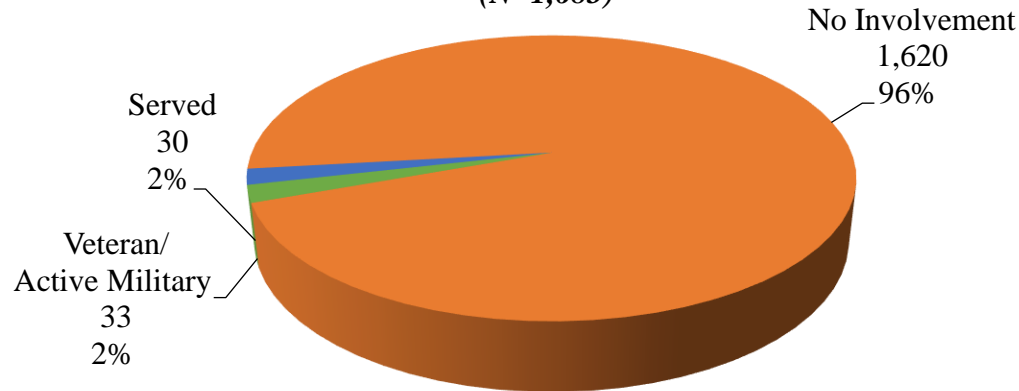
**2021 Current Gender Identity**  
**(N=958)**



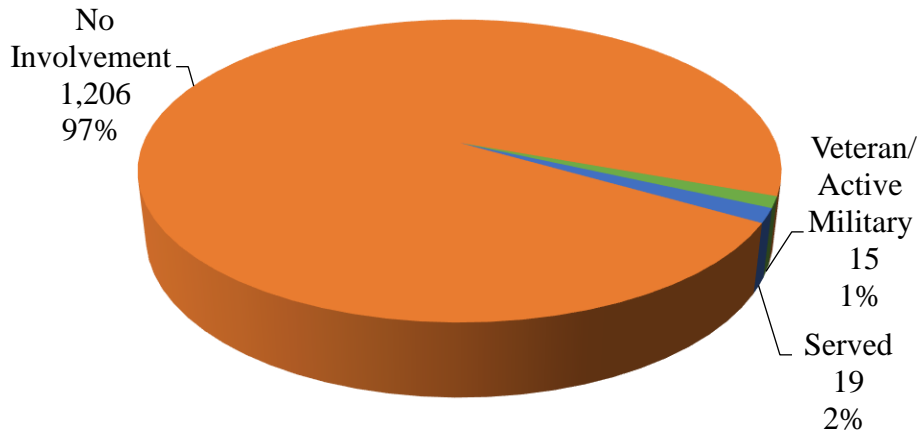
**Fresno County Department of Behavioral Health**  
***Client Cultural Humility Survey***

Comparison Between 2019, 2020, and 2021 Survey Results

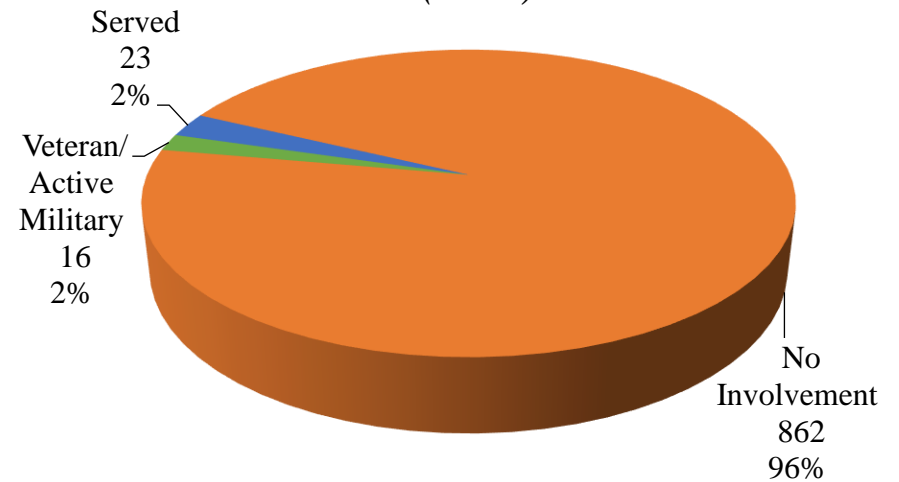
***2019 Military/Service Involvement***  
***(N=1,683)***



***2020 Military/Service Involvement***  
***(N=1,240)***



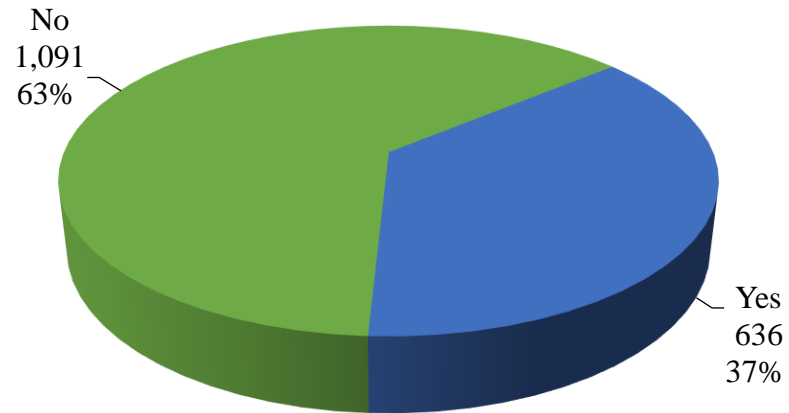
***2021 Military/Service Involvement***  
***(N=901)***



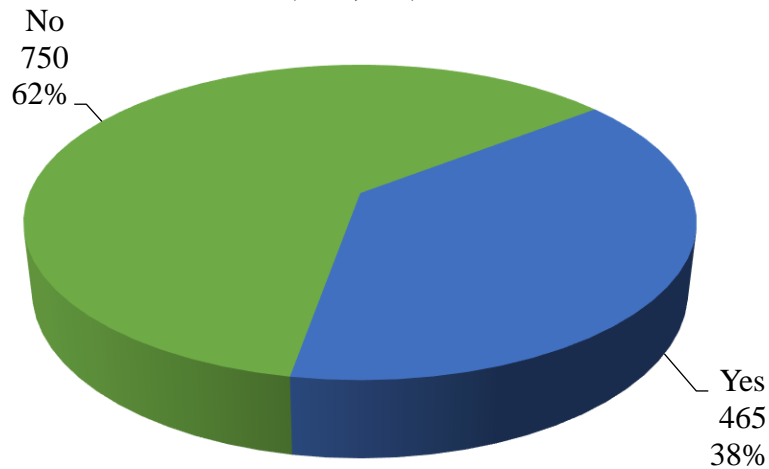
**Fresno County Department of Behavioral Health**  
***Client Cultural Humility Survey***

Comparison Between 2019, 2020, and 2021 Survey Results

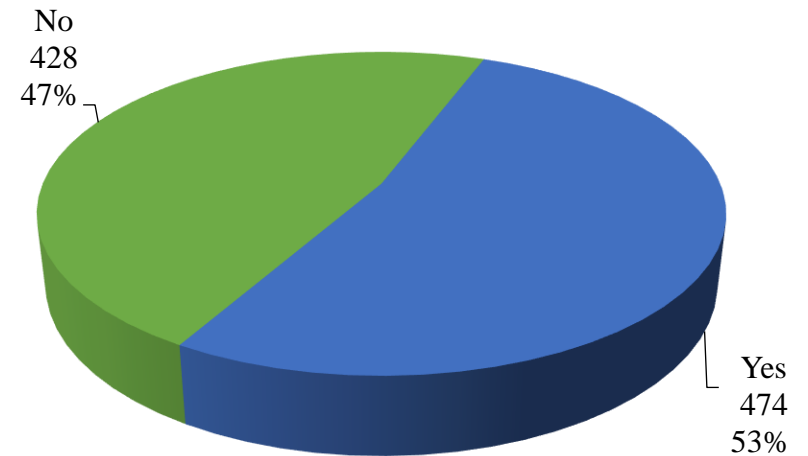
***2019 Do you have a disability?***  
***(N=1,727)***



***2020 Do you have a disability?***  
***(N=1,215)***



***2021 Do you have a disability?***  
***(N=902)***

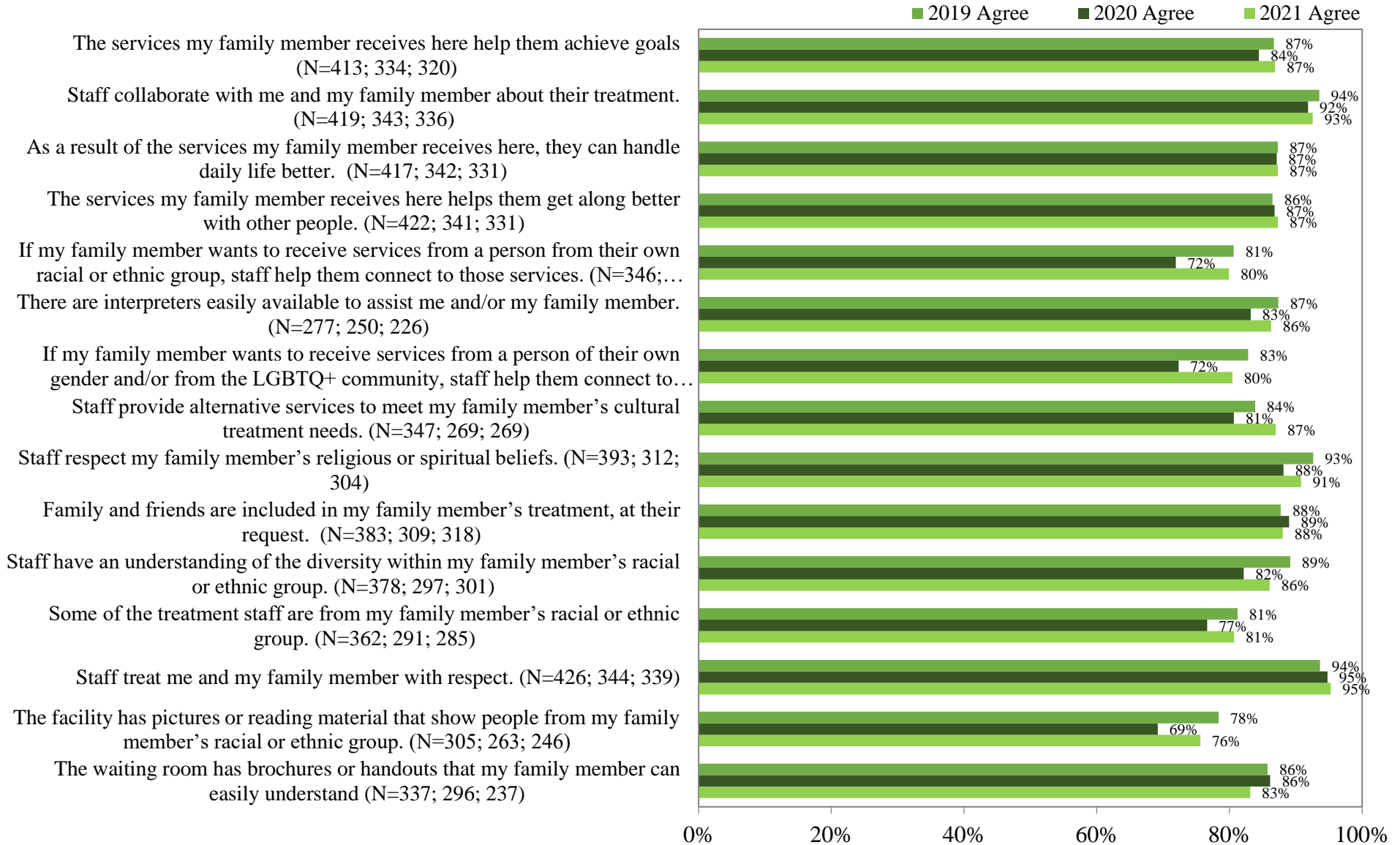


## **Attachment G: Family/Caregiver Cultural Humility Survey Results**



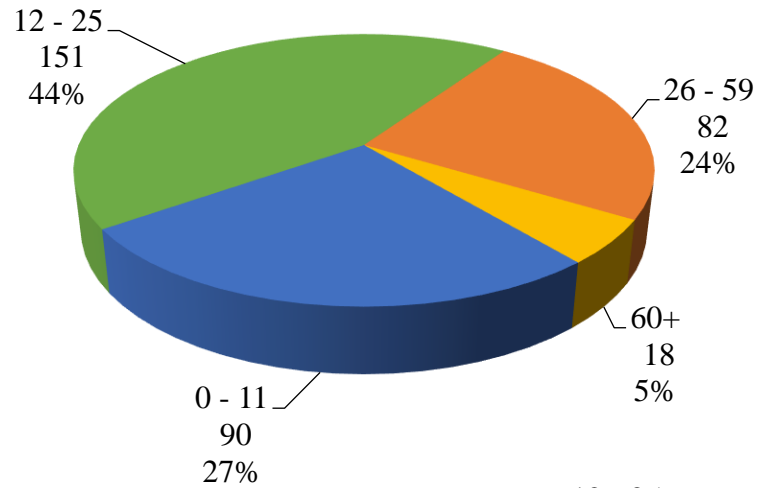
## Fresno County Department of Behavioral Health *Family/Caregiver Cultural Humility Survey*

Comparison Between 2019, 2020, and 2021 Survey Results

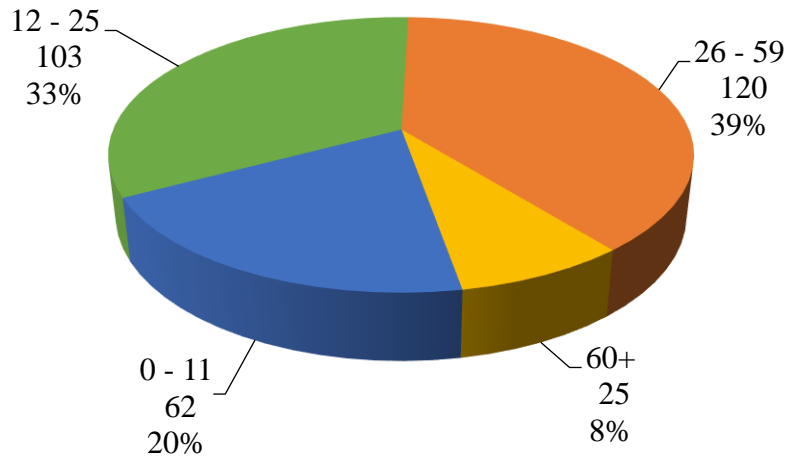


**Fresno County Department of Behavioral Health**  
***Family/Caregiver Cultural Humility Survey***  
 Comparison Between 2019, 2020, and 2021 Survey Results

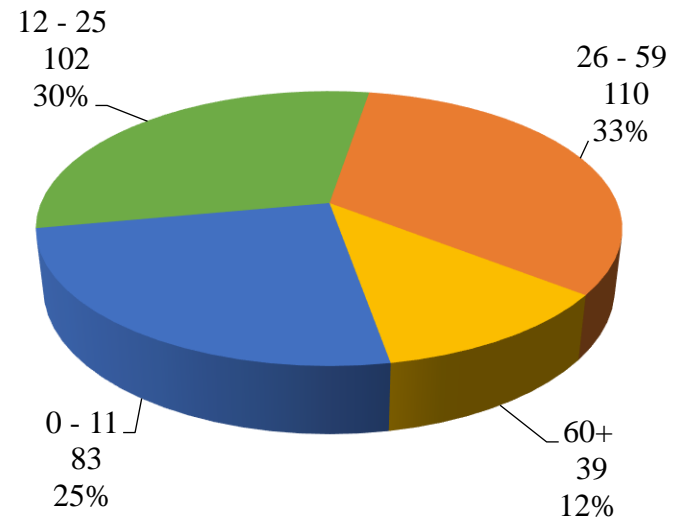
**2019 Age (N=341)**



**2020 Age (N=310)**

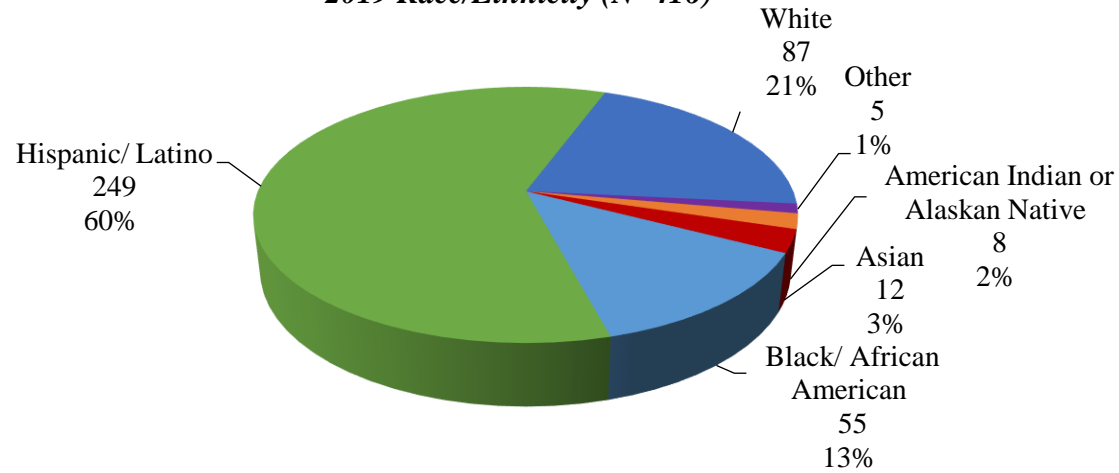


**2021 Age (N=334)**

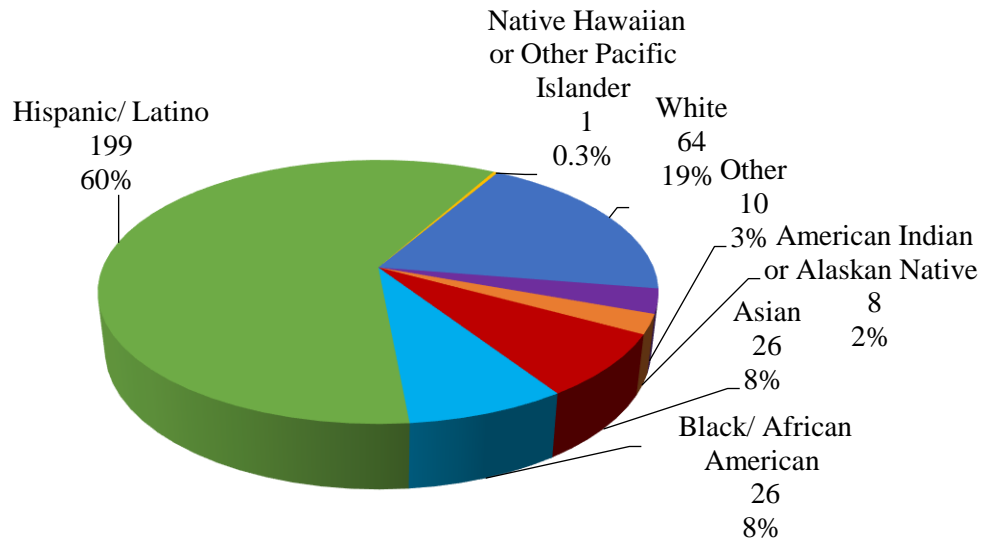


**Fresno County Department of Behavioral Health**  
***Family/Caregiver Cultural Humility Survey***  
 Comparison Between 2019, 2020, and 2021 Survey Results

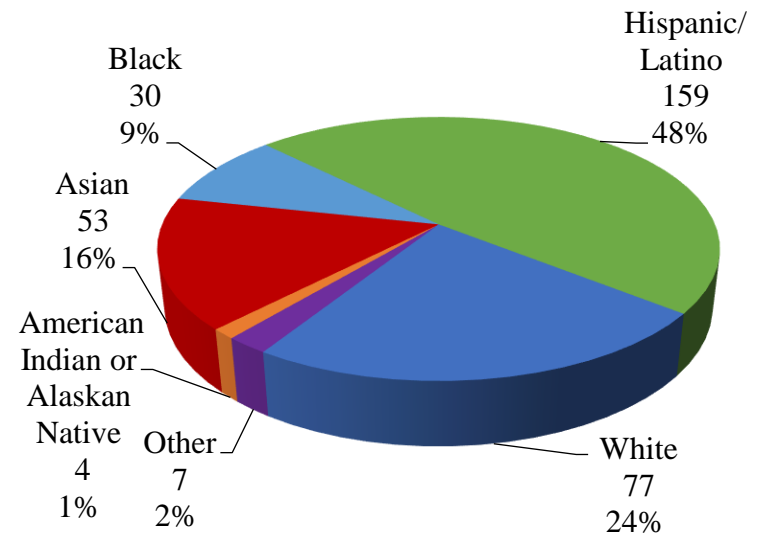
**2019 Race/Ethnicity (N=416)**



**2020 Race/Ethnicity (N=334)**

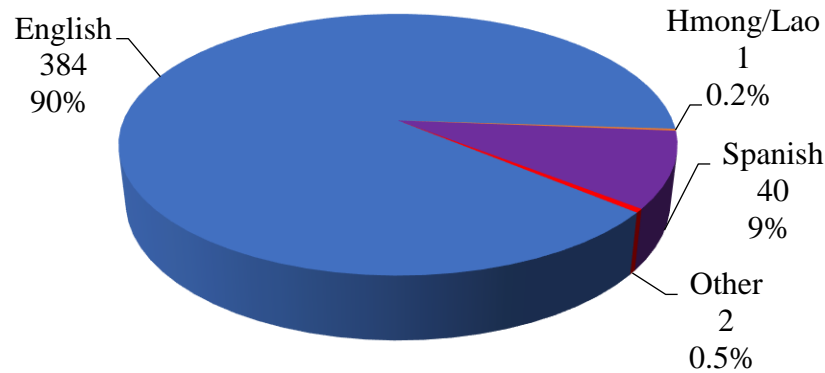


**2021 Race/Ethnicity (N=330)**

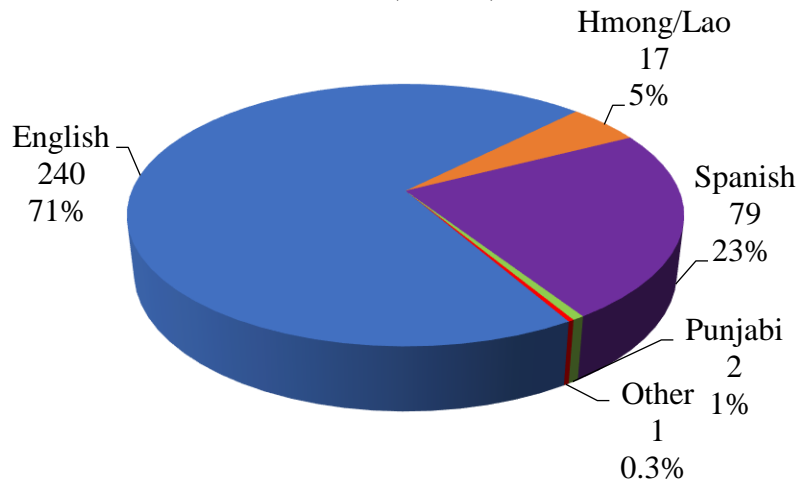


**Fresno County Department of Behavioral Health**  
***Family/Caregiver Cultural Humility Survey***  
 Comparison Between 2019, 2020, and 2021 Survey Results

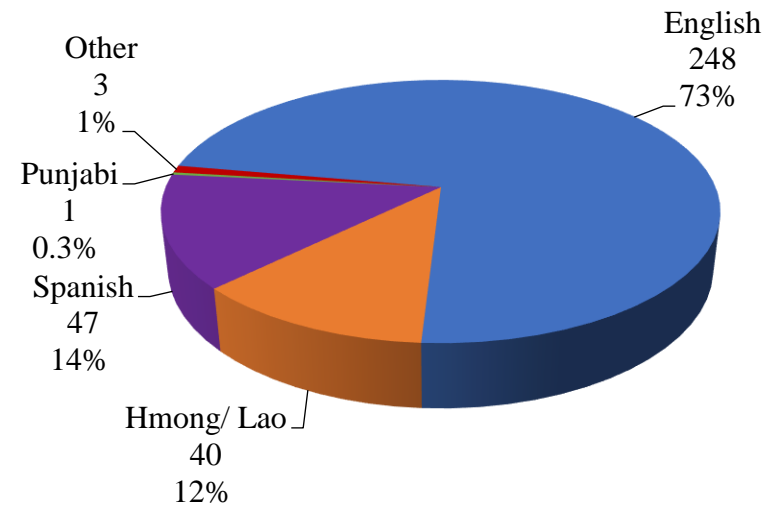
***2019 Primary Language Spoken at home***  
***(N=427)***



***2020 Primary Language Spoken at home***  
***(N=339)***

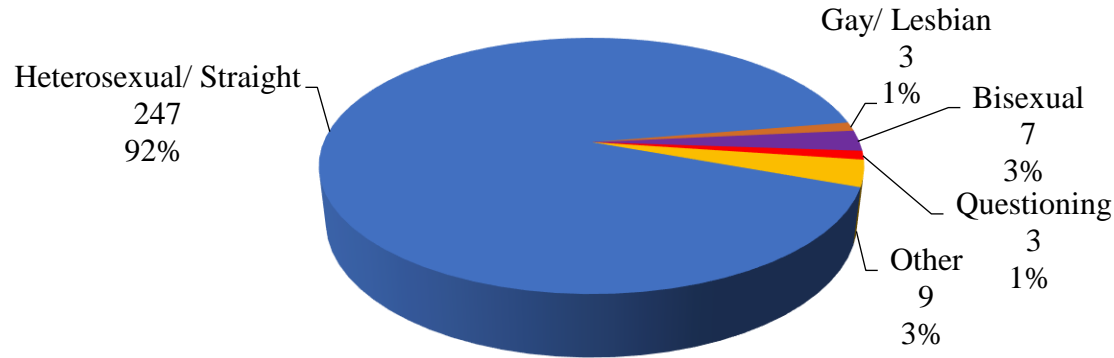


***2021 Primary Language Spoken at home***  
***(N=339)***

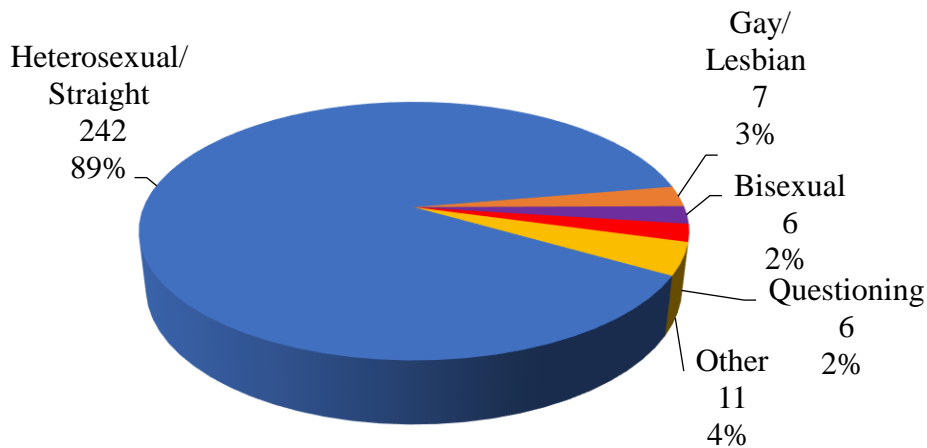


**Fresno County Department of Behavioral Health**  
***Family/Caregiver Cultural Humility Survey***  
 Comparison Between 2019, 2020, and 2021 Survey Results

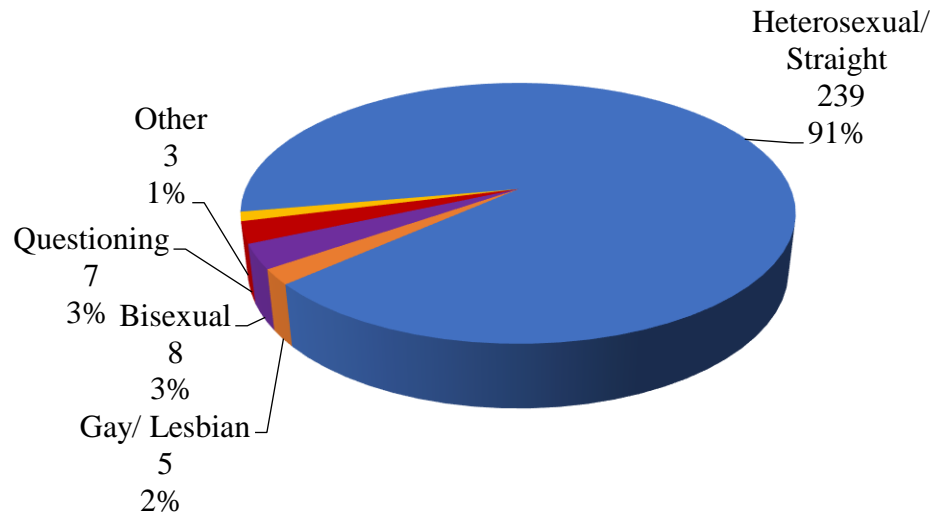
**2019 Sexual Orientation (N=269)**



**2020 Sexual Orientation (N=272)**

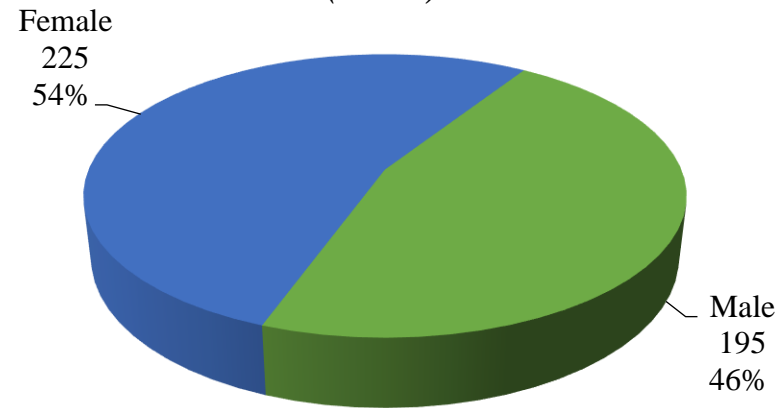


**2021 Sexual Orientation (N=262)**

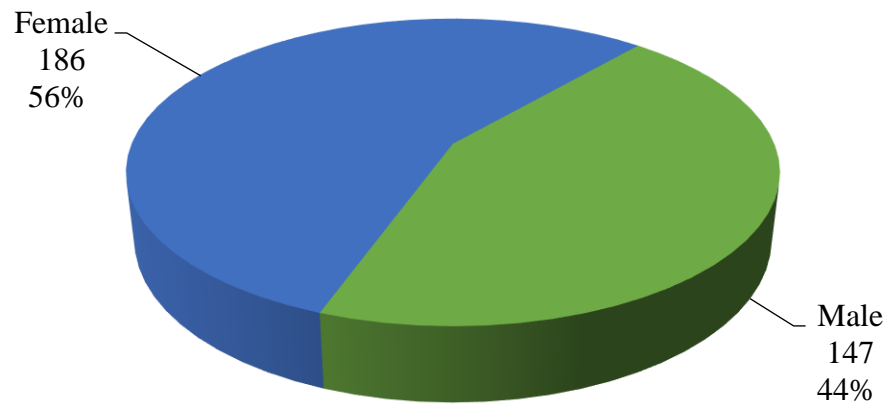


**Fresno County Department of Behavioral Health**  
***Family/Caregiver Cultural Humility Survey***  
Comparison Between 2019, 2020, and 2021 Survey Results

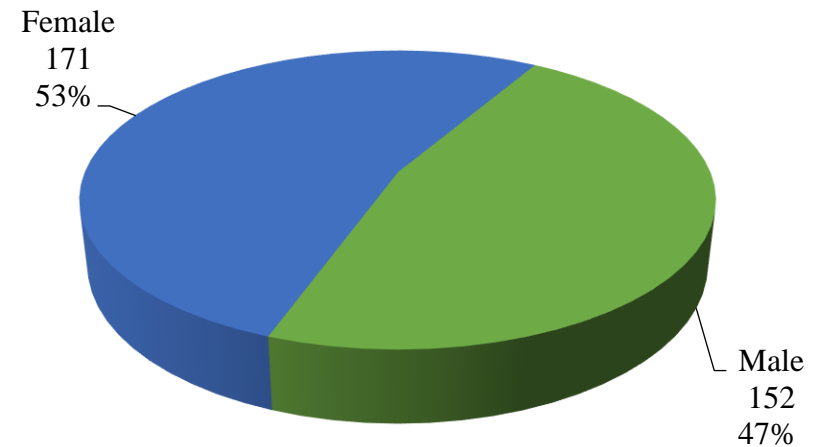
***2019 Gender Assigned at Birth***  
***(N=420)***



***2020 Gender Assigned at Birth***  
***(N=333)***

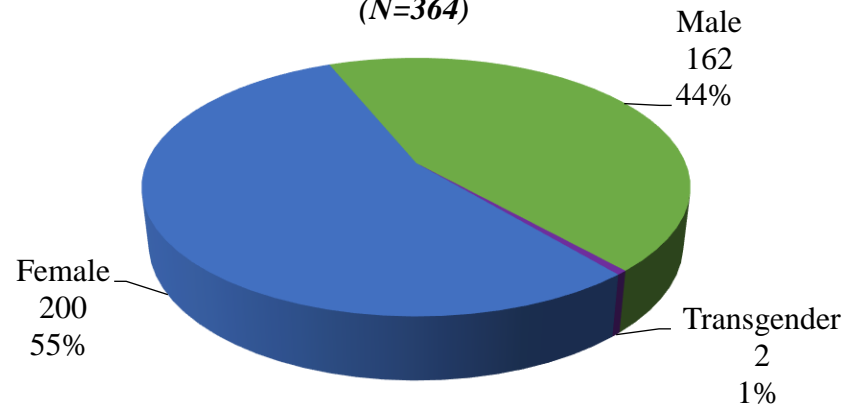


***2021 Gender Assigned at Birth***  
***(N=323)***

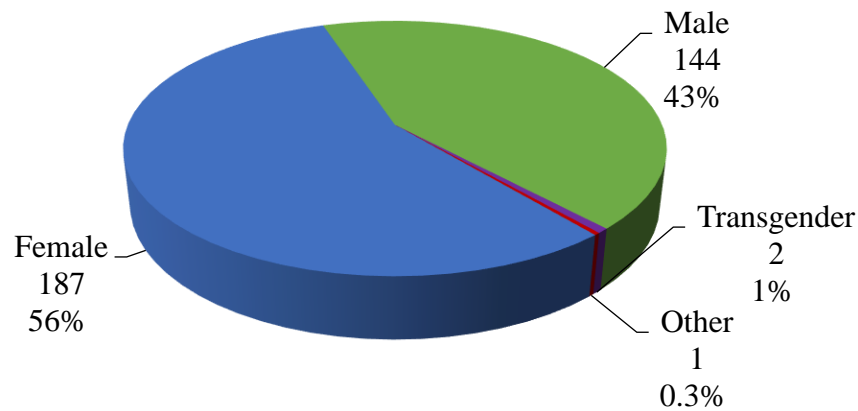


**Fresno County Department of Behavioral Health**  
***Family/Caregiver Cultural Humility Survey***  
 Comparison Between 2019, 2020, and 2021 Survey Results

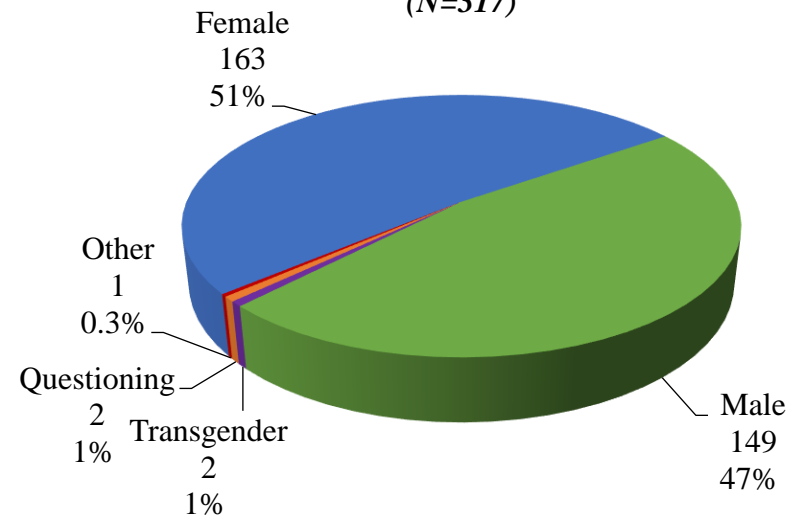
**2019 Current Gender Identity**  
 (N=364)



**2020 Current Gender Identity**  
 (N=334)

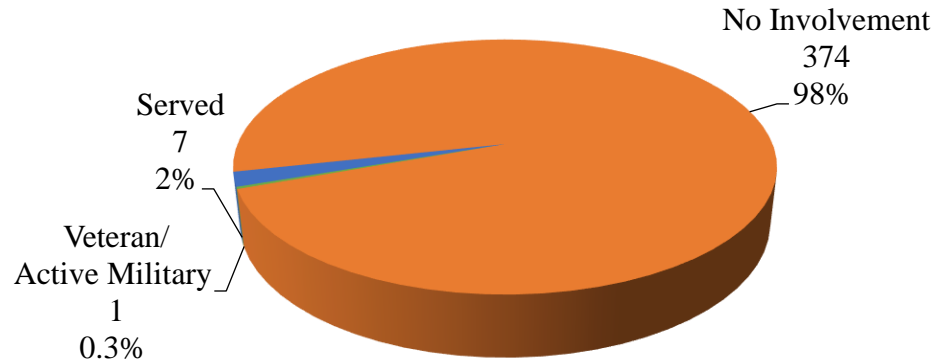


**2021 Current Gender Identity**  
 (N=317)

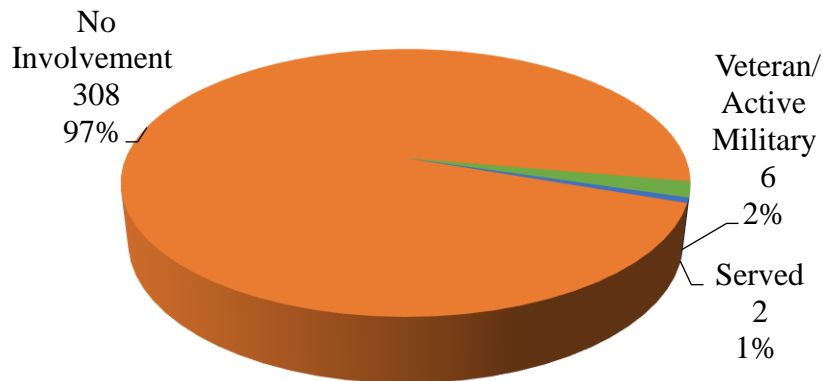


**Fresno County Department of Behavioral Health**  
***Family/Caregiver Cultural Humility Survey***  
 Comparison Between 2019, 2020, and 2021 Survey Results

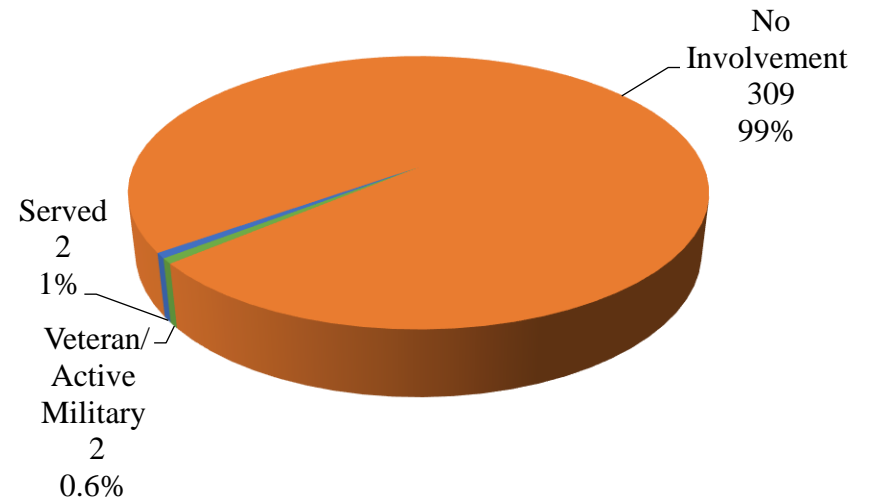
**2019 Military/Service Involvement**  
**(N=382)**



**2020 Military/Service Involvement**  
**(N=316)**



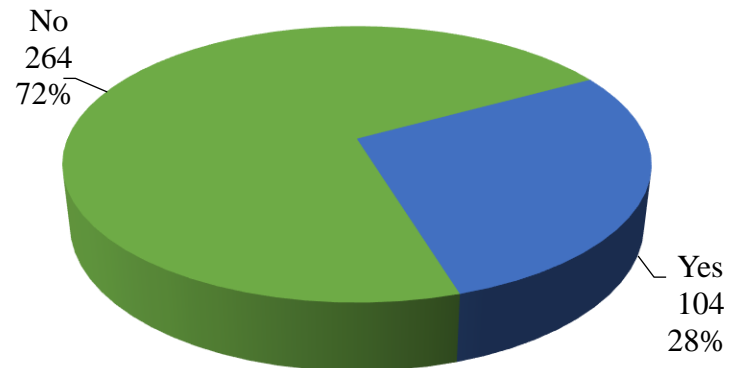
**2021 Military/Service Involvement**  
**(N=313)**



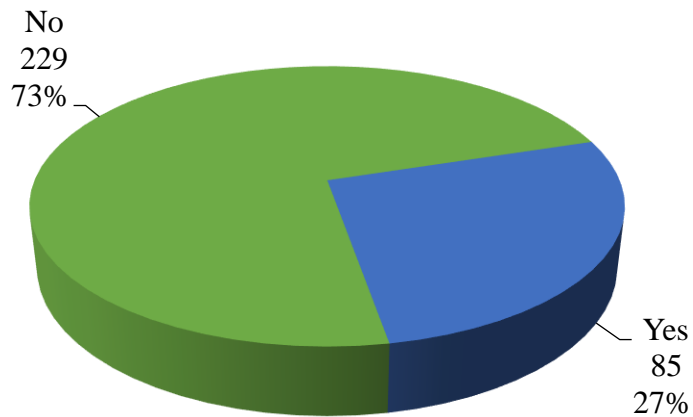


**Fresno County Department of Behavioral Health**  
***Family/Caregiver Cultural Humility Survey***  
Comparison Between 2019, 2020, and 2021 Survey Results

***2019 Does your family member have a disability? (N=368)***



***2020 Does your family member have a disability? (N=314)***



***2021 Does your family member have a disability? (N=291)***

