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

Culturally Responsive Plan
Delivered with Humility
FY 2022/23 Update

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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 June 2021, Fresno DBH developed and implemented the following inclusion statement:

> *Fresno County is a richly diverse community, and in order to support and serve ALL persons in our community, the Fresno County Department of Behavioral Health is dedicated to ensuring an inclusive overall system of care through a commitment to equity, diversity, and affirming care. We are dedicated to providing quality, culturally responsive services that promote wellness, recovery and resilience for individuals and families whom we serve.*
>
> *It is imperative for us to protect and improve the lives of Fresno County residents served by the Department and our partners in our system of care by acknowledging the long standing historic and on-going inequities that black, indigenous and people of color, those living in poverty and other marginalized and underserved communities have experienced with the behavioral health system.*
>
> *We place a great deal of importance in having Behavioral Health system of care team members who value lived experience, are reflective of our community and have the expertise to ensure our workforce is culturally and linguistically responsive and maximizes our diversity to render quality services in the most responsive, affirming, and caring manner possible for the persons we serve.*

The inclusion statement appears on all job flyers for DBH, and is included on the DBH website (e.g., on the *About Us* page), setting the tone from the first encounter, and promoting our expectations of a culturally-responsive system of care.

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 care; 2) Maximize resources while focusing on efficiency; 3) Provide an excellent care experience; and 4) Promote workforce well-being.

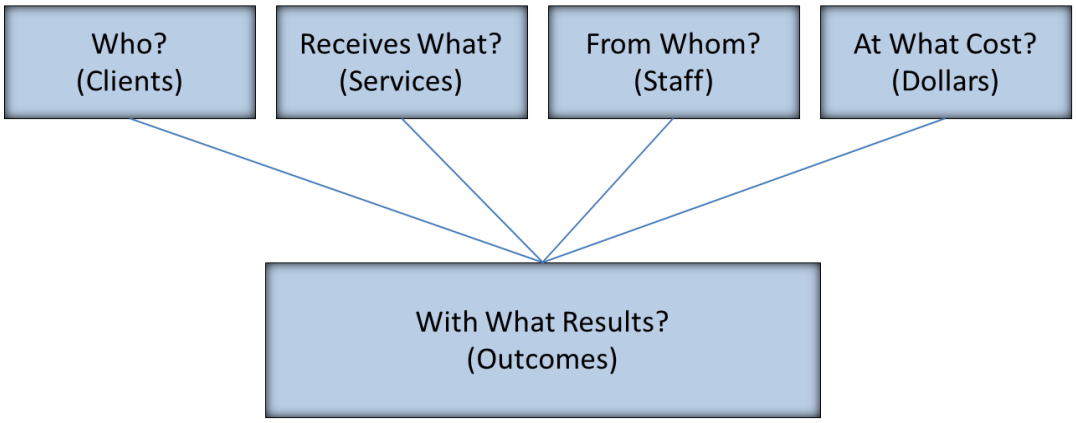
It is the vision and mission of the BHSOC to deliver culturally responsive services that promote individualized wellness and recovery to diverse cultures that reflect the health beliefs and practices of these communities. BHSOC has identified eleven guiding principles of care that are described on the 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 2022/23 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 five 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 behavioral health equity 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 Diversity, Equity, and Inclusion Committee (DEIC) 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 2022/23 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.

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

  - **Objective 1a**: BHSOC will increase the number of 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 had been left out. The data review showed the reductions were proportional across the various groups. SUD services were the most impacted by COVID-19, as many of the services were traditionally provided in a 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 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 other county peer positions in the region; and found that DBH wages were some of the highest in the area. However, there is still a high vacancy in DBH peer positions. Efforts are being made to explore the barriers to hiring. DBH had*

three MHSA Innovation Projects approved in FY 2019-20 which have full-time peer components, including one project that has a majority of positions being peers. Since the passage of SB 803, which provides a certification for Peers to expand the types of services that they can deliver, DBH has been involved in statewide and regional efforts to support peer inclusion into the workforce. In the coming year, DBH, through regional work, will support opportunities for persons with lived experience to pursue certification to work in the behavioral health setting. This strategy 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 in the individual's preferred language, whenever possible.
    - *This process was delayed by COVID-19 and will be developed this year. DBH is continuously working to identify training and staff qualifications to develop a process for identifying individuals' language preferences.*
    - *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. There are also limited SEI providers who speak languages such as Lao, Khmer, and Mien, which will need to be explored and expanded to meet the needs of these communities.*

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

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

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

- **Goal 2: To create a work environment where cultural humility, dignity, inclusion, and respect are 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 that address the CLAS standards have been developed and will soon be finalized. Revisions include an increase in the required minimum hours of annual training. All DBH supervisors were offered an Applied CLAS training, and over 50 of the 70 supervisors/managers completed 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. Additional resources have been established with the county library to access additional books.*
    - *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, CLAS standards, equity; inclusion; diversity; social determinants of behavioral health; health disparities, 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, Social Determents of Health (SDOH), BIPOC LGBTQ, etc. DBH supervisors participated in 12 hours of Diversity, Equity, and Inclusion training in the past year, provided by Terry Berman and Associates; and all DBH supervisory staff participated (including indirect services).*

  - **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 BH staff or other community providers. Behavioral Health Interpreter Training (BHIT) was offered to providers who deliver services in languages other than English.*

  - **Objective 2d**: BHSOC will support the development of a Language Services Subcommittee which supports BHSOC bilingual staff to meet regularly to create an opportunity to share ideas on how to interpret complex medical terms and meet the needs

of individuals and families receiving services. This Subcommittee 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. DBH has begun to explore training for managers to ensure practices of inclusivity to improve retention.

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

➢ **Goal 3: To deliver innovative, evidence-based, promising and community defined, trauma-informed, strengths-based, wellness and recovery focused behavioral health services in collaboration with other community organizations and co-locate services whenever possible, including in diverse community settings (e.g., homes, schools, organizational providers, senior centers, churches, etc.) to promote health and wellness.**

- **Objective 3a**: BHSOC will provide training and implementation strategies on identified culturally responsive, evidence-based, promising and community-defined practices for both mental health and substance use disorder services. This training will include, but not limited to, trauma informed Cognitive Behavioral Therapy; Motivational Interviewing; Stages of Change; Harm Reduction; Wellness and Recovery Action Plans (WRAP), 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).
  - *COVID-19 restrictions limited in-home, in-school, and many in-person service opportunities. BHSOC increased and improved its service delivery using Tele-*

health, and is actively working to create opportunities for more community-based services.

- **Objective 3e**: BHSOC will identify and implement innovative services that utilize cultural leaders, spiritual healers, cultural brokers, and culturally responsive services and practices to create healthy communities that support the delivery of services.
    - *For a number of years, DBH has funded programs that work to address community needs through culturally-relevant activities. DBH funds the Holistic Wellness Center Program, and provides education, wellness activities, training and referrals to individuals who may not seek out traditional western mental health services. Culturally Based Access and Navigation Services (CBANS) is a program that uses cultural brokers and community health workers, offering aid in Spanish, Hmong, Lao, Khmer, Hindi, and Punjabi, to assist those communities in accessing traditional or non-traditional behavioral health services.*
    - *DBH is currently working on several additional projects. One project will be funded through MHSA Innovation and focuses on collaborating with local youth to develop a program designed for youth, by youth. Using MHSA Innovation funds, the Department is also working on a Community Participatory Action Research Project to explore collaboration with local Black leaders and faith communities to enhance behavioral health literacy through community participatory action research. DBH has identified several communities for specific engagement. These projects are working with indigenous communities from Mexico and Central American; refugees and immigrants from Africa, Asia, Eastern Europe, and the Middle East; and the Muslim-American community.*
    - *Through a current MHSA Innovation Plan, DBH is funding three local California Reducing Disparities Project Phase II programs, which are community defined and population specific. To date, Fresno is the only county to fund any community-defined evidence-based practice (CDEP).*
    - *In the last year, DBH MHSA funds were used to develop an LGBTQ-BIPOC training with input from LGBTQ community and behavioral health professionals.*
    - *DBH also completed work through a third party to examine its own county RFP process. The review identified possible structural and process barriers which hinder or limit community organizations from becoming BHSOC providers. The review also identified the lack of service providers from underserved or inappropriately-served communities.*
    - *In addition, DBH is working through MHSA PEI to address Suicide Prevention opportunities with local LGBTQ+ providers.*

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

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

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

  - **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.
    - *Fresno County participated in the annual Rainbow Pride Event (May 2022); Hosted three Black History three different virtual events (Feb 2022); Women's History Panel (March 2022); virtual Native American Panel (Nov 2021); and API panel (May 2022). Also, in collaboration with several other counties, DBH participated in an API History Month virtual summit (May 2022). DBH participated in a multi-agency virtual event for International Migrants Day 2021.*
    - *The Department hosted numerous virtual panels and discussions in the past year as well. These were all streamed on the Department's social media platforms and are still available for public viewing.*
    - *DBH also expanded its reach by facilitated four community discussions in Spanish through work with Univision via social media streaming. It also participated in the Central Valley API Virtual Summit.*
    - *In Spring 2022, DBH participated in a SEA Student Career fair at Fresno State.*

  - **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 limited many of these trainings in the past few years. In May 2020, eight (8) feedback/market research groups with different target populations were held to understand how to communicate information about behavioral health,*

services, stigma reduction, etc. to specific groups/communities. This feedback helped to structure how outreach was conducted for DBH.
    - *Many of the DBH live stream events and panel discussions have been made available on Relias as additional training opportunities. Many trainings were placed on hold during the COVID 19 pandemic, including CIT, ASIST, and Mental Health First Aid. At this time, DBH has updated the list of trainers and trainings topics to meet the need and current interest.*
    - *DBH collaborated in developing the second Central California Suicide Prevention Summit, which provided free training and free Continuing Education Credits to licensed professionals in 2021. It 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.*

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

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

- **Objective 5a**: BHSOC will provide guidance and training on collecting consistent and reliable demographic data on individuals, services delivered, staff areas of specialization, and outcomes.
    - *The Rand Corp completed an evaluation for 10 of Fresno County's 17 MHSA PEI programs. The Rand Corp is developing a database for all programs that do not utilize the EHR to input data into a PEI system. They will also develop a training for the database to ensure proper data entry and submission.*

- **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 the Rand Corp for evaluation of PEI programs (many of which have a culturally specific focus). The evaluation was completed in FY 2021/22 and the results were submitted as part of the County's PEI-Three Year Evaluation Report (May 2022).*
    - *DBH completed its work 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, DEI Committee, Quality Improvement Committee, BHSOC staff, individuals, and family members to identify opportunities to continually improve access, quality, cost-effectiveness, and service outcomes.

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

E. Diversity, Equity, and Inclusion Committee

The Diversity, Equity, and Inclusion Committee (DEIC) is the identified committee that guides the CRP goals and objectives, and continually reviews and analyzes data to better understand our current service delivery system and the impact of the CRP as new strategies are implemented. The DEIC 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 DEIC include developing the official Committee 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. Updating and developing Policy and Procedure Guide (PPG) for the DEIC membership, Translation Process, and minimum training requirements for DEI for providers has also been developed and will be finalized.

In FY 2021/22, 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 DEIC 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. Outreach materials such a mental health lapel pin with the Pan-African flag colors were developed and is used during Black History Month. The county also developed mental health pins that featured the rainbow flag, and those were used during LGBTQ History Month and Pride Month as a way to build community alliance. The approach also promoted greater awareness of mental health issues in both the African American community and LGBTQ+ communities.

DBH developed a targeted survey to help its better understand how diverse communities identify

themselves and thus how to communicate effectively. The small, targeted survey sought to see how persons who self-identify as Latino/a refer to themselves. They survey collected demographic data and sought to see if persons had a preference in the use of the term Latino/a or Latinx, how that may vary by age, location, gender identity, sexual orientation, education, etc. These efforts are to help provide more effective engagement.

In addition, the DBH also supported the development of employee resource and affinity groups. The LGBTQ+ Coalition will develop recommendations to improve and expand behavioral health services for members of this community in Fresno County. The Behavioral Health for Black Lives (BHBL) affinity group was formed to advocate for behavioral health equity for all members of the Black community in Fresno County, including DBH staff and individuals served. 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's purpose is to create a safe space for API staff to come together to share experiences and concerns, and to find support. The group was meeting twice a month initially; but once they felt that they had obtained the support that they needed at the time, they moved to meet on an as-needed basis.

DBH is working with members of all of the affinity groups to explore transitioning some of them from affinity groups to employee resource workgroups which support DEI work and are able to focus on specific issues or needs of the organization.

F. Diversity, Equity, and Inclusion Subcommittees

There are three (3) separate DEIC 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 DEIC Subcommittee meeting schedule to accommodate a transition to virtual meetings. The DEIC 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 DEIC, 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 DEIC 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 DEIC 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 2022/23, the DEIC 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 DEIC Language subcommittee corresponds to CRP Goal 1, to provide improved and timely access to quality culturally- and linguistically-appropriate, integrated, behavioral health services for persons from various race/ethnicity groups; across all ages; veterans and their families; individuals who are Lesbian, Gay, Bisexual, Transgender, and Questioning Plus (LGBTQ+); persons living with disabilities (hearing, vision, physical); persons released from jail and their families; immigrants and refugees; and other diverse cultures. This subcommittee focuses its efforts on improving and expanding linguistically appropriate services for persons served. Objectives include: (1) develop the Language Champion group for Spanish and Hmong languages; (2) review service-level language data trends and identify needs annually; (3) increase bilingual-skills-proficient staffing for interpretation service to better meet the needs of Limited English Proficient (LEP) populations; and (4) identify interpreter trainings and other learning opportunities for monolingual direct-facing and bilingual speaking staff (county and contract providers).

In FY 2022/23, the DEIC Language subcommittee continued to examine the designation and certification of bilingual staff and worked closely with the Human Resources Department to expand the number of paid bilingual positions and develop strategies to help certify bilingual staff in a timely manner. The subcommittee identified an organization, Voiance, to certify bilingual staff's skills in Spanish and/or Hmong. In addition, the DEIC Language subcommittee is working to develop an Interpreter Champions group to support bilingual staff to discuss cases, consult with one another, and provide additional training. The subcommittee also identified a Behavioral Health Interpreter Training (BHIT) for interpreters and direct service staff. BHIT is a four-part, fourteen-hour workshop designed to provide instruction on the fundamental principles of interpreting.

The DEI Language Subcommittee also developed a Spanish Language Champions Guide, which is available on its website. This guide provides comprehensive English-to-Spanish translations to use when providing mental health services. This guide shows the English and corresponding Spanish words and phrases, to help communicate with Spanish speakers. It is well organized

into different topics from Introductory phrases for counselors to use, through explaining different diagnostic terms (e.g., Depression; Anxiety); Behavioral Health clinical terms; medical terms; and other mental health symptoms and concepts. This provides an excellent guide for creating a common language across interpreters to help 'standardize' terms. This helps both the persons served and family members to have the information translated consistently across interpreters and for behavioral health staff.

3. Access

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

In FY 2022/23, the DEIC Access subcommittee reviewed service-level data by race/ethnicity, gender, age, language, LGBTQ+, and region to identify strategies to improve engagement with underserved populations in Fresno County. The subcommittee also identified the need to improve data collection, especially for language, gender, and sexual orientation. The subcommittee is also discussing strategies for having the Access Line Provider(s), 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. Exodus became the designated provider for the Access Line for both mental health and substance use calls beginning July 2022. In addition, the Access subcommittee is actively researching the most effective methods for asking demographic questions and continues to work with the Quality Management department to develop strategies to improve data collection and quality.

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

II. DATA AND ANALYSIS

A. Fresno County Geographic, Demographic, and Socioeconomic Profile

1. Geographical Location and Attributes of the County

Fresno County is a large county (population of 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, American Indian/ Alaskan Native 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)

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

NOTE: *Fresno DBH utilized 2010 Census data for the Cultural Competence Plan. The 2020 Census was collected during the COVID-19 pandemic, and there have been concerns that the numbers are not as accurate as the 2010 Census data.*

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 2021/22). From this data, a penetration rate was calculated, showing the percent of persons in the general population that received mental health services in FY 2021/22. 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 26,618 people who received one or more mental health services in FY 2021/22. Of these individuals, 34.9% were children ages 0-15; 17.6% were Transition Age Youth (TAY) ages 16-25; 40.2% were adults ages 26-59; and 7.3% were 60 and older. There were 21.2% of the individuals who were White, 47.3% Hispanic/Latino, 10.2% Black, 4.6% Asian/Pacific Islander and 0.8% American Indian/ Alaskan Native. 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 (81.8%), 12.4% have a primary language of Spanish, and 1.6% have a primary language of Hmong/Lao.

The penetration rate data shows that 2.9% of the Fresno County population received mental health services. Of these individuals, children ages 0-15 had a penetration rate of 4%, TAY ages 16-25 had a penetration rate of 3.0%, adults ages 26-59 had a penetration rate of 2.6%, and older adults ages 60 and older had a penetration rate of 1.5%.

For race/ethnicity, persons who are White had a penetration rate of 1.9%, persons who are Hispanic/Latino had a penetration rate of 2.7%, 6.1% 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. Data shows that there are 3,301 individuals who reported Spanish as their primary language and 436 who reported Hmong/Lao as their primary language.

Males had a slightly lower mental health penetration rate (2.8%), compared to females (2.9%).

NOTE: *This data was collected from the DBH Avatar Electronic Health Record. The data does not include all persons served through the Mental Health Services Act (MHSA) programs, as only some MHSA programs and providers utilize or have access to Avatar.*

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 2021-22		Fresno County Population Mental Health Penetration Rate FY 2021-22
Age Distribution					
0 - 15 years	229,429	24.7%	9,281	34.9%	9,281 / 229,429 = 4.0%
16 - 25 years	156,596	16.8%	4,679	17.6%	4,679 / 156,596 = 3.0%
26 - 59 years	411,057	44.2%	10,711	40.2%	10,711 / 411,057 = 2.6%
60+ years	133,368	14.3%	1,947	7.3%	1,947 / 133,368 = 1.5%
Total	**930,450**	**100.0%**	**26,618**	**100.0%**	**26,618 / 930,450 = 2.9%**
Race/Ethnicity Distribution					
Black	44,662	4.8%	2,722	10.2%	2,722 / 44,662 = 6.1%
American Indian/ Alaskan Native	6,513	0.7%	219	0.8%	219 / 6,513 = 3.4%
Asian/ Other Pacific Islander	86,532	9.3%	1,224	4.6%	1,224 / 86,532 = 1.4%
White	304,257	32.7%	5,651	21.2%	5,651 / 304,257 = 1.9%
Hispanic/ Latino	468,016	50.3%	12,600	47.3%	12,600 / 468,016 = 2.7%
Other/ Not Reported	20,470	2.2%	4,202	15.8%	4,202 / 20,470 = 20.5%
Total	**930,450**	**100.0%**	**26,618**	**100.0%**	**26,618 / 930,450 = 2.9%**
Language Distribution					
English	-	-	21,780	81.8%	-
Spanish	-	-	3,301	12.4%	-
Hmong/ Lao	-	-	436	1.6%	-
Other/ Not Reported	-	-	1,101	4.1%	-
Total	-	-	**26,618**	**100.0%**	-
Gender Distribution					
Male	464,811	50.0%	12,957	48.7%	12,957 / 464,811 = 2.8%
Female	465,639	50.0%	13,623	51.2%	13,623 / 465,639 = 2.9%
Transgender	-	-	33	0.12%	-
Other/ Not Reported	-	-	5	0.02%	-
Total	**930,450**	**100.0%**	**26,618**	**100.0%**	**26,618 / 930,450 = 2.9%**

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. When Medicare services are delivered by private providers, the data on service utilization is not 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 2.9%. 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 2.7% with 12,600 accessing mental health services out of the total Hispanic/Latino population of 468,016. The penetration rate for persons who are Black is 6.1%, with a smaller number of people served (2,722) and smaller population in the county (44,662). The penetration rate for persons who are White is 1.9%, with 5,651 persons served, out of 304,257 in the population. There were 4,202 out of 20,470 people with an 'Other/Not Reported' for data reported on race/ethnicity, showing a penetration rate of 20.5%. There is a very high rate of Other/Not Reported race/ethnicity for FY 2021/22. This high rate of Other/Not Reported which may reflect the impact of COVID on the system of care. If all services for an individual are delivered through telehealth, demographic information is not consistently collected by service delivery staff.

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 accurately 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.

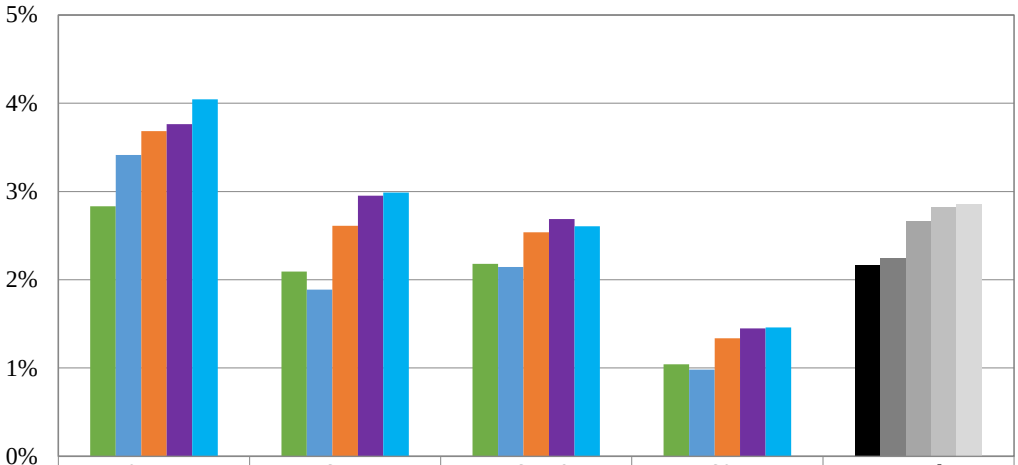
This data provides important information on documenting the ongoing need to hire bilingual/bicultural staff, improve access, and identify other opportunities to engage culturally diverse communities. The development of additional positions and expanding workforce to address cultural/language needs will 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 using accurate and reliable data.

The data on gender distribution shows that there are many challenges in collecting accurate information on Sexual Orientation and Gender Identity (SOGI) data. Out of the 26,618 persons served, only 33 reported Transgender. This area will continue to be a focus for DBH, as well as the DEI Committee, to identify strategies for collecting this important information.

6. Mental Health Penetration Rate Trends for Five Fiscal Years

Figure 3 shows the penetration rates data for five (5) years, FY 2017/18 to FY 2021/22, by age. The data shows an increase in the number of individuals served between FY 2017/18 through FY 2021/22 across all age groups. The total number of individuals served increased from 20,135 to 26,618 individuals in this period. The number of individuals served ages 0-15 increased from 6,499 to 9,281, and the number of TAY ages 16-25 increased from 3,279 to 4,679. The number of adult individuals served ages 26-59 increased from 8,967 to 10,711, and the number of Older Adults ages 60 and older increased from 1,390 to 1,947.

Figure 3
Fresno County Mental Health Services
Mental Health Penetration Rate, by Age
FY 2017-18 to FY 2021-22



	0 - 15	16 - 25	26 - 59	60+	Total
FY 2017-18 # Participants	6,499	3,279	8,967	1,390	20,135
FY 2017-18 Penetration Rate	2.8%	2.1%	2.2%	1.0%	2.2%
FY 2018-19 # Participants	7,831	2,956	8,822	1,309	20,918
FY 2018-19 Penetration Rate	3.4%	1.9%	2.1%	1.0%	2.2%
FY 2019-20 # Participants	8,453	4,088	10,434	1,783	24,758
FY 2019-20 Penetration Rate	3.7%	2.6%	2.5%	1.3%	2.7%
FY 2020-21 # Participants	8,632	4,623	11,052	1,932	26,239
FY 2020-21 Penetration Rate	3.8%	3.0%	2.7%	1.4%	2.8%
FY 2021-22 # Participants	9,281	4,679	10,711	1,947	26,618
FY 2021-22 Penetration Rate	4.0%	3.0%	2.6%	1.5%	2.9%
Fresno County Census Population	229,429	156,596	411,057	133,368	930,450

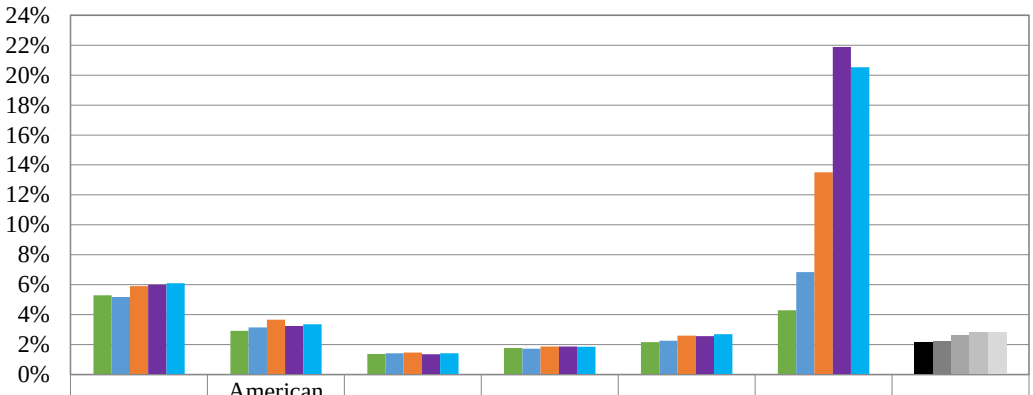
Figure 4 shows the Penetration Rate for the same five (5) years for race/ethnicity. The total number of clients served each year increased across all race and ethnicity categories, and for the total number of clients. The number of clients increased from 20,135 in FY 2017/18 to 26,618 in FY 2021/22. This is an increase of 6,483 clients across the five years.

Overall, the penetration rate shows an increase, 2.2% to 2.9%. Each of the five primary race/ethnicity groups also show an increase in the penetration rate. The number of individuals served who are Black increased slightly (2,680 to 2,722). The number of individuals served who are American Indian/Alaska Native increased slightly (211 to 219). The number of individuals served who are Asian/Other Pacific Islander increased slightly (1,178 to 1,224).

The number of individuals served who are White increased across the five years from 5,396 to 5,651). The number of Hispanic/Latino individuals served showed an increase, from 10,119 to 12,600.

The large number of persons who did not have race/ethnicity reported for FY 2021/22 is also shown in this figure. Across the five years, there has also been a large increase in the number of individuals served whose race/ethnicity is Not Reported (879 to 4,202). This increase was most significant from 2,766 in FY 2019/20 to 4,479 in FY 2020/21. This increase is likely due to COVID-19 and the increase in the use of telehealth. Compared to FY 2020/21, there has been a slight decrease from 4,479 to 4,202 in FY 2021/22.

Figure 4
Fresno County Mental Health Services
Mental Health Penetration Rate, by Race/Ethnicity
FY 2017-18 to FY 2021-22



	Black	American Indian/ Alaskan Native	Asian/ Other Pacific Islander	White	Hispanic/ Latino	Other/ Not Reported	Total
FY 2017-18 # Participants	2,366	190	1,185	5,396	10,119	879	20,135
FY 2017-18 Penetration Rate	5.3%	2.9%	1.4%	1.8%	2.2%	4.3%	2.2%
FY 2018-19 # Participants	2,310	205	1,221	5,238	10,545	1,399	20,918
FY 2018-19 Penetration Rate	5.2%	3.1%	1.4%	1.7%	2.3%	6.8%	2.2%
FY 2019-20 # Participants	2,640	238	1,269	5,678	12,167	2,766	24,758
FY 2019-20 Penetration Rate	5.9%	3.7%	1.5%	1.9%	2.6%	13.5%	2.7%
FY 2020-21 # Participants	2,680	211	1,178	5,671	12,020	4,479	26,239
FY 2020-21 Penetration Rate	6.0%	3.2%	1.4%	1.9%	2.6%	21.9%	2.8%
FY 2021-22 # Participants	2,722	219	1,224	5,651	12,600	4,202	26,618
FY 2021-22 Penetration Rate	6.1%	3.4%	1.4%	1.9%	2.7%	20.5%	2.9%
Fresno County Census Population	44,662	6,513	86,532	304,257	468,016	20,470	930,450

7. Mental Health Medi-Cal Population

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

The first column of numbers in Figure 5 shows the total number of persons served in the mental health system in FY 2021/22. For children, there were 9,281 children served (34.59% of all clients). The middle column shows the number of mental health participants that had Medi-Cal. For children, there were 8,287 children with Medi-Cal (37.0% of all clients). The far-right column shows the percent of children with Medi-Cal (89.3%). Across the ages, children have the highest proportion of mental health clients on Medi-Cal. The smallest proportion is Older Adults, at 65.5%. Many older adults have Medicare, so access services through private providers.

For Race/ethnicity, Asian/Pacific Islander have the highest proportion on Medi-Cal at 89.4%, followed by Black and American Indian/Alaskan Native at 86.8%. Hispanic is 88.3% and White is 84.5%.

Language shows 92.2% of all Hmong/Lao clients have Medi-Cal while 87.8% of Spanish speakers. Females have a higher proportion on Medi-Cal with 868% compared to males at 81.3%.

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 2021-22		Medi-Cal Mental Health Participants Served FY 2021-22		MH Medi-Cal Participants out of Total MH Participants FY 2021-22
Age Distribution					
0 - 15 years	9,281	34.9%	8,287	37.0%	8,287 / 9,281 = 89.3%
16 - 25 years	4,679	17.6%	3,965	17.7%	3,965 / 4,679 = 84.7%
26 - 59 years	10,711	40.2%	8,859	39.6%	8,859 / 10,711 = 82.7%
60+ years	1,947	7.3%	1,275	5.7%	1,275 / 1,947 = 65.5%
Total	**26,618**	**100.0%**	**22,386**	**100.0%**	**22,386 / 26,618 = 84.1%**
Race/Ethnicity Distribution					
Black	2,722	10.2%	2,363	10.6%	2,363 / 2,722 = 86.8%
American Indian/ Alaskan Native	219	0.8%	190	0.8%	190 / 219 = 86.8%
Asian/ Other Pacific Islander	1,224	4.6%	1,094	4.9%	1,094 / 1,224 = 89.4%
White	5,651	21.2%	4,776	21.3%	4,776 / 5,651 = 84.5%
Hispanic/ Latino	12,600	47.3%	11,125	49.7%	11,125 / 12,600 = 88.3%
Other/ Not Reported	4,202	15.8%	2,838	12.7%	2,838 / 4,202 = 67.5%
Total	**26,618**	**100.0%**	**22,386**	**100.0%**	**22,386 / 26,618 = 84.1%**
Language Distribution					
English	21,780	81.8%	18,543	82.8%	18,543 / 21,780 = 85.1%
Spanish	3,301	12.4%	2,898	12.9%	2,898 / 3,301 = 87.8%
Hmong/ Lao	436	1.6%	402	1.8%	402 / 436 = 92.2%
Other/ Not Reported	1,101	4.1%	543	2.4%	543 / 1,101 = 49.3%
Total	**26,618**	**100.0%**	**22,386**	**100.0%**	**22,386 / 26,618 = 84.1%**
Gender Distribution					
Male	12,957	48.7%	10,534	47.1%	10,534 / 12,957 = 81.3%
Female	13,623	51.2%	11,826	52.8%	11,826 / 13,623 = 86.8%
Transgender	33	0.12%	24	0.11%	24 / 33 = 72.7%
Other/ Not Reported	5	0.02%	2	0.01%	2 / 5 = 40.0%
Total	**26,618**	**100.0%**	**22,386**	**100.0%**	**22,386 / 26,618 = 84.1%**

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, 84.1% of the persons served had Medi-Cal. Persons ages 60 and older had the lowest proportion of Medi-Cal benefits at 65.5%. For race/ethnicity, 67.5% of those with other/not reported had Medi-Cal benefits and those with other/not reported for Language (49.3%) had Medi-Cal. Males had a lower proportion of males with Medi-Cal (81.3%) compared to females (86.8%). 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 2021/22. 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 4,842 individuals who received one or more SUD services in FY 2021/22. Of these individuals, 8% were children ages 0-15; 14.3% were TAY ages 16-25; 69% were adults ages 26-59; and 8.7% were ages 60 and older.

Of the individuals who received SUD services, 46.6% identified as Hispanic/Latino and 28% identified as White. All other race/ethnicity groups represented a small number of individuals. Most individual's primary language was English (87.1%), 9.5% reported a primary language of Spanish, and 0.6% reported a primary language of Hmong/Lao. More individuals receiving SUD services identified as male (59.7%) as compared to female (40.3%).

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 0.2%, 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 0.5% ~~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 higher penetration rate (0.6%) compared to females (0.4%).

***NOTE: The Race/Ethnicity data for FY 2021/22 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 Age, Race/Ethnicity, Language, and Gender
(Population Source: 2010 Census)

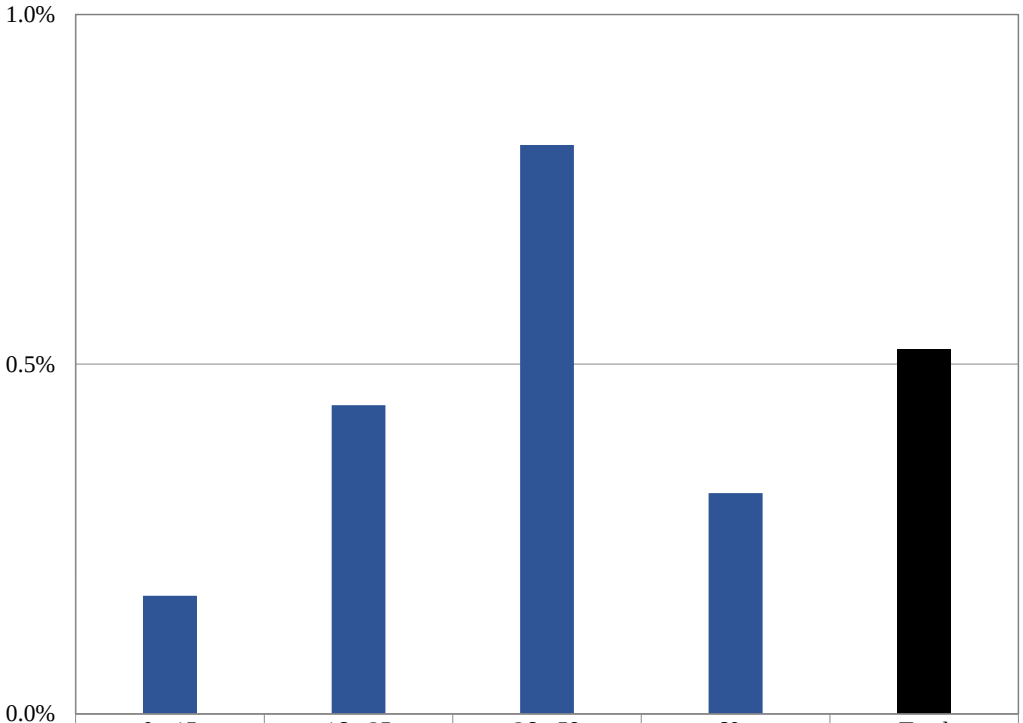
	Fresno County Population 2010 Census		All Substance Use Participants FY 2021-22		Fresno County Population Substance Use Penetration Rate FY 2021-22
Age Distribution					
0 - 15 years	229,429	24.7%	387	8.0%	387 / 229,429 = 0.2%
16 - 25 years	156,596	16.8%	691	14.3%	691 / 156,596 = 0.4%
26 - 59 years	411,057	44.2%	3,343	69.0%	3,343 / 411,057 = 0.8%
60+ years	133,368	14.3%	421	8.7%	421 / 133,368 = 0.3%
Total	**930,450**	**100.0%**	**4,842**	**100.0%**	**4,842 / 930,450 = 0.5%**
Race/Ethnicity Distribution**					
Black	44,662	4.8%	341	7.0%	341 / 44,662 = 0.8%
American Indian/ Alaskan Native	6,513	0.7%	64	1.3%	64 / 6,513 = 1.0%
Asian/ Other Pacific Islander	86,532	9.3%	108	2.2%	108 / 86,532 = 0.1%
White	304,257	32.7%	1,357	28.0%	1,357 / 304,257 = 0.4%
Hispanic/ Latino	468,016	50.3%	2,254	46.6%	2,254 / 468,016 = 0.5%
Other/ Not Reported**	20,470	2.2%	718	14.8%	718 / 20,470 = 3.5%
Total	**930,450**	**100.0%**	**4,842**	**100.0%**	**4,842 / 930,450 = 0.5%**
Language Distribution					
English	-	-	4,219	87.1%	-
Spanish	-	-	462	9.5%	-
Hmong/ Lao	-	-	29	0.6%	-
Other/ Not Reported	-	-	132	2.7%	-
Total	-	-	**4,842**	**100.0%**	-
Gender Distribution					
Male	464,811	50.0%	2,889	59.7%	2,889 / 464,811 = 0.6%
Female	465,639	50.0%	1,950	40.3%	1,950 / 465,639 = 0.4%
Transgender	-	-	3	0.1%	-
Total	**930,450**	**100.0%**	**4,842**	**100.0%**	**4,842 / 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 2021/22, by age. Of the total number of individuals served (4,842) there were a small number of children ages 0-15 (N=387) and a penetration rate of 0.2%. Transition Age Youth, ages 16-25 had a penetration rate of 0.4%, with 691 served. Adults ages 26-59 had a penetration rate of 0.8% with 3,343 served. Older adults had a penetration rate of 0.5%, with 421 served.

NOTE: The FY 2020/21 SUD data was only available for January – June 2021, because SUDS only implemented DMC-ODS in January 2021. Only six months of data was available for FY 2020/21. FY 2021/22 is the first fiscal year with 12 full months of data.

Figure 7
Fresno County Substance Use Disorder Outpatient Services
Penetration Rate, by Age
FY 2021-22



	0 - 15	16 - 25	26 - 59	60+	Total
FY 2021-22 # Participants	387	691	3,343	421	4,842
FY 2021-22 Penetration Rate	0.2%	0.4%	0.8%	0.3%	0.5%
Fresno County Census Population	229,429	156,596	411,057	133,368	930,450

10. Analysis of Disparities identified in SUD Services

Figure 6 data also shows that the majority of SUD outpatient services individuals served are adults (69% compared to 44.2% of the population). Individuals served who identified as Hispanic/Latino represent 44.6% 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 (7% compared to 4.8% of the population), as did American Indian/Alaskan Native (1.3% compared to 0.7% of the population). There was a higher proportion of individuals served who identified as male (59.7%) than female (40.3%). This data illustrates the need to provide culturally responsive/appropriate services to individuals receiving SUD services.

***NOTE: The Race/Ethnicity data for FY 2021/22 had a large number of persons recorded as Other/Not Reported. This result may have been due to a reporting issue with Avatar, and Race/Ethnicity was not collected for several months in the FY 2021/22 fiscal year.*

B. Utilization of Behavioral Health Services

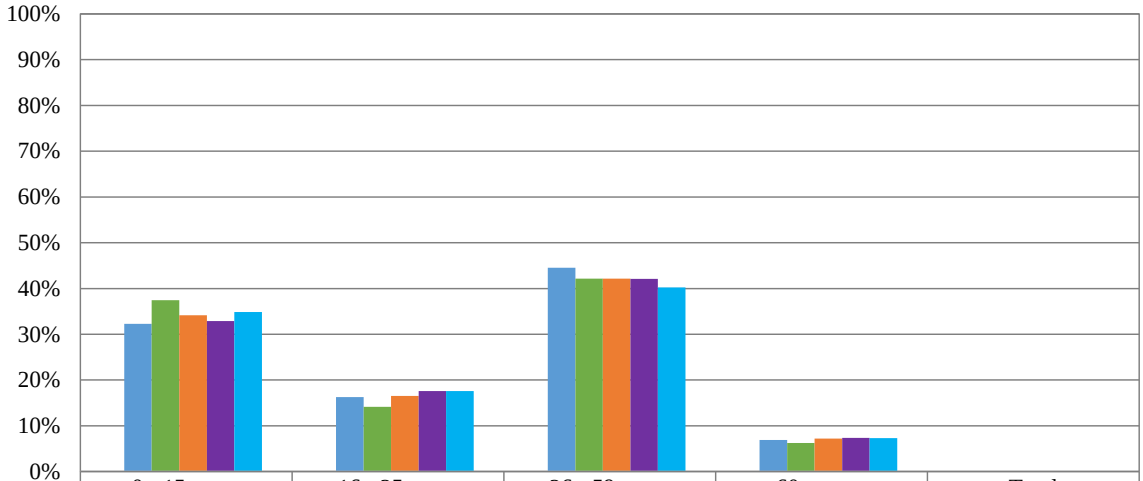
1. Mental Health Outpatient Services by Demographics

Figure 8 shows the number and percent of individuals who received mental health outpatient services by age group for five years, FY 2017/18 to FY 2021/22. 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 five fiscal years, by age group. Each fiscal year represents services delivered from July 1 through June 30.

Of the 26,618 people served in FY 2021/22:

- 34.9% were Children ages 0-15;
- 17.6% were TAY, ages 16-25;
- 40.2% were Adults ages 26-59; and
- 7.3% were Older Adults, ages 60+.

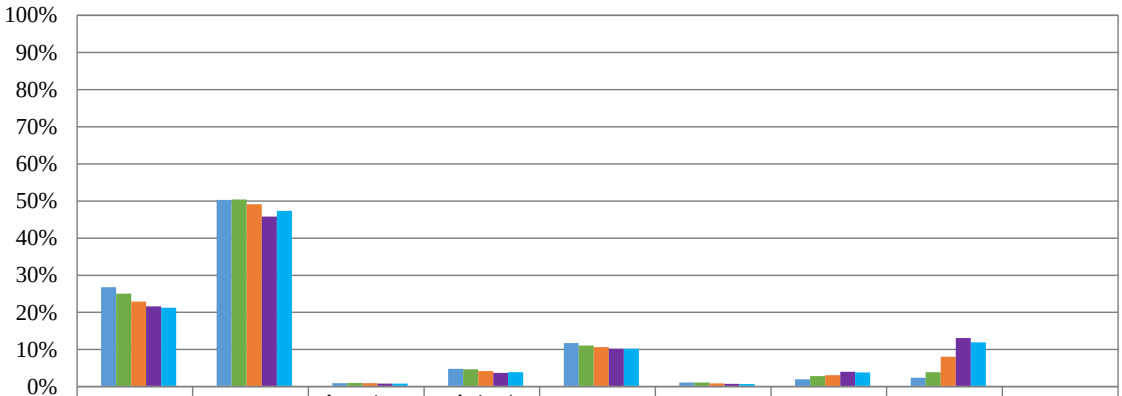
Figure 8
Fresno County Mental Health Outpatient Services
Number and Percent of Individuals Served, by Age
FY 2017-18 to FY 2021-22



	0 - 15 years	16 - 25 years	26 - 59 years	60+ years	Total
# FY 2017-18 Individuals	6,499	3,279	8,967	1,390	20,135
% FY 2017-18 Individuals	32.3%	16.3%	44.5%	6.9%	100.0%
# FY 2018-19 Individuals	7,831	2,956	8,822	1,309	20,918
% FY 2018-19 Individuals	37.4%	14.1%	42.2%	6.3%	100.0%
# FY 2019-20 Individuals	8,453	4,088	10,434	1,783	24,758
% FY 2019-20 Individuals	34.1%	16.5%	42.1%	7.2%	100.0%
# FY 2020-21 Individuals	8,632	4,623	11,052	1,932	26,239
% FY 2020-21 Individuals	32.9%	17.6%	42.1%	7.4%	100.0%
# FY 2021-22 Individuals	9,281	4,679	10,711	1,947	26,618
% FY 2021-22 Individuals	34.9%	17.6%	40.2%	7.3%	100.0%

Figure 9 shows the number and percent of individuals who received one or more mental health outpatient services from FY 2017/18 to FY 2021/22, by race/ethnicity. This data is collected from Avatar. This data shows that in FY 2021/22, of the 26,618 individuals receiving mental health services, 21.2% are White, 47.3% are Hispanic/Latino, 0.8% are American Indian/Alaskan Native, 3.9% are Asian/Other Pacific Islander, 10.2% are Black, 0.7% are Hmong/Laotian, and 3.8% Other. There were 3,181 (12%) 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.

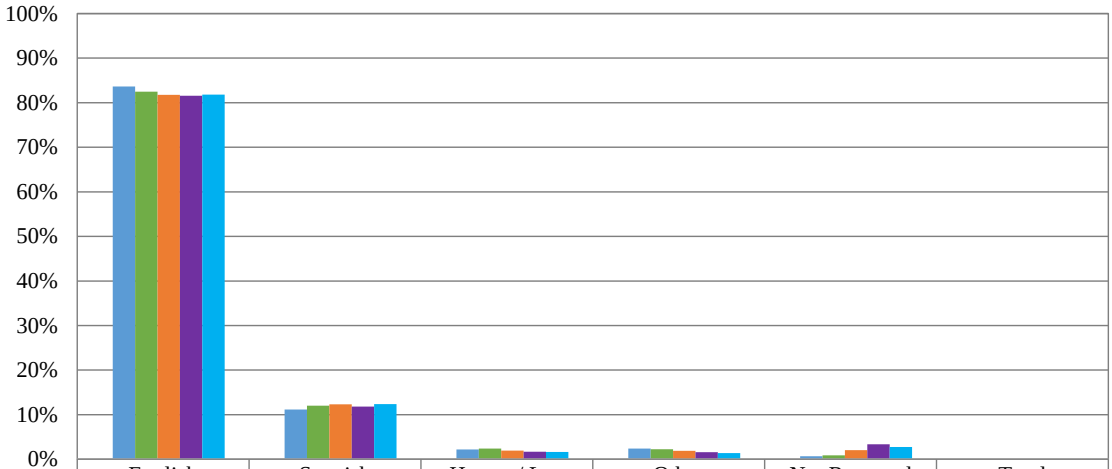
Figure 9
Fresno County Mental Health Outpatient Services
Number and Percent of Individuals Served, by <u>Race/Ethnicity</u>
FY 2017-18 to FY 2021-22



	White	Hispanic/ Latino	American Indian/ Alaskan Native	Asian/ Other Pacific Islander	Black	Hmong/ Laotian	Other	Not Reported	Total
# FY 2017-18 Individuals	5,396	10,119	190	963	2,366	222	398	481	20,135
% FY 2017-18 Individuals	26.8%	50.3%	0.9%	4.8%	11.8%	1.1%	2.0%	2.4%	100.0%
# FY 2018-19 Individuals	5,238	10,545	205	984	2,310	237	589	810	20,918
% FY 2018-19 Individuals	25.0%	50.4%	1.0%	4.7%	11.0%	1.1%	2.8%	3.9%	100.0%
# FY 2019-20 Individuals	5,678	12,167	238	1,046	2,640	223	772	1,994	24,758
% FY 2019-20 Individuals	22.9%	49.1%	1.0%	4.2%	10.7%	0.9%	3.1%	8.1%	100.0%
# FY 2020-21 Individuals	5,671	12,020	211	975	2,680	203	1,050	3,429	26,239
% FY 2020-21 Individuals	21.6%	45.8%	0.8%	3.7%	10.2%	0.8%	4.0%	13.1%	100.0%
# FY 2021-22 Individuals	5,651	12,600	219	1,042	2,722	182	1,021	3,181	26,618
% FY 2021-22 Individuals	21.2%	47.3%	0.8%	3.9%	10.2%	0.7%	3.8%	12.0%	100.0%

Figure 10 shows the number and percent of individuals who received one or more mental health outpatient services for five years (FY 2017/18 to FY 2021/22) by primary language. This data shows that in FY 2021/22, 81.8% of individuals served reported English, 12.4% reported Spanish, 1.6% reported Hmong/Laotian, and 1.4% reported Other Languages. There were 732 that did not report a primary language (2.8%).

Figure 10
Fresno County Mental Health Outpatient Services
Number and Percent of Individuals Served, by Primary Language
FY 2017-18 to FY 2021-22

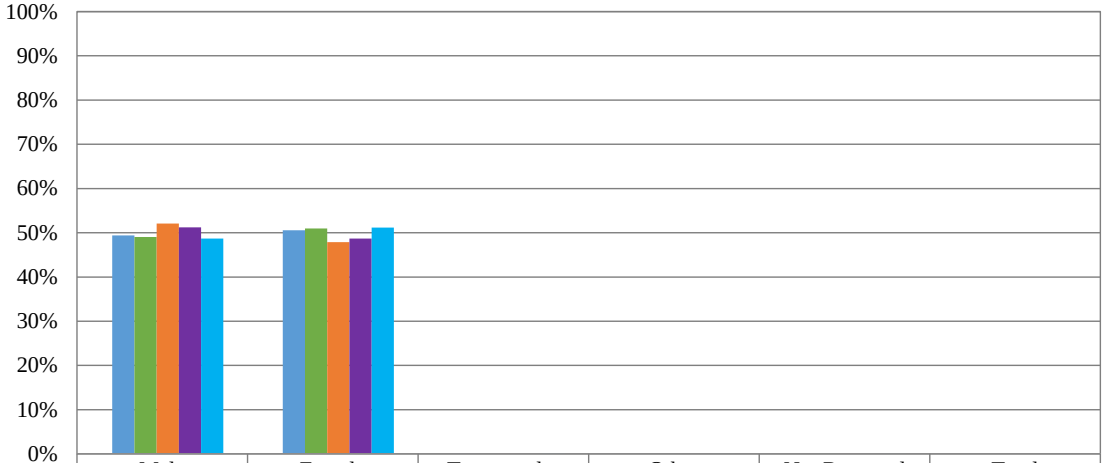


	English	Spanish	Hmong/ Lao	Other	Not Reported	Total
# FY 2017-18 Individuals	16,838	2,244	438	479	136	20,135
% FY 2017-18 Individuals	83.6%	11.1%	2.2%	2.4%	0.7%	100.0%
# FY 2018-19 Individuals	17,253	2,512	501	470	182	20,918
% FY 2018-19 Individuals	82.5%	12.0%	2.4%	2.2%	0.9%	100.0%
# FY 2019-20 Individuals	20,244	3,054	479	473	508	24,758
% FY 2019-20 Individuals	81.8%	12.3%	1.9%	1.9%	2.1%	100.0%
# FY 2020-21 Individuals	21,398	3,107	438	416	880	26,239
% FY 2020-21 Individuals	81.6%	11.8%	1.7%	1.6%	3.4%	100.0%
# FY 2021-22 Individuals	21,780	3,301	436	369	732	26,618
% FY 2021-22 Individuals	81.8%	12.4%	1.6%	1.4%	2.8%	100.0%

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

Figure 11 shows the number and percent of individuals who received one or more mental health outpatient services for five years, FY 2017/18 to FY 2021/22, by gender. This data was collected from Avatar. This data shows that in FY 2021/22, 48.7% males and 51.2% female. There were 33 individuals that were transgender (0.1%); two (2) reported "Other;" and three (3) did not report gender.

Figure 11
Fresno County Mental Health Outpatient Services
Number and Percent of Individuals Served, by Gender
FY 2017-18 to FY 2021-22



	Male	Female	Transgender	Other	Not Reported	Total
# FY 2017-18 Individuals	9,951	10,180	4	-	-	20,135
% FY 2017-18 Individuals	49.4%	50.6%	0.0%	0.0%	0.0%	100.0%
# FY 2018-19 Individuals	10,256	10,659	-	-	3	20,918
% FY 2018-19 Individuals	49.0%	51.0%	0.0%	0.0%	0.0%	100.0%
# FY 2019-20 Individuals	12,896	11,852	5	-	5	24,758
% FY 2019-20 Individuals	52.1%	47.9%	0.0%	0.0%	0.0%	100.0%
# FY 2020-21 Individuals	13,434	12,780	17	4	4	26,239
% FY 2020-21 Individuals	51.2%	48.7%	0.1%	0.0%	0.0%	100.0%
# FY 2021-22 Individuals	12,957	13,623	33	2	3	26,618
% FY 2021-22 Individuals	48.7%	51.2%	0.1%	0.0%	0.0%	100.0%

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.

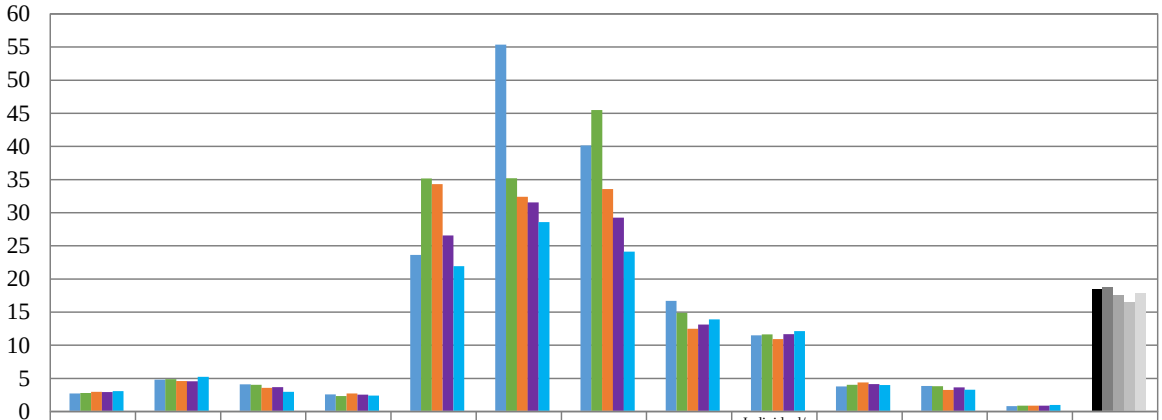
2. Utilization of Mental Health Outpatient Services

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 five years, FY 2017/18 to FY 2021/22. This Avatar data shows that the 26,618 individuals served in FY 2021/22 received a total of 475,699 hours of mental health outpatient services in the year. This calculates into an average of 17.87 hours per individual per year. This data also shows the number of individuals and average hours for each type of service. Individuals can receive more than one type of service. The number of individuals varies by type of service.

In FY 2021/22, individuals who received an assessment averaged 3.08 hours of assessment in the year; case management averaged 5.24 hours; collateral averaged 2.98; crisis intervention averaged 2.40 hours; Intensive Care Coordination (ICC) averaged 21.92 hours; Intensive Home Based Services (IHBS) averaged 28.58 hours; group averaged 24.11 hours; individual rehab averaged 13.89 hours; individual/family therapy averaged 12.13 hours; medication management averaged 3.98 hours; placement averaged 3.29 hours; and plan development averaged 1.01 hours.

Approximately 50% of all persons served received an assessment; case management; individual therapy; medication management; and plan development services. It is also important to review the number of clients that received each type of service.

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 2021-22



	Assessment	Case Management	Collateral	Crisis Intervention	ICC	IHBS	Group	Individual Rehabilitation	Individual/ Family Therapy	Medication	Placement	Plan Development	Total
# FY 2017-18 Individuals	10,000	7,197	2,908	1,403	349	256	1,692	3,813	7,203	12,257	482	10,417	20,135
# FY 2017-18 Hours	27,394.75	34,572.15	11,949.30	3,614.07	8,247.93	14,172.82	67,959.53	63,645.07	82,822.93	46,581.82	1,856.60	8,416.23	371,233.20
FY 2017-18 Avg. Hours per Individual	2.74	4.80	4.11	2.58	23.63	55.36	40.17	16.69	11.50	3.80	3.85	0.81	18.44
# FY 2018-19 Individuals	10,746	7,690	3,170	1,315	393	285	1,612	4,206	7,700	12,365	402	10,803	20,918
# FY 2018-19 Hours	30,200.98	37,649.93	12,765.27	3,091.77	13,813.48	10,030.48	73,319.55	62,659.30	89,675.93	49,956.80	1,537.72	9,430.05	394,131.27
FY 2018-19 Avg. Hours per Individual	2.81	4.90	4.03	2.35	35.15	35.19	45.48	14.90	11.65	4.04	3.83	0.87	18.84
# FY 2019-20 Individuals	12,200	12,058	4,329	2,885	528	380	1,449	5,362	10,173	11,862	500	12,003	24,758
# FY 2019-20 Hours	36,329.93	55,697.00	15,513.12	7,869.30	18,120.83	12,310.12	48,664.83	66,907.92	111,270.15	52,235.87	1,625.55	10,603.77	437,148.38
FY 2019-20 Avg. Hours per Individual	2.98	4.62	3.58	2.73	34.32	32.40	33.59	12.48	10.94	4.40	3.25	0.88	17.66
# FY 2020-21 Individuals	11,714	13,760	4,629	4,653	546	325	855	5,107	10,914	12,106	473	11,817	26,239
# FY 2020-21 Hours	34,449.98	62,956.87	17,124.33	11,842.35	14,501.18	10,260.25	25,001.98	67,099.50	127,302.05	50,314.28	1,729.67	10,608.63	433,191.08
FY 2020-21 Avg. Hours per Individual	2.94	4.58	3.70	2.55	26.56	31.57	29.24	13.14	11.66	4.16	3.66	0.90	16.51
# FY 2021-22 Individuals	12,462	13,369	5,178	4,866	702	269	1,167	5,779	11,930	12,569	480	12,241	26,618
# FY 2021-22 Hours	38,336.92	70,010.80	15,435.95	11,692.15	15,390.48	7,687.18	28,139.80	80,293.83	144,720.77	50,075.12	1,577.85	12,338.23	475,699.08
FY 2021-22 Avg. Hours per Individual	3.08	5.24	2.98	2.40	21.92	28.58	24.11	13.89	12.13	3.98	3.29	1.01	17.87

3. Analysis of the Mental Health Data

The FY 2021/22 data was only recently available and analyzed. The DEIC will review the Mental Health population data and develop recommendations in the next six (6) months. This review will allow the DEIC to better understand the service utilization data and make recommendations for enhancing services.

4. SUD Outpatient Services by Demographics

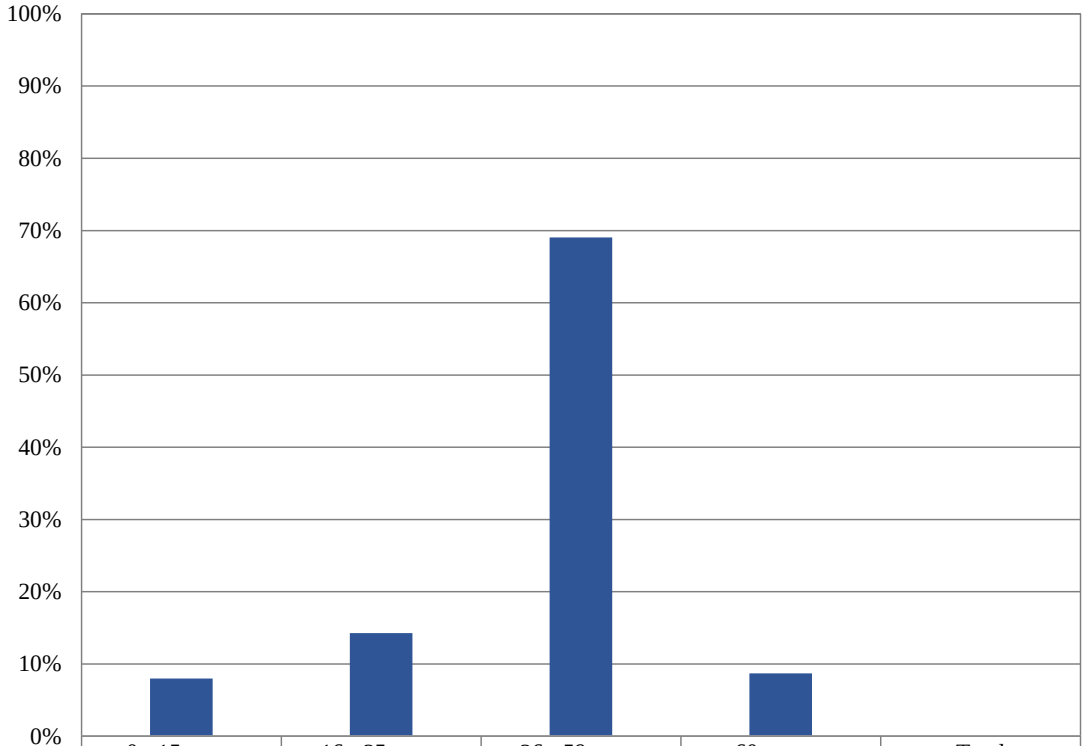
Figures 13 through 18 show SUD outpatient service utilization data by demographics for FY 2021/22. The implementation of this complex system transformed the service delivery system, which in turn changed the data collection processes in the county's Electronic Health Record (EHR). As a result, the timeliness and quality of the data is being refined. The data for the SUD outpatient services is shown only for one year: FY 2021/22. 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 2021/22. The data shows SUD services delivered between July 1, 2021 and June 30, 2022.

Figure 13 shows the number and percent of individuals who received SUD outpatient services by age group for FY 2021/22. This Avatar data shows an unduplicated count of individuals served by age group. Each individual received one or more SUD services between July 1, 2020 and June 30, 2021.

Of the 4,202 (unduplicated) people receiving SUD outpatient services in FY 2021/22:

- 8% were ages 0-15
- 14.3% were ages 16-25
- 69% were ages 26-59
- 8.7% were ages 60+

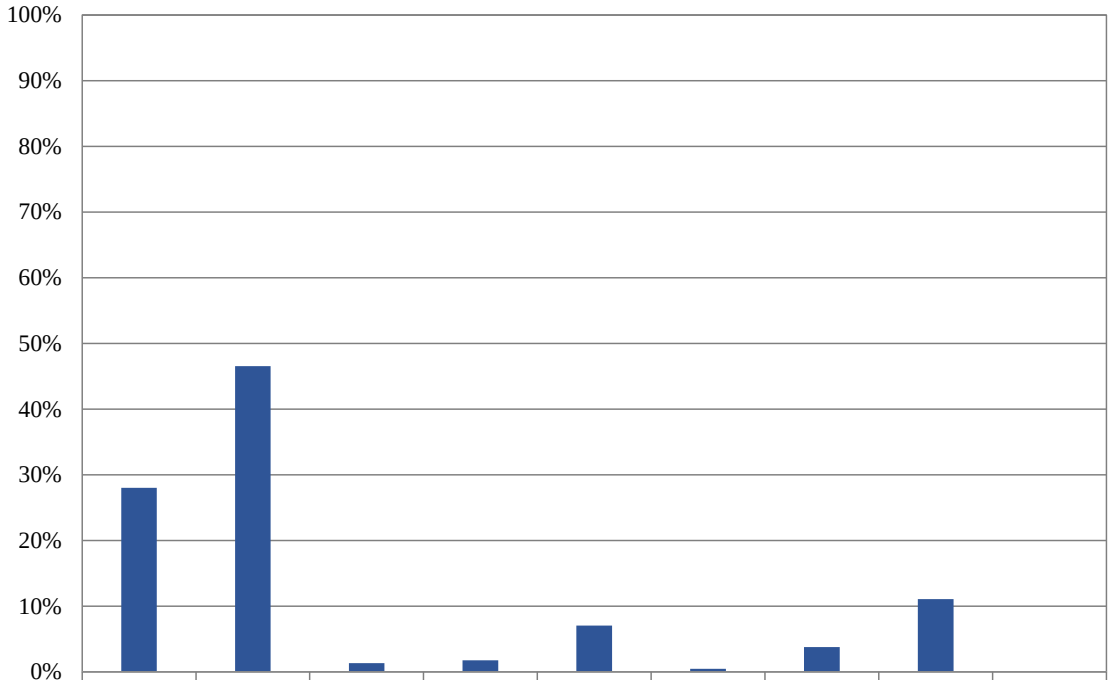
Figure 13
Fresno County Substance Use Disorder Outpatient Services
Number and Percent of Individuals Served, by Age
FY 2021-22



	0 - 15 years	16 - 25 years	26 - 59 years	60+ years	Total
# Individuals FY 2021-22	387	691	3,343	421	4,842
% Individuals FY 2021-22	8.0%	14.3%	69.0%	8.7%	100.0%

Figure 14 shows the number and percent of individuals who received one or more SUD outpatient service in FY 2021/22, by race/ethnicity. This data shows that from July 1, 2021 through June 30, 2022, of the 4,842 individuals receiving SUD services, 28% are White, 46.6% e Hispanic/Latino, 1.3% are American Indian/Alaskan Native, 1.8% are Asian/Other Pacific Islander, 7% are Black, 0.5% are Hmong/Laotian, 3.8% Other, and 11.1% (536) were not reported.

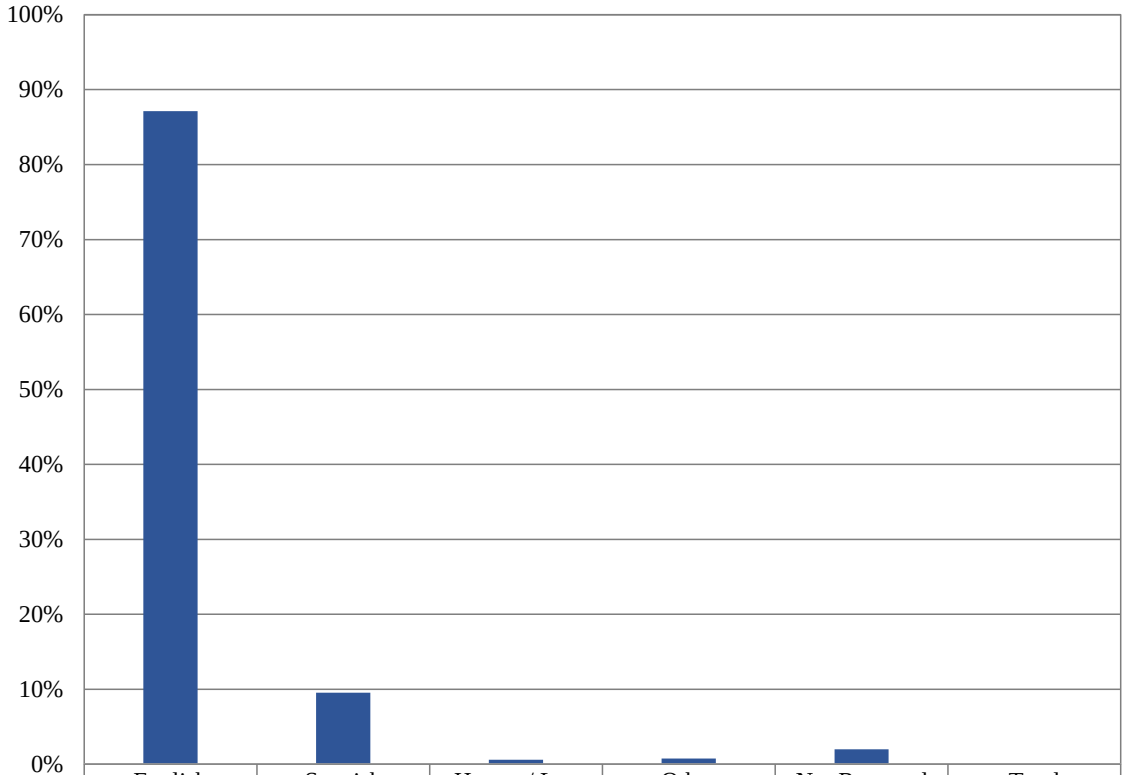
Figure 14
Fresno County Substance Use Disorder Outpatient Services
Number and Percent of Individuals Served, by Race/Ethnicity
FY 2021-22



	White	Hispanic/ Latino	American Indian/ Alaskan Native	Asian/ Other Pacific Islander	Black	Hmong/ Laotian	Other	Not Reported**	Total
# Individuals FY 2021-22	1,357	2,254	64	86	341	22	182	536	4,842
% Individuals FY 2021-22	28.0%	46.6%	1.3%	1.8%	7.0%	0.5%	3.8%	11.1%	100.0%

Figure 15 shows the number and percent of individuals who received one or more SUD outpatient service in FY 2021/22, by primary language. This data shows that 87.1% of individuals served speak English, 9.5% speak Spanish, 0.6% speak Hmong or Lao, 0.7% reported that they speak a different language, and 2% were Not Reported from July 1, 2021 through June 30, 2022.

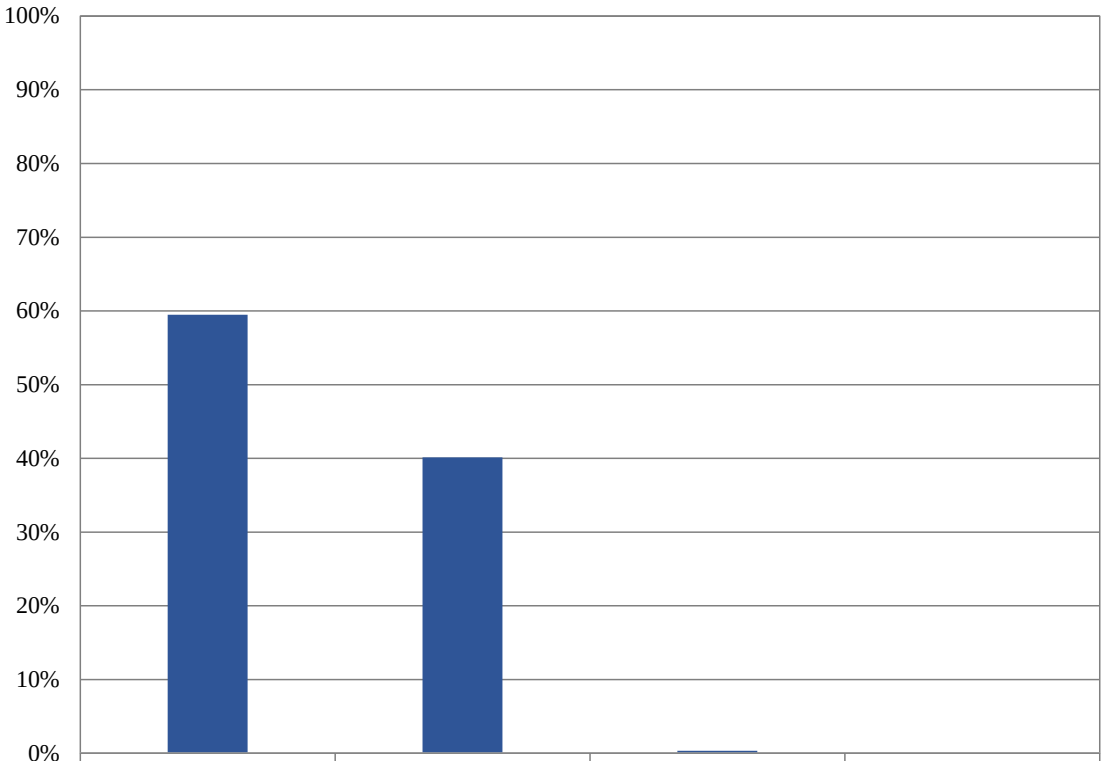
Figure 15
Fresno County Substance Use Disorder Outpatient Services
Number and Percent of Individuals Served, by Primary Language
FY 2021-22



	English	Spanish	Hmong/ Lao	Other	Not Reported	Total
# Individuals FY 2021-22	4,219	462	29	36	96	4,842
% Individuals FY 2021-22	87.1%	9.5%	0.6%	0.7%	2.0%	100.0%

Figure 16 shows the number and percent of individuals who received one or more SUD outpatient services in FY 2021/22, by gender. This data was collected from SAIS. This data shows that for the 4,842 individuals served from July 1, 2021 through June 30, 2022, 59.5% were male and 40.1% were female. There were 17 people who reported transgender (0.4%).

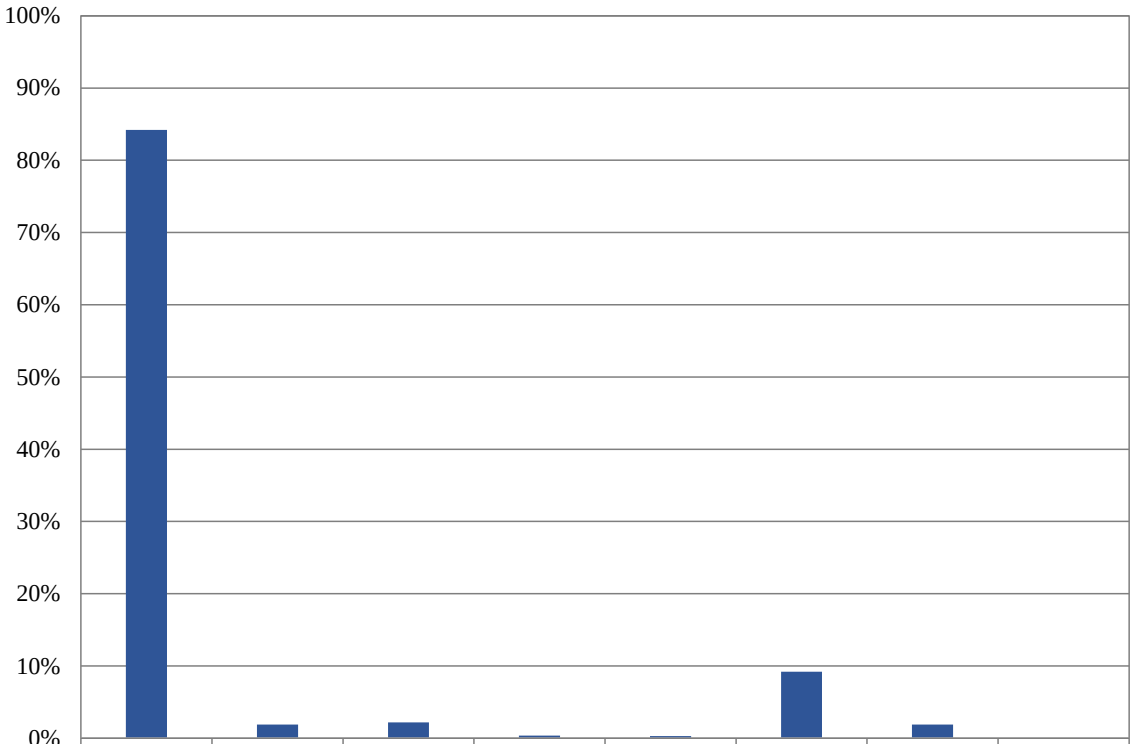
Figure 16
Fresno County Substance Use Disorder Outpatient Services
Number and Percent of Individuals Served, by Gender
FY 2021-22



	Male	Female	Transgender	Total
# Individuals FY 2021-22	2,881	1,944	17	4,842
% Individuals FY 2021-22	59.5%	40.1%	0.4%	100.0%

Figure 17 shows the number and percent of individuals who received one or more SUD outpatient service in FY 2021/22, by sexual identity. This data shows that from July 1, 2021 through June 30, 2022, 4,077 individuals (84.2%) reported they identified as Heterosexual/Straight; 92 individuals (1.9%) identified as Gay or Lesbian; 106 individuals identify as Bisexual (2.2%); 17 individuals (0.4%) identified as Transgender; 14 individuals (0.3%) identified as Unsure/Questioning; and 445 individuals (9.2%) Declined to State. There were 91 individuals (1.9%) did not report sexual identity.

Figure 17
Fresno County Substance Use Disorder Outpatient Services
Number and Percent of Individuals Served, by Sexual Identity
FY 2021-22



	Heterosexual / Straight	Gay/ Lesbian	Bisexual	Transgender	Unsure/ Questioning	Declined to State	Not Reported	Total
# Individuals FY 2021-22	4,077	92	106	17	14	445	91	4,842
% Individuals FY 2021-22	84.2%	1.9%	2.2%	0.4%	0.3%	9.2%	1.9%	100.0%

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 2021/22 are shown below.

- Total SUD Outpatient Services N= 4,842
- Narcotic Treatment Program (NTP) Services N= 1,976

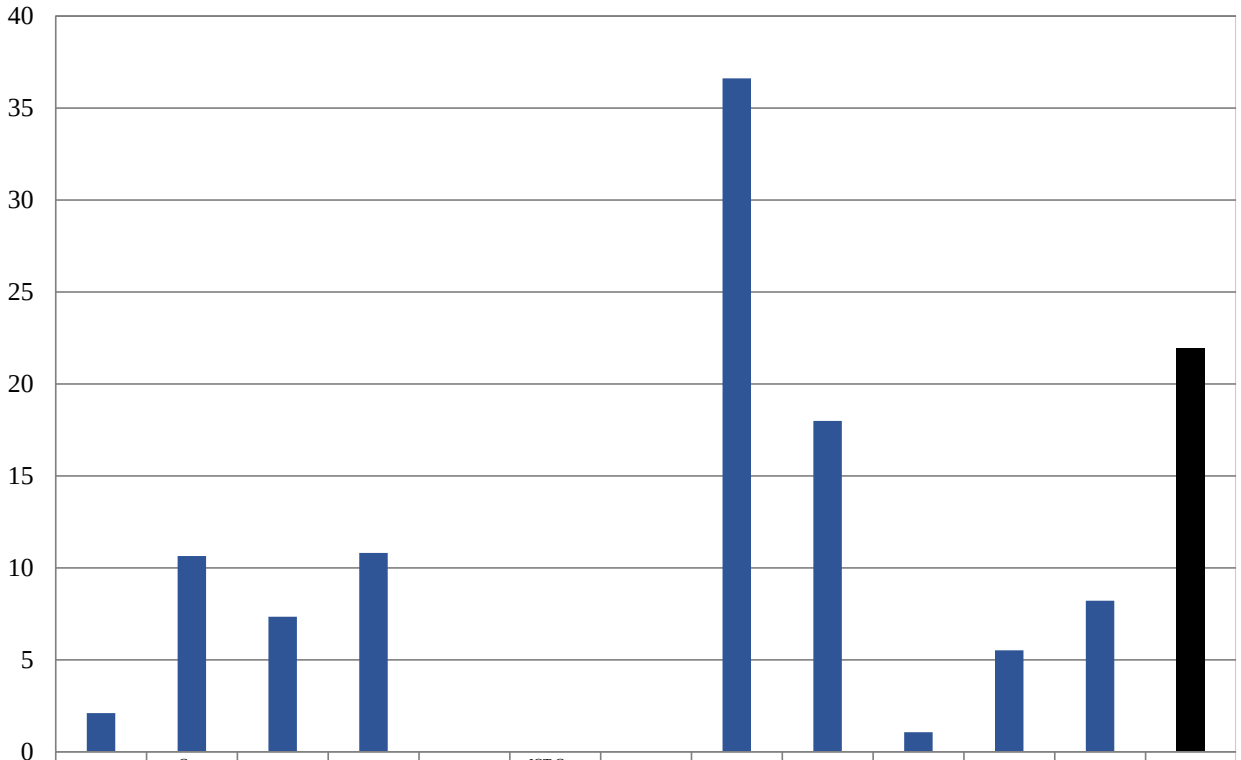
Figure 18 shows the total number of individuals that received SUD outpatient services, the total hours of outpatient services delivered by type of SUD outpatient service for FY 2021/22, and the average hours of outpatient services per individual.

This graph shows data from the FY 2021/22. There were 4,842 individuals that received a total of 106,230 hours of SUD outpatient services. This data calculates into an average of 21.94 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 person served data shows: case management for adults averaged 2.11 hours; case management youth was 10.65 hours; individual therapy for adults, 7.35 hours; individual therapy for youth, 10.81 hours; group services for adults, 36.62 hours; group services for youth, 17.99; MAT, 1.07 hours; NTP, 5.52 hours; and Recovery Services, 8.21 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 2021-22



	Case Management	Case Management <21	Individual	Individual <21	IOT Individual*	IOT Case Management *	IOT Group*	Group	Group <21	MAT	NTP	Recovery Services	Total
# Individuals FY 2021-22	991	666	2,002	768	176	130	78	1,616	141	203	1,976	145	4,842
# Hours FY 2021-22	2,086.92	7,092.92	14,712.13	8,304.08	-	-	-	59,174.38	2,536.38	216.65	10,915.37	1,190.83	106,229.67
Avg. Hours per Individual FY 2021-22	2.11	10.65	7.35	10.81	-	-	-	36.62	17.99	1.07	5.52	8.21	21.94

** IOT hours are not available for the FY 2022/23 CRP.*

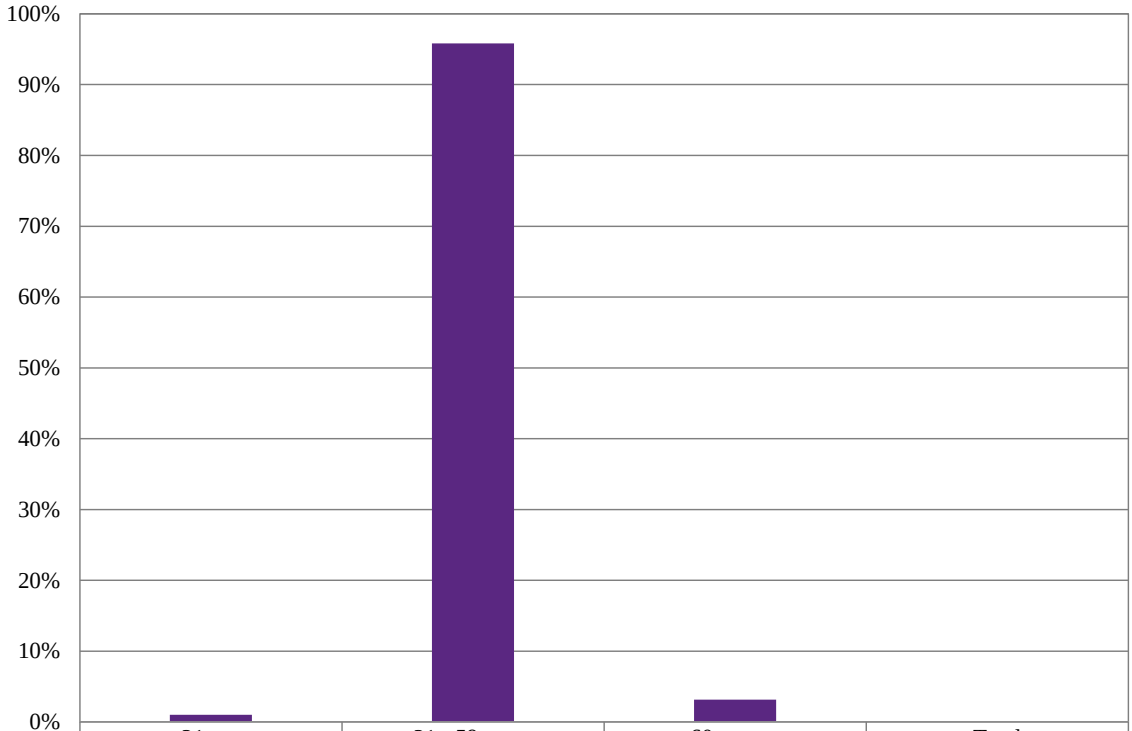
6. SUD Residential Treatment Services by Demographics

Figure 19 shows the number and percent of individuals who received substance use disorder residential treatment services by age group for FY 2021/22. 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 2021/22 is counted once.

Of the 959 (unduplicated) people that received residential treatment in FY 2021/22:

- 1% were ages youth ages <21 years (N=11)
- 95.8% were ages 21-59 (N=1,033); and
- 3.2% were ages 60+ (N=34).

Figure 19
Fresno County Substance Use Disorder Residential Treatment
Number and Percent of Individuals Served, by Age
FY 2021-22

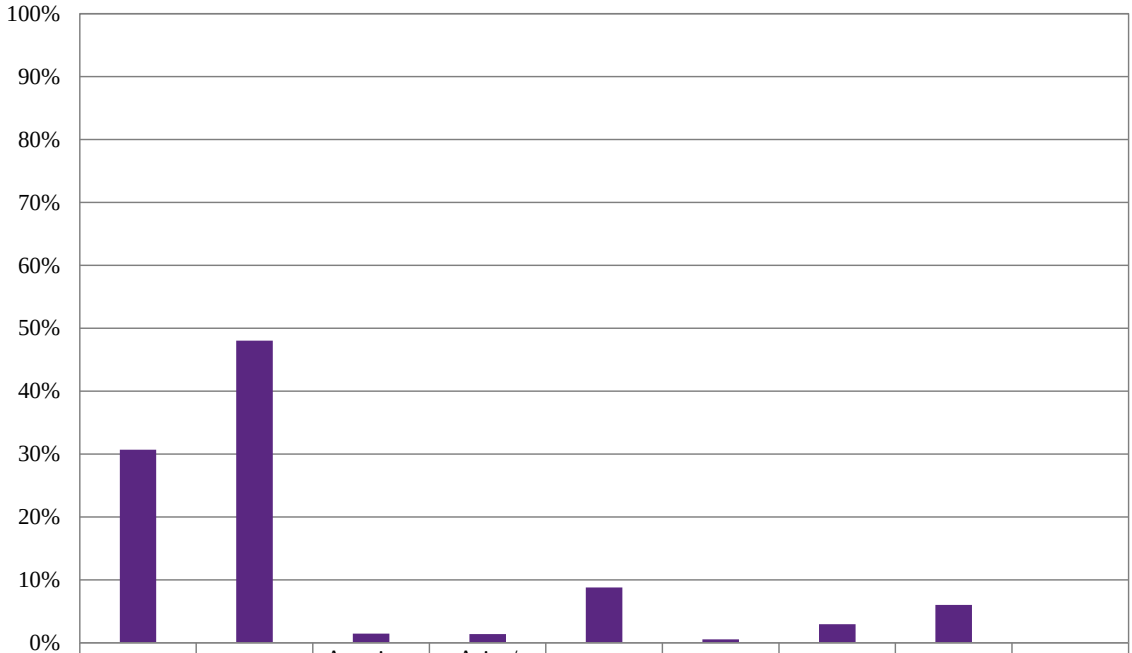


	< 21 years	21 - 59 years	60+ years	Total
# Individuals FY 2021-22	11	1,033	34	1,078
% Individuals FY 2021-22	1.0%	95.8%	3.2%	100.0%

Figure 20 shows the number and percent of individuals who received one or more SUD residential treatment services by race/ethnicity for FY 2021/22. This data is calculated from Avatar data. This Avatar data shows an **unduplicated** count of individuals served by race/ethnicity for FY 2021/22. Each individual received one or more residential treatment service in FY 2021/22.

This data shows that for FY 2021/22, of the 1,078 individuals receiving SUD residential treatment services, 30.7% are White; 48.1% are Hispanic/Latino; 1.5% are American Indian/Alaskan Native; 1.4% are Asian/Other Pacific Islander; 8.8% are Black; 3% Other; and 6% (65) were not reported.

Figure 20
Fresno County Substance Use Disorder Residential Treatment
Number and Percent of Individuals Served, by Race/Ethnicity**
FY 2021-22



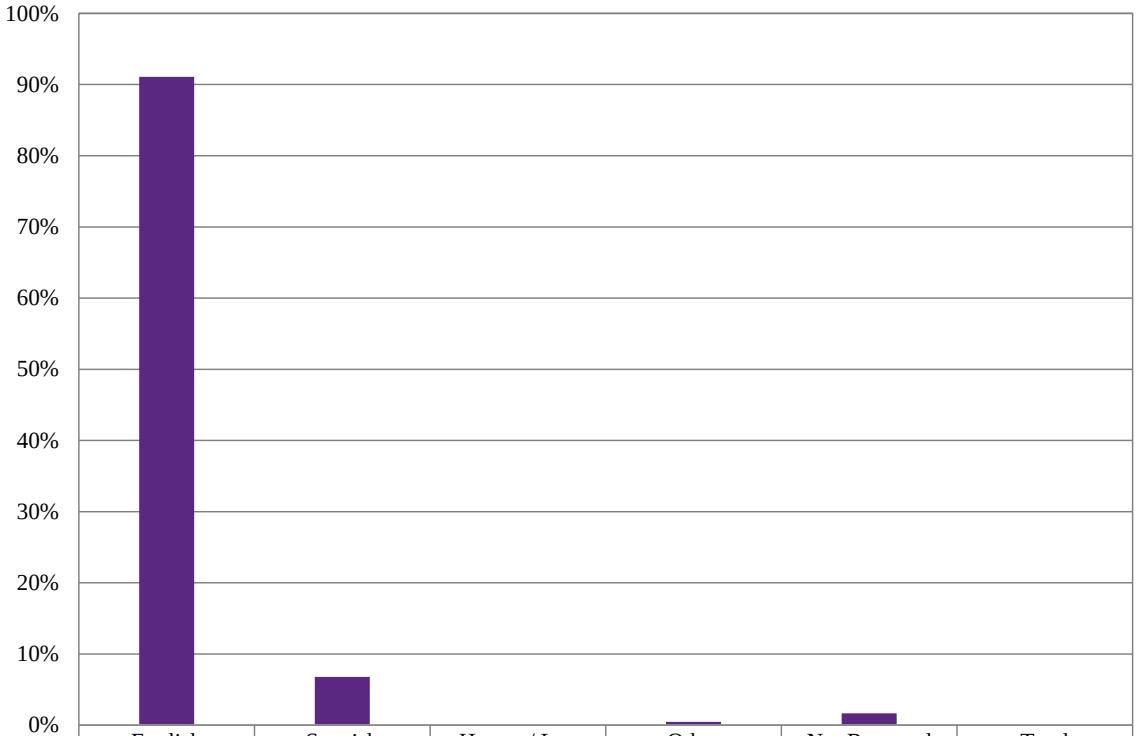
	White	Hispanic/ Latino	American Indian/ Alaskan Native	Asian/ Other Pacific Islander	Black	Hmong/ Laotian	Other	Not Reported	Total
# Individuals FY 2021-22	331	518	16	15	95	6	32	65	1,078
% Individuals FY 2021-22	30.7%	48.1%	1.5%	1.4%	8.8%	0.6%	3.0%	6.0%	100.0%

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

Figure 21 shows the number and percent of individuals who received one or more SUD residential treatment service by Primary Language for the FY 2021/22. Data is shown for FY 2021/22. This data is calculated from Avatar data. This Avatar data shows an **unduplicated** count of individuals served by Primary Language for FY 2021/22. Each individual that received one or more services between July 1, 2021 through June 30, 2022 is counted once.

This data shows that 91.1% of individuals served speak English; 6.8% speak Spanish, 0% speak Hmong/Lao; 0.5% reported that they speak a different language; and 1.7% were Not Reported.

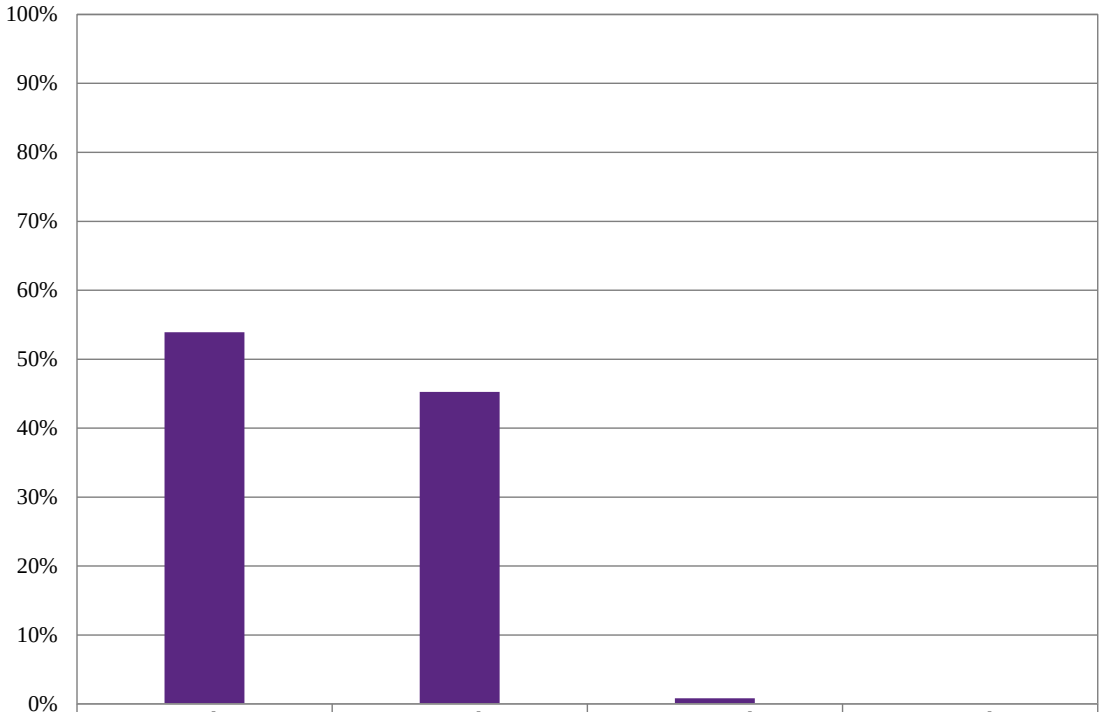
Figure 21
Fresno County Substance Use Disorder Residential Treatment
Number and Percent of Individuals Served, by Primary Language
FY 2021-22



	English	Spanish	Hmong/ Lao	Other	Not Reported	Total
# Individuals FY 2021-22	982	73	-	5	18	1,078
% Individuals FY 2021-22	91.1%	6.8%	0.0%	0.5%	1.7%	100.0%

Figure 22 shows the number and percent of individuals who received one or more SUD residential treatment services for FY 2021/22. This data is calculated from Avatar data. This Avatar data shows an **unduplicated** count of individuals served by gender for the FY 2021/22. Each individual that received one or more services in FY 2021/22 is counted once. This data shows that for the 1,078 individuals served in FY 2021/22, 53.9% were males and 45.3% were females. There were nine (9) people who reported Transgender.

Figure 22
Fresno County Substance Use Disorder Residential Treatment
Number and Percent of Individuals Served, by Gender
FY 2021-22

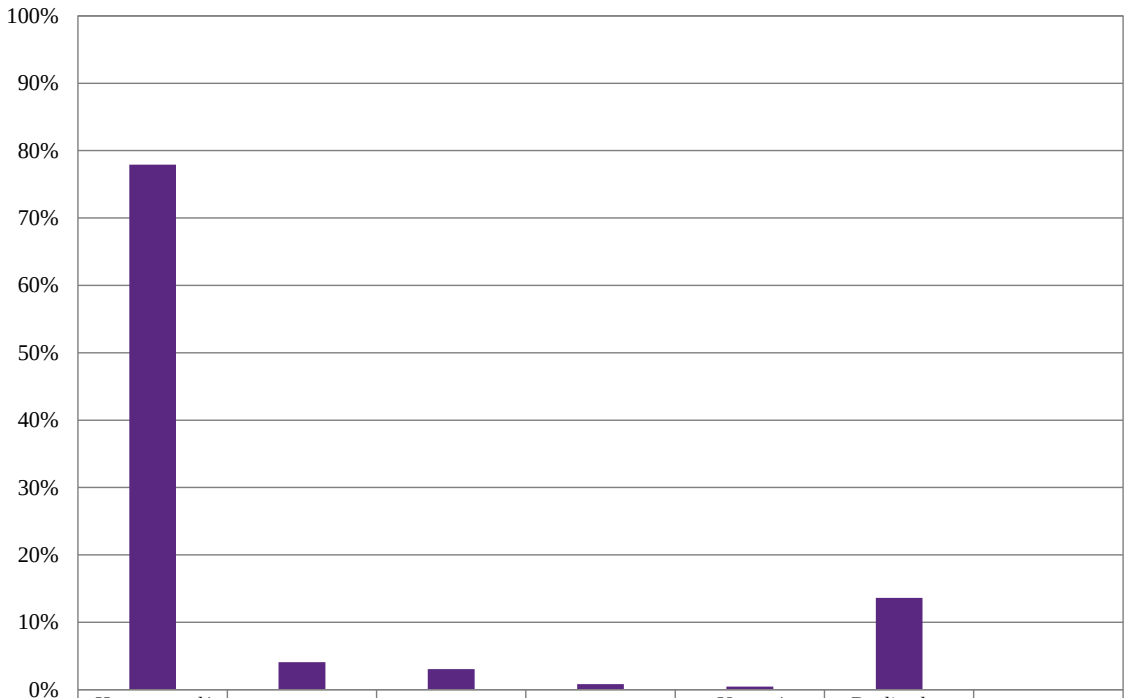


	Male	Female	Transgender	Total
# Individuals FY 2021-22	581	488	9	1,078
% Individuals FY 2021-22	53.9%	45.3%	0.8%	100.0%

Figure 23 shows the number and percent of individuals who received one or more SUD residential treatment services by Sexual Identity for FY 2021/22. 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 2021/22.

This data shows that 77.9% of individuals served identified as Heterosexual/ Straight; 4.1% identified as Gay or Lesbian; 3.1% identified as Bisexual; 0.8% identified as Transgender; 0.5% identified as Unsure/Questioning, and 13.6% Declined to Answer.

Figure 23
Fresno County Substance Use Disorder Residential Treatment
Number and Percent of Individuals Served, by Sexual Identity
FY 2021-22

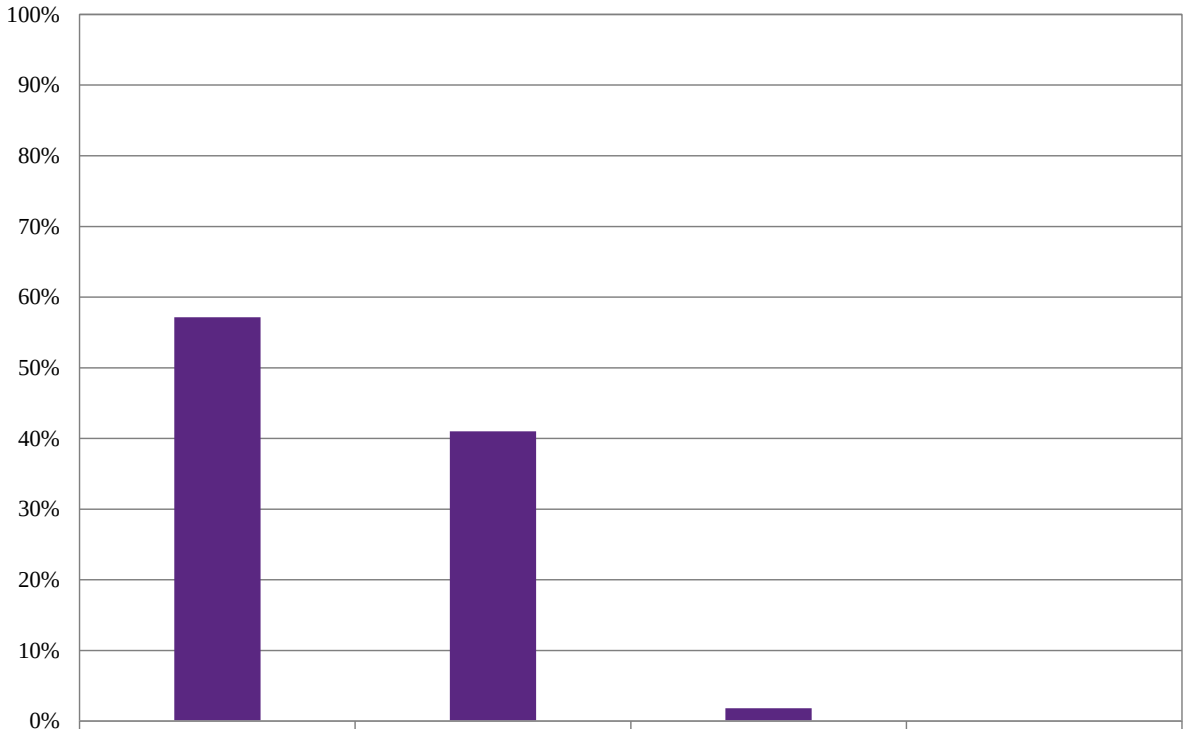


	Heterosexual/ Straight	Gay/ Lesbian	Bisexual	Transgender	Unsure/ Questioning	Declined to State	Total
# Individuals FY 2021-22	840	44	33	9	5	147	1,078
% Individuals FY 2021-22	77.9%	4.1%	3.1%	0.8%	0.5%	13.6%	100.0%

7. Utilization of SUD Residential Treatment Services

Figure 24 shows the number and percent of days that substance use disorder individuals served accessed Level 3.1 residential services, Level 3.5 residential services, and withdrawal management services in FY 2021/22. There were 49,620 total days of services delivered to substance use disorder individuals, with 28,362 days of residential Level 3.1 (57.2%), 20,355 days of Level 3.5 residential services (41%), and 903 days of withdrawal management (1.8%).

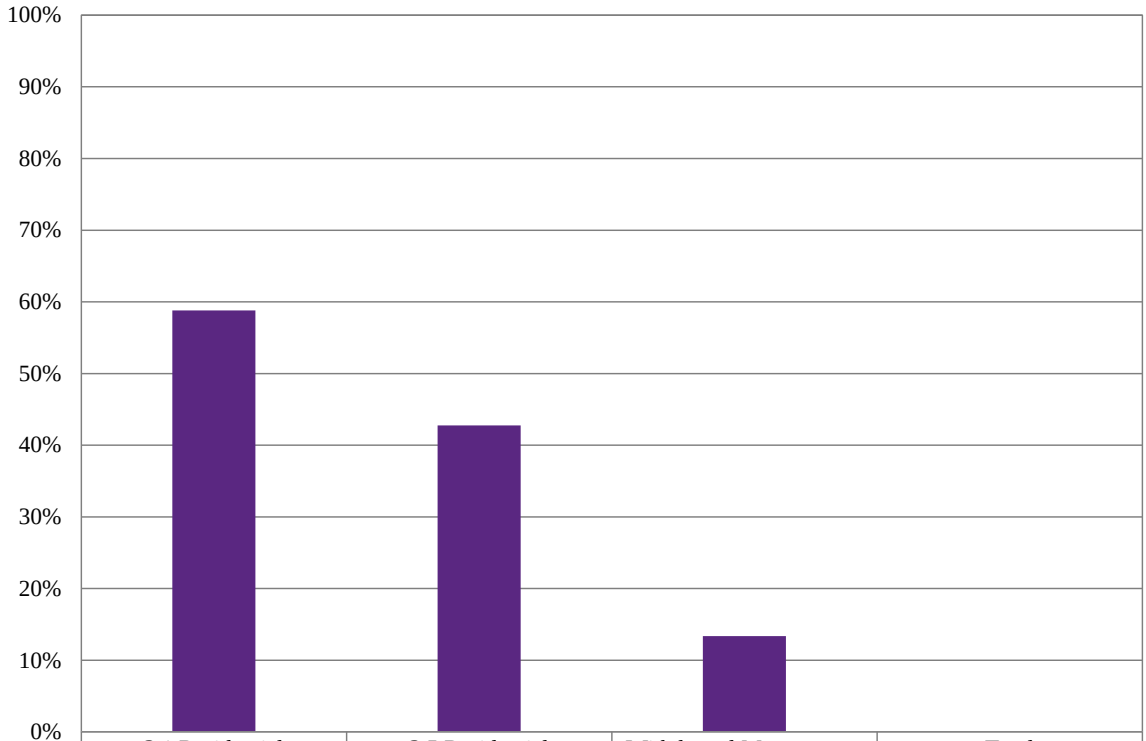
Figure 24
Fresno County Substance Use Disorder Residential Treatment
Number and Percent of Days
FY 2021-22



	3.1 Residential	3.5 Residential	Withdrawal Management	Total
# Days FY 2021-22	28,362	20,355	903	49,620
% Days FY 2021-22	57.2%	41.0%	1.8%	100.0%

Figure 25 shows the number and percent of individuals served who received Level 3.1 residential services, Level 3.5 residential services, and withdrawal management services for FY 2021/22. Data is shown for each individual that received one or more services in FY 2021/22. There were 1,078 individuals who receive SUD residential services, with 634 individuals that received Level 3.1 residential services (58.8%), 461 individuals that received Level 3.5 residential services (42.8%), and 144 individuals that received withdrawal management services (13.4%).

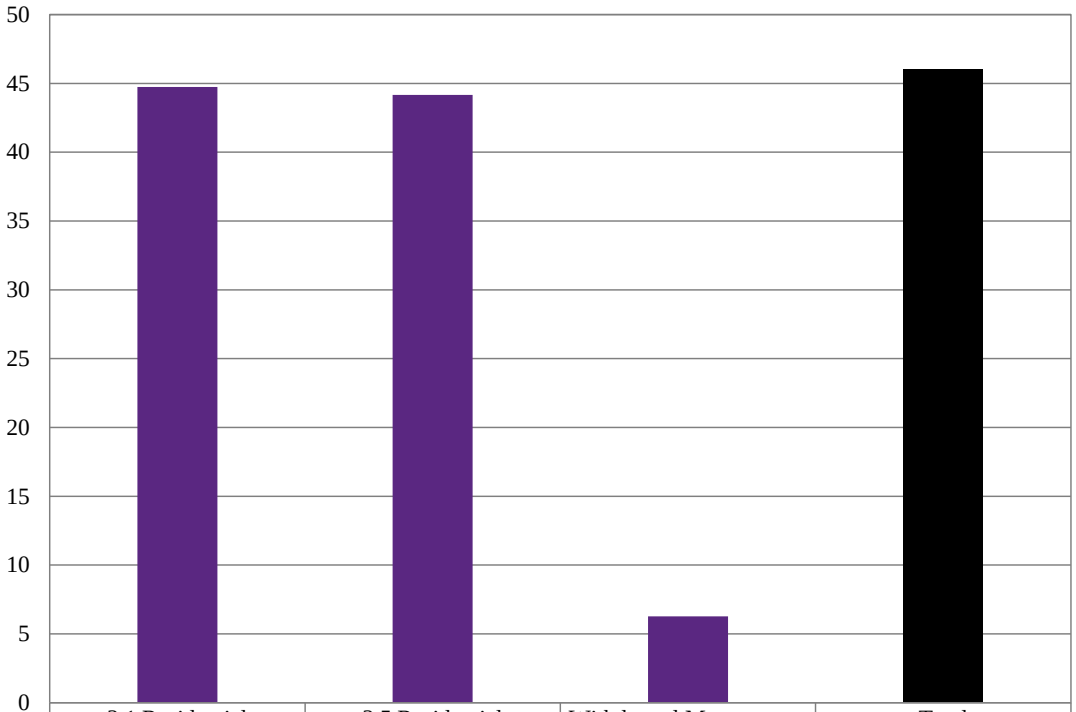
Figure 25
Fresno County Substance Use Disorder Residential Treatment
Number and Percent of <u>Individuals Served</u>
FY 2021-22



	3.1 Residential	3.5 Residential	Withdrawal Management	Total
# Individuals FY 2021-22	634	461	144	1,078
% Individuals FY 2021-22	58.8%	42.8%	13.4%	100.0%

Figure 26 shows the number of residential treatment days, number of individuals served, and average days per individual served in residential treatment services for FY 2021/22. There were 1,078 individuals served. These individuals received a total of 49,620 days of service, which calculates to an average of 46 days per client. There were 634 individuals that received 28,362 days of 3.1 residential services (44.7 days per individual); 461 individuals that received 20,355 days of 3.5 residential service (44.2 days per individual); and 144 individuals that received 903 days of withdrawal management services (6.3 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 2021-22



	3.1 Residential	3.5 Residential	Withdrawal Management	Total
# Days FY 2021-22	28,362	20,355	903	49,620
# Individuals FY 2021-22	634	461	144	1,078
Avg. Days per Clt. FY 2021-22	44.7	44.2	6.3	46.0

8. Analysis of the SUD Data

The FY 2021/22 data was only recently available and analyzed. The DEIC will review the SUD utilization data and develop recommendations in the next six months. This will allow the DEIC to better understand the service utilization data and make recommendations for enhancing services.

III. MEETING CULTURAL AND LINGUISTIC REQUIREMENTS

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

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

- Fresno County has one of the only culturally focused Full Service Partnership (FSP) programs in the state. The BHSOC has a FSP called Living Well which provided those services to a Southeast Asian adult population through the Fresno Center.
- The BHSOC also has an FSP program that is specifically for individuals who are actively involved in the justice system. This program is operated by Mental Health Systems.
- The BHSOC has specific continuum of care for rural communities which are predominantly Latino and a number who are Spanish speaking. Services are located in many of those communities and are staffed by personnel who reflect the communities being served.
- At the end of FY 2020/2021, through the use of its MHSA prevention dollars, the Department established a Pop Up for the local LGBTQ+ community. The service is part of a suicide prevention effort for LGBTQ+ young people, which seeks to provide safe and affirming space to reduce risk factors for this population.
- In the past year, the Youth Empowerment Program contract was awarded to a provider who operates in the western portion of the county, and provides youth prevention services to small farming communities who are predominantly Latino. This program thus provides prevention services to Latino youth in rural communities.
- The Innovation Plan CRDP Evolutions is made up of three CRDP/CDEP programs that each have a specific population focus. The Sweet Potato Program serves African American Youth. The Hmong Helping Hand provides PEI services to older adult Hmong and other SEA seniors. The *Plactica Y Plenta* provides PEI services to local metro Latino youth.
- Programs such as the Cultural Based Access and Navigation (CBANS) assist with linkages and accessing care, through the use of cultural brokers and community health workers.
- The Holistic Wellness Center provides engagement, stigma reduction, and outreach to underserved communities through non-traditional practices and approaches for mental health and wellness.
- The Lodge is an active INN Plan that seeks to engage unhoused persons with an SMI and who are not in care, but in the pre-contemplation stage of change. The program is peer driven, and has 7 full-time peers and two clinicians. The program focuses on exploring how peers may effectively help the target population engage in care.

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 and continually strive to expand services to reach unserved and underserved individuals in the community. The DBH will continue to explore opportunities to expand services and provide outreach to communities to reduce barriers to services.

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 and expertise understanding medical term for psychiatric services; wait time for accessing an interpreter) to ensure quality and continuity of care
- Identify goals for the ratio of bilingual and bicultural staff to individuals served to address equity
- Provide 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. The service pages have language on them in Spanish, Hmong and Punjabi of accessing services in their preferred language w/o cost to them. DBH has also set up a page that has been translated into Spanish on its website to make access and information more readily available and has created a specific URL to help accessing the page easier via www.DBHespanol.com and www.DBHespanol.org. The website for the Hmong community has also been created www.DBHhmoob.com and www.DBHhmoob.org

A *Provider Directory* is available to individuals which lists provider names, population specialty (children, adult, veterans, LGBTQ+ when available, etc.), services provided, language capability, and whether or not the provider is accepting new individuals. This Directory is provided to individuals upon intake and is available at our clinics, organizational providers, and wellness centers. The Provider List is 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 Person Served/Client Intake Log to ensure that when a person is new to receiving BHSOC services and requests specialty behavioral health services, that individual is informed about the availability of free language assistance services. This document is completed by front office staff, added to the individual's Electronic Health Record (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 /Person Served/Client Intake Tracking Sheet allows BHSOC to document when an individual requests an interpreter. This form is forwarded to clinical staff for the intake assessment and included in the individual's EHR. This information is also utilized when individuals are assigned to a service provider, to help determine the need for a bilingual staff to provide ongoing services in the individual's primary language, whenever possible.

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

Objective: In FY 2021/22, BHSOC is updating the process for assessing both county staff, and organization provider's staff bilingual language skills. This process will create the opportunity to analyze staff and provider disparities and identify opportunities for meeting the needs of individuals receiving services, and the needs of their families, when the family is involved in supporting the individual meet their goals.

The Diversity, Equity, and Inclusion Committee (DEIC) is 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 DEIC 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 service 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 DEIC 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 DEIC will work together to identify additional issues and objectives to help improve services during the coming year. The QIC and DEIC 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 Diversity, Equity, and Inclusion Committee (DEIC) will coordinate with Department of Behavioral Health (DBH) to provide summary data on the number of persons employed by the county, and at organizational providers, on race, ethnicity, and language. 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 2021/22, 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 DEI Language Subcommittee has also recommended starting two Language Champions Committees, to provide support to persons who serve as interpreters. One committee will support Spanish language interpreters and one will support Hmong/Lao interpreters. Each committee will hold a monthly meeting to provide a forum for people to develop common translations for key words that are frequently used in mental health. The Language Champions Committee will help provide consistency of interpreting across both interpreters and staff who use interpreters.

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

This committee has also helped create standard practices for interpreting and identify training opportunities for both interpreters and staff who use interpreters, to improve the experience for monolingual individuals served. A group for Spanish speakers and a group for Hmong/Lao speakers will be developed to support the Language Champions Committee for the two languages that meet the threshold language requirement in Fresno County. In addition, the committee will review service-level language data and identify needs; assess interpretation service capacity and quality; identify interpreter trainings; and reviewing translated materials for accuracy.

3. Staff and Volunteer Cultural Humility Survey

To assess the cultural responsiveness of our workforce, staff and volunteers were asked to complete the Staff and Volunteer Cultural Humility Survey in Spring 2022. The complete results are shown in Attachment E.

433 staff completed the survey. Of these individuals, 58.3% were county staff, 41.2% were contract provider staff, and less than 1% were volunteers. Of all staff responding to the survey, 36.5% were direct service/clinical/case management staff, 29.3% were administration/clerical staff who do *not* routinely interact with persons served, 14.3% were administration/clerical staff who *do* routinely interact with persons served, 15.2% were management staff, 3.7% were peer support, and 0.9% were paid peer staff.

Of the 433 individuals who completed the survey, the breakdown of staff by department/program is as follows: 21% from Children's Mental Health, 15.5% from Contracts Department (MH/SUD), 14.5% from the Adult System of Care, 13.4% from Administration, 7.2% from Finance/Accounting/Business Office, 8.8% from Managed Care, 4.6% from ISDS/Quality Improvement/Medical Records, 1.2% from Compliance, and 13.9% from Public Behavioral Health.

Of these 409 survey respondents who reported their race/ethnicity, 43.8% were Hispanic/Latino, 30.3% were White, 15.2% were Asian, 7.8% were Black, 0.2% were Native Hawaiian or Other Pacific Islanders, 1.2% were American Indian or Alaska Native, 1% were Middle Eastern, and 0.5% identified as 'Other.' For the 408 respondents who report their current gender identity, 74.5% identify as Female, 23.8% identify as Male, and 1.7% identify as another gender. For sexual orientation, 91.1% of staff identified as Heterosexual/Straight, and 8.9% as LGBTQ+.

Of the 433 survey respondents, 167 (38.6%) were bilingual, with 67% of those bilingual staff speaking Spanish, 15% speaking Hmong, 3% speaking Punjabi, and 18% speaking another language. Staff may speak more than one language other than English. Of the 167 bilingual staff, 83 (49.7%) acted as an interpreter as a part of their job function, and 9.6% of received bilingual pay (16/167). This 2022 data shows a decrease from the 2021 survey results, in which 61% of bilingual staff acted as an interpreter as a part of their job function (140/228), and 21% received bilingual pay (48/228). These results highlight an area of potential growth for the County and support the importance of the DBH's efforts to hire and train bilingual staff. One of the goals of the DEI Language Committee is to develop a process for certifying bilingual staff so more staff can receive bilingual pay.

Other survey results show that 60.1% of staff identified as a person with lived Mental Health experience and 69.8% reported having a family member with lived Mental Health experience; 17.6% of staff identified as a person with lived substance use disorder experience and 50% reported having a family member with lived substance use disorder experience.

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

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

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

- *I recognize and accept that clients are the primary decision makers about their treatment, even though they may be different from my own beliefs. (Frequently = 86%)*
- *I recognize that family may be defined differently by different cultures. (Frequently = 79%)*
- *I recognize that gender roles in families may vary across different cultures. (Frequently = 77%)*

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

- *I intervene, in an appropriate manner, when I observe other staff exhibit behaviors that show cultural insensitivity or prejudice. (Rarely or Never = 14%, Did not Occur to Me = 7%)*
- *I attempt to learn a few key words in the client's primary language (e.g., "Hello, Goodbye, Thank you, etc.). (Rarely or Never = 19%, Did not Occur to Me = 6%)*

Overall, these results indicate that staff recognize the importance of clients' autonomy in decision making, and that family and gender roles may vary across different cultures. However, the results also indicate an opportunity to offer additional staff training regarding how to appropriately intervene if they observe another staff member exhibiting behaviors that show cultural insensitivity or prejudice. In addition, future training could offer staff an opportunity to learn a few key words in a client's primary language.

Survey results were also analyzed across the past four years (2019; 2020; 2021; 2022). In 2019, 460 staff completed the survey items; 2020, 582 staff completed the survey; in 2021, 494 staff completed the survey; and in 2022, 433 staff completed the survey. We compared the responses to see how we have improved from 2019 to 2022.

There was an **increase** in the percentage of staff who responded "**Frequently**" or "**Occasionally**" to the following two questions from 2019 to 2022:

- *I intervene, in an appropriate manner, when I observe other staff exhibit behaviors that show cultural insensitivity or prejudice. (Frequently or Occasionally = 76% in 2019; 79% in 2022)*
- *I examine my own cultural background and biases (race, culture, sexual orientation) and how they may influence my behavior towards others. (Frequently or Occasionally = 89% in 2019; 93% in 2022)*

Staff also reported on their participation in professional development activities during the past six months. The trends in survey responses were similar across all respondents (N=416); White respondents (N=118); Hispanic/Latino respondents (N=170), and respondents of another race/ethnicity (N=128).

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

- *Talked to a colleague about a racial and/or cultural issue (57%).*
- *Read/watched/listened to media about multicultural issues (79%).*
- *Learned something about a racial and/or cultural group other than my own (73%).*

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

- *Sought guidance about a racial and/or cultural issue that arose during therapy/service delivery (27%).*
- *Sought supervision about multicultural issues (20%).*
- *Attended a training on Implicit Bias (25%).*

B. Analyze Staff Disparities and Related Objectives

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

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

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

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

A. Survey Distribution

In an effort to assess the cultural responsiveness of our service delivery, we asked individuals who received behavioral health services through Fresno County DBH to complete the Client (Person Served) Cultural Humility Survey and Family/Caregiver Cultural Humility Survey Spring 2022. In total, 1,337 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/Person Served Cultural Humility Survey Results

There were 1,170 individuals who completed the Client/Persons Served Cultural Humility Survey. For the 1,123 individuals served who reported their age, 30.6% were children ages 0 – 11 and TAY 12 – 25; 55.8% were adults ages 26 – 59, and 13.6% were older adults, ages 60 and over. Of the 1,108 survey respondents who reported their race/ethnicity, 54.2% reported Hispanic/Latino; 23.5% as White; 6.2% as Black; 11.8% as Asian; 2.8% as American Indian or Alaska Native; 0.2% as Native Hawaiian or Other Pacific Islander; and 1.3% as 'Other'.

Of the 1,133 individuals reporting primary language, 77.1% reported English; 13.9% reported Spanish; 6.3% as Hmong/Lao; 0.1% as Punjabi; and 2.6% as 'Other.'

For sexual orientation, 1,017 individuals responded to this question. 85.8% of respondents identified as Heterosexual/Straight; and 14.2 identified as LGBTQ+. For current gender identity, 47.9% of the 1,108 survey respondents identify as Female; 48.8% as Male; and 3.3% identify as another gender. 97.2% of respondents reported not being involved with the military; and 38.4% reported that they have a disability.

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

Across all Respondents:

- *If I want to receive services from a person of my racial or ethnic group, staff help me connect to those services. (Agree = 73.2%)*
- *If I want to receive services from a person of my own gender and/or from the LGBTQ+ community, staff help me connect to those services. (Agree = 68.9%)*
- *Staff provide alternative services to meet my cultural treatment needs. (Agree = 74.6%)*
- *The facility has pictures or reading material that show people from my racial or ethnic group. (Agree = 67.1%)*

C. Family/Caregiver Cultural Humility Survey Results

There were 195 individuals who completed the Family/Caregiver Cultural Humility Survey. For the 184 individuals who reported their age, 29.9% were children ages 0 – 11; 33.2% were TAY ages 12 – 25; 35.3% were adults ages 26 – 59; and 1.6% were older adults, ages 60 and over.

For the 180 individuals who reported their race/ethnicity, 77.8% reported Hispanic/Latino; 11.7% as White; 4.4% as Black; 2.2% as Asian; 1.1% as American Indian or Alaska Native, and 0.6% as Native Hawaiian or Pacific Islander. 2.2% of survey respondents reported their race/ethnicity as 'Other.'

For the 192 individuals who reported their primary language, 72.4% reported English; 25.5% reported Spanish; 0.5% as Hmong/Lao; 0.5% as Punjabi; and 1% as an 'Other' language.

For sexual orientation, 142 individuals responded to this survey item. 89.4% of respondents identified as Heterosexual/Straight; and 10.6% as LGBTQ+. For current gender identity, 58.8% of survey respondents identify as Female; 38.5% as Male; and 2.7% identify as another gender. The majority (98.9%) of respondents reported not being involved with the military; and 17.6% reported that their family member has a disability.

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

Across all Respondents:

- *If my family member wants to receive services from a person from their own racial or ethnic group, staff help them connect to those services. (Agree = 79%)*
- *If my family member wants to receive services from a person of their own gender and/or from the LGBTQ+ community, staff help them connect to those services. (Agree = 76%)*
- *Some of the treatment staff are from my family member's racial or ethnic group. (Agree = 80%)*
- *The facility has pictures or reading material that show people from my family member's racial or ethnic group. (Agree = 74%)*

D. Analyze Disparities and Related Objectives

Survey results will be analyzed and shared with the DEIC to help identify new strategies and goals over the coming year (2023).

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

These survey results provide valuable information on staff, family members, and individual's understanding of culture and their experience with mental health services within the system of care. The results also help identify training opportunities to support staff to deliver culturally

responsive services. The DEI Committee, and subcommittees have made great strides in creating a system of care that delivers culturally, ethnically, and linguistically responsive services to individuals receiving behavioral health services. This supports services that are sensitive to other cultures, including individuals in recovery; Lesbian, Gay, Bisexual, Transgender and Questioning (LGBTQ+) community; veterans; persons living with disabilities (hearing, vision, physical); various age groups (Children: 0-15; Transition Age Youth [TAY]: 16-25; Adults: 26-59; Older Adults: 60+); immigrants and refugees; and persons involved in the justice system.

The development and implementation of a culturally and linguistically responsive system requires the commitment and dedication from leadership, staff, organizational providers, and the community to continually strive to learn from each other and by offering ongoing training and education. This helps to identify and mitigate barriers to ensure a service delivery system that respects the whole person.

VI. TRAINING IN CULTURAL RESPONSIVENESS AND HUMILITY

Behavioral Health System of Care (BHSOC) will continuously offer Core Cultural Competency Trainings for county staff and contracted providers. The expectation is for these trainings to be completed by the target audience within six (6) months of hire date and/or contract execution and repeated every five (5) years. 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 have been nationally recognized and officially documented in landmark reports and publications: The Surgeon General's 2001 Report, IOM 2000, and Stanley Sue's research. The County's service utilization data in the last several years suggested gender, age, and racial/ethnic related disparities. The County's BHSOC workforce assessments show: shortages of psychiatrists with special skills working with children and older adults, none-White individuals in managerial positions requiring licenses and advanced degrees, in direct care providers, especially licensed staff with working with American Indian, Hmong, Cambodian, Laotian, Vietnamese, Hispanic/Latino and other immigrant and refugee groups indigenous communities from Mexico and Central America.

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

B. Training Participation

This section describes cultural responsiveness and humility trainings for staff and providers, including training in the use of interpreters, in FY 2021/22.

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, 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 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 will have a Fresno-Centric LGBTQ-BIPOC training completed and available to help improve equity and responsiveness of services for those intersectionalities.

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

C. Core Cultural Competency Trainings in FY 2021/22

Title of Training / Event / Conference	Number of Participants
Using Communication Strategies to Bridge Cultural Divides (Relias)	21
Your Role in Workplace Diversity (Relias)	88
Introduction & Implementation of Cultural Responsiveness (IICR)	343
Behavioral Health Interpreter Training (BHIT) Interpreter Trainings	25
Behavioral Health Interpreter Training (BHIT) Providers Trainings	70

D. Additional Cultural Competency Trainings in FY 2021/22

Title of Training / Event / Conference	Number of Participants
Best Practices for Working with LGBTQ Children and Youth	1
Bridging the Diversity Gap (Relias)	162
A Culture-Centered Approach to Recovery (Relias)	3
Behavioral Health Services and the LGBTQ+ Community (Relias)	2
Building a Multicultural Care Environment (Relias)	138
Cultural Competence and Sensitivity in the LGBTQ Community - California (Relias)	39
Cultural Awareness and the Older Adult (Relias)	2
Cultural Competence (Relias)	96
How Culture Impacts Communication (Relias)	10
Overcoming Barriers to LGBTQ+ Affirming Behavioral Health Services (Relias)	3

Title of Training / Event / Conference	Number of Participants
Patient Cultural Competency for Non-Providers (Relias)	2
Understanding and Minimizing Cultural Bias for Paraprofessionals (Relias)	6
Using Communication Strategies to Bridge Cultural Divides (Relias)	21
Working More Effectively with LGBTQ+ Children and Youth (Relias)	4
Working More Effectively with the LGBTQ+ Community (Relias)	3
Prevalence and Treatment of Substance Use Disorders in the LGBTQ+ Community (Relias)	4
Mitigating Risk Factors-Affirming & Accepting Environments for LGBTQ+ Youth Panel Discussion (Relias)	2
Care of the LGBTQ Resident in California (Relias)	14
Improving Care Through Understanding the Intersectionalities of LGBTQ+ Persons Served Discussion Panel (Relias)	1

VII. ADAPTATION OF SERVICES

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

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.

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

www.ThinkCulturalHealth.hhs.gov

THINK CULTURAL HEALTH

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)

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

CLAS Standard	CCPR Criteria	Framework Guiding Principles
12) Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.	Criterion 8: Adaptation of Services	Identification of Disparities and Assessment of Needs and Assets (8)
13) Partner with the community to design, implement and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.	Criterion 4: 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)

Attachment C

Fresno County Department of Behavioral Health

Cultural Humility Committee (CHC) Charter

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

Type of Committee: Standing Committee (as mandated)

Membership:

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

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

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

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

Objectives:

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

1

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

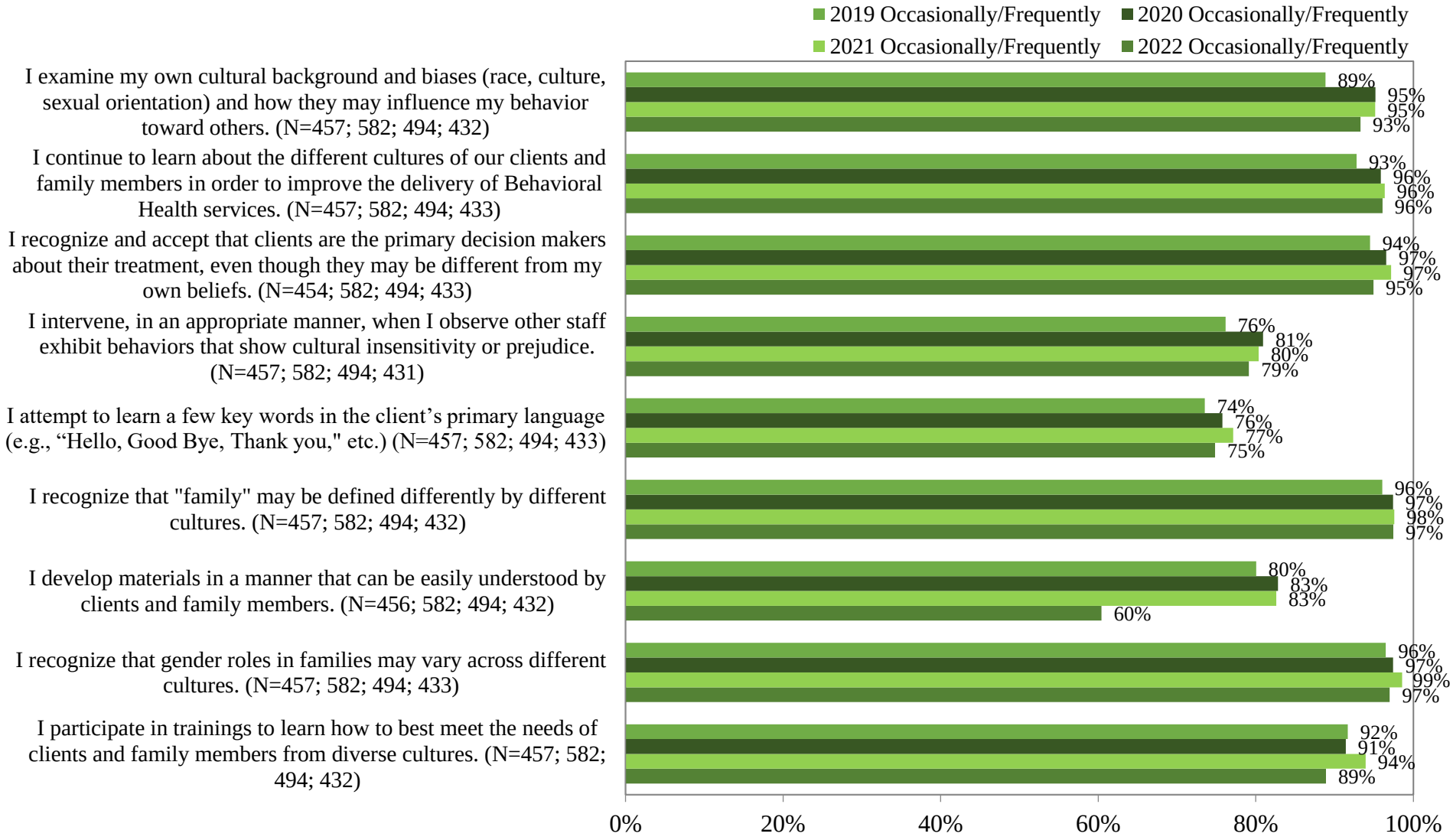
Attachment E: Staff and Volunteer Cultural Humility Survey Results

Fresno County Department of Behavioral Health

Staff Cultural Humility Survey

Comparison Between 2019, 2020, 2021 and 2022 Survey Results

All Respondents

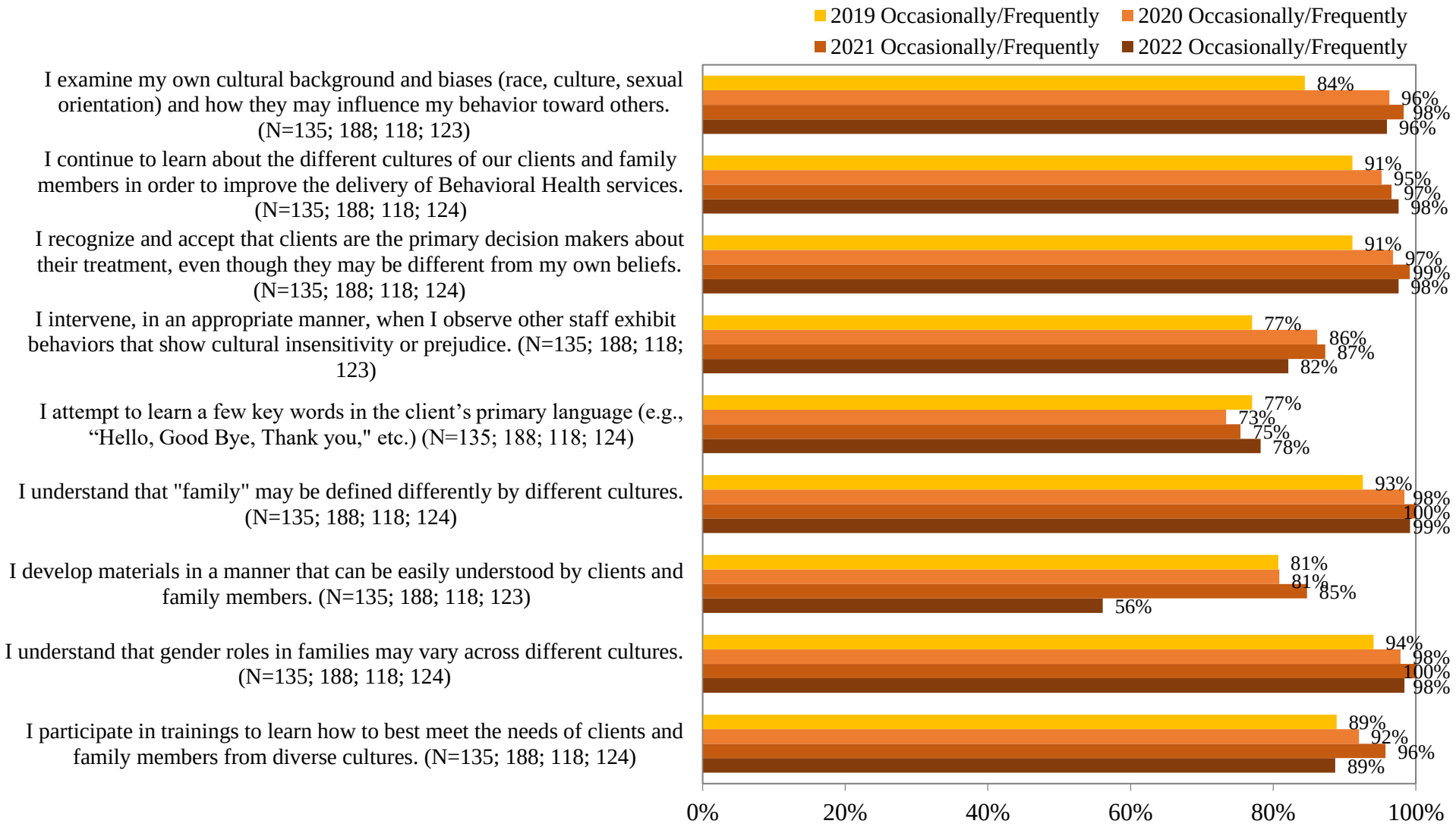


Fresno County Department of Behavioral Health

Staff Cultural Humility Survey

Comparison Between 2019, 2020, 2021 and 2022 Survey Results

White/ Caucasian Respondents

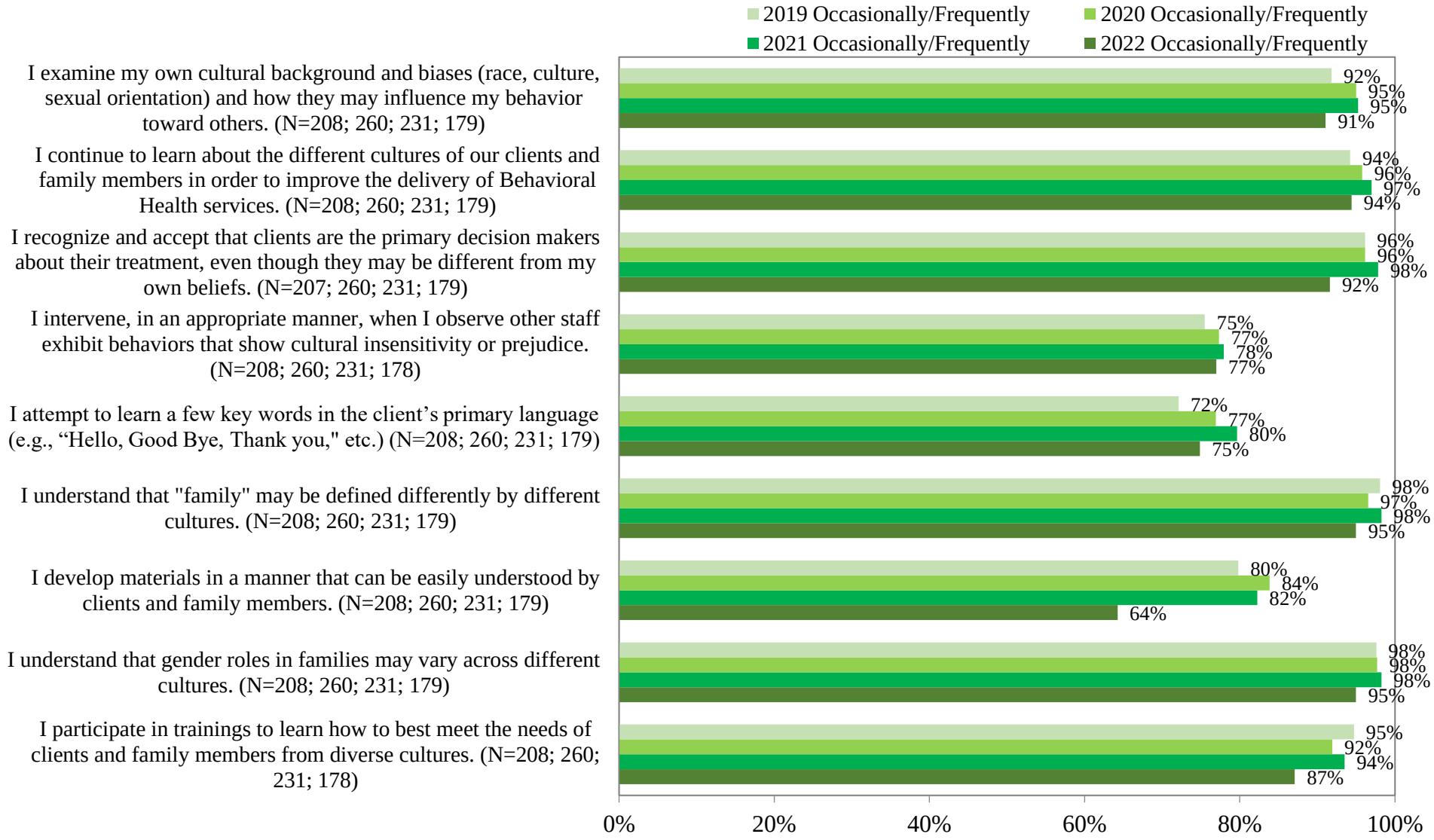


Fresno County Department of Behavioral Health

Staff Cultural Humility Survey

Comparison Between 2019, 2020, 2021 and 2022 Survey Results

Hispanic Respondents

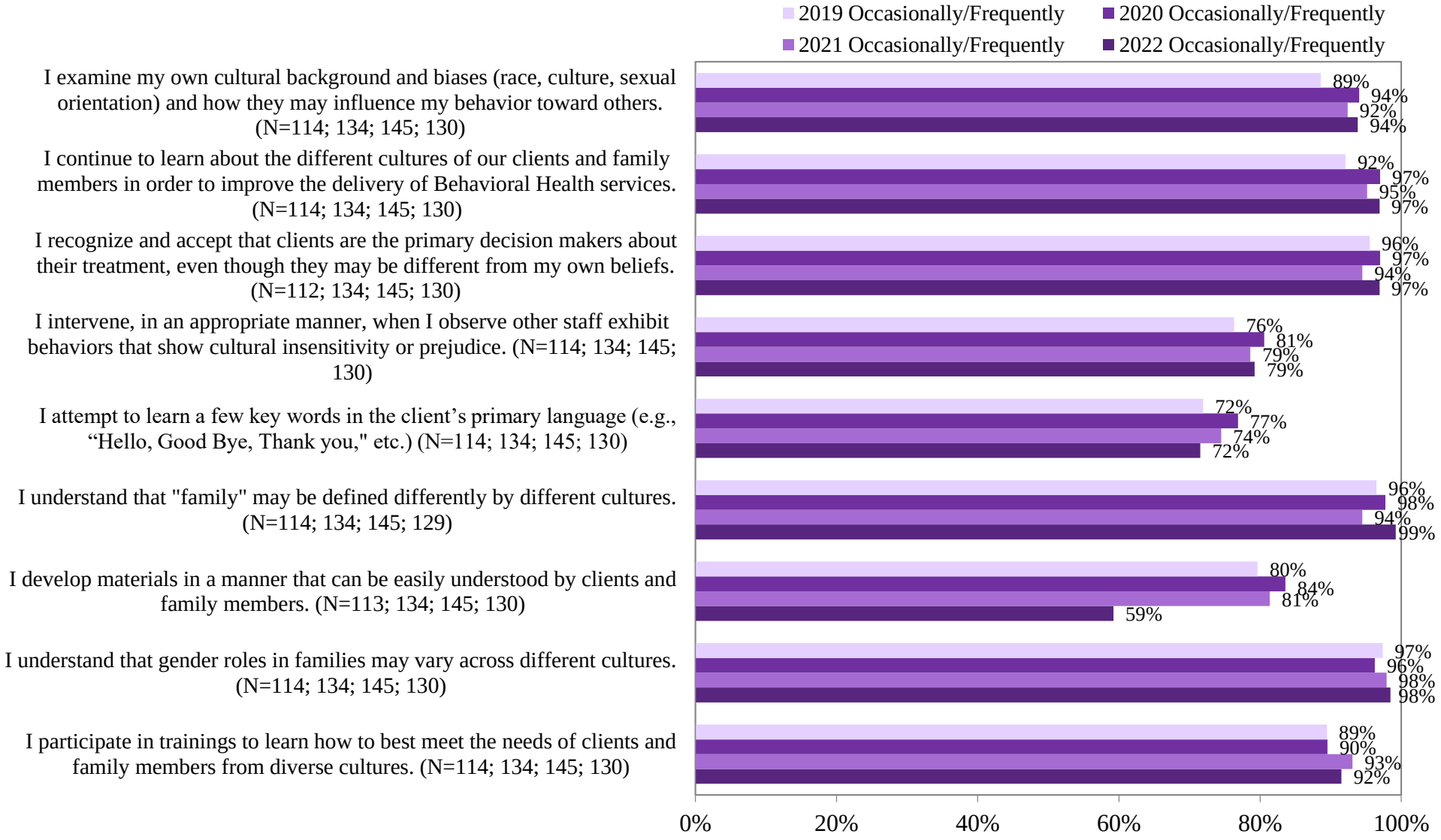


Fresno County Department of Behavioral Health

Staff Cultural Humility Survey

Comparison Between 2019, 2020, 2021 and 2022 Survey Results

All Other Ethnicity Respondents



Fresno County Department of Behavioral Health

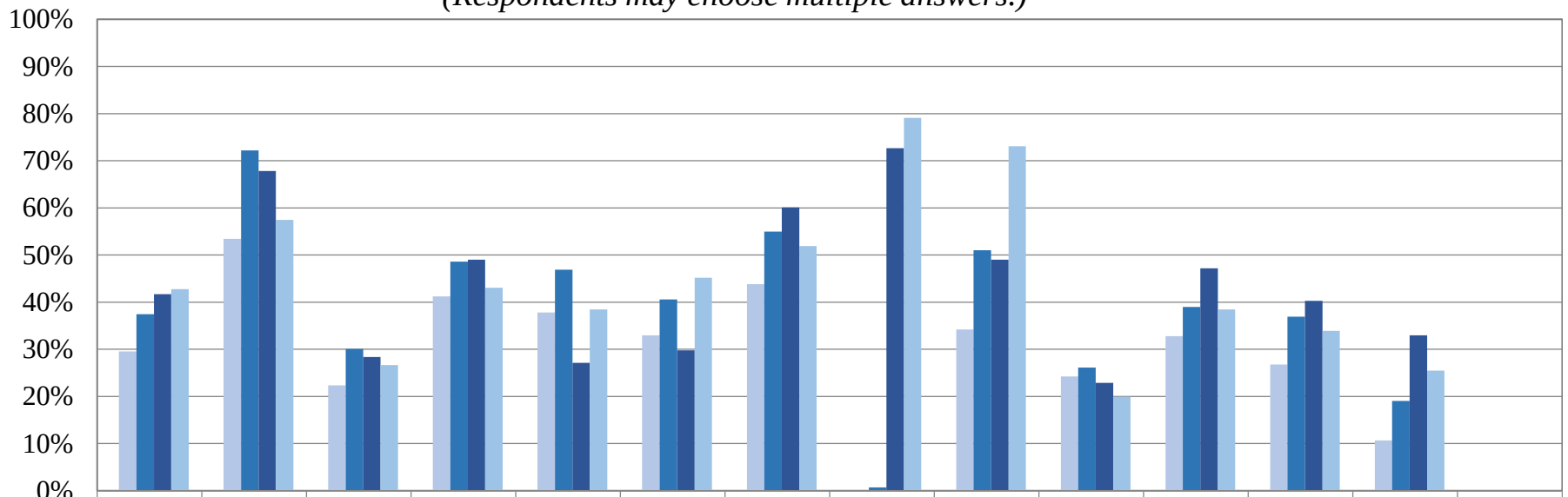
Staff Cultural Humility Survey

Comparison Between 2019, 2020, 2021 and 2022 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) 2022 All Respondents (N=416)

(Respondents may choose multiple answers.)



	Recognized a prejudice I have about certain people	Talked to a colleague about a racial and/or cultural issue	Sought guidance about a racial and/or cultural issue that arose during therapy/ service delivery	Attended a multi-cultural training seminar	Attended a cultural event	Attended an event in which most of the other people were not my race	Reflected on my racial identity and how it affects my work with clients	Read/ watched/ listened to media about multicultural issues	Learned something about a racial and/or cultural group other than my own	Sought supervision about multicultural issues	Talked to a friend about how our racial differences affect our relationship	Challenged a racist remark - my own or someone else's	Attended a training on Implicit Bias	Total Respondents
2019 # Respondents	172	311	130	240	220	192	255	0	199	141	191	156	62	455
2019 % Respondents	30%	53%	22%	41%	38%	33%	44%	0%	34%	24%	33%	27%	11%	78%
2020 # Respondents	218	420	175	283	273	236	320	4	297	152	227	215	111	582
2020 % Respondents	37%	72%	30%	49%	47%	41%	55%	1%	51%	26%	39%	37%	19%	100%
2021 # Respondents	206	335	140	242	134	147	297	359	242	113	233	199	163	494
2021 % Respondents	42%	68%	28%	49%	27%	30%	60%	73%	49%	23%	47%	40%	33%	100%
2022 # Respondents	178	239	111	179	160	188	216	329	304	83	160	141	106	416
2022 % Respondents	43%	57%	27%	43%	38%	45%	52%	79%	73%	20%	38%	34%	25%	100%

Fresno County Department of Behavioral Health

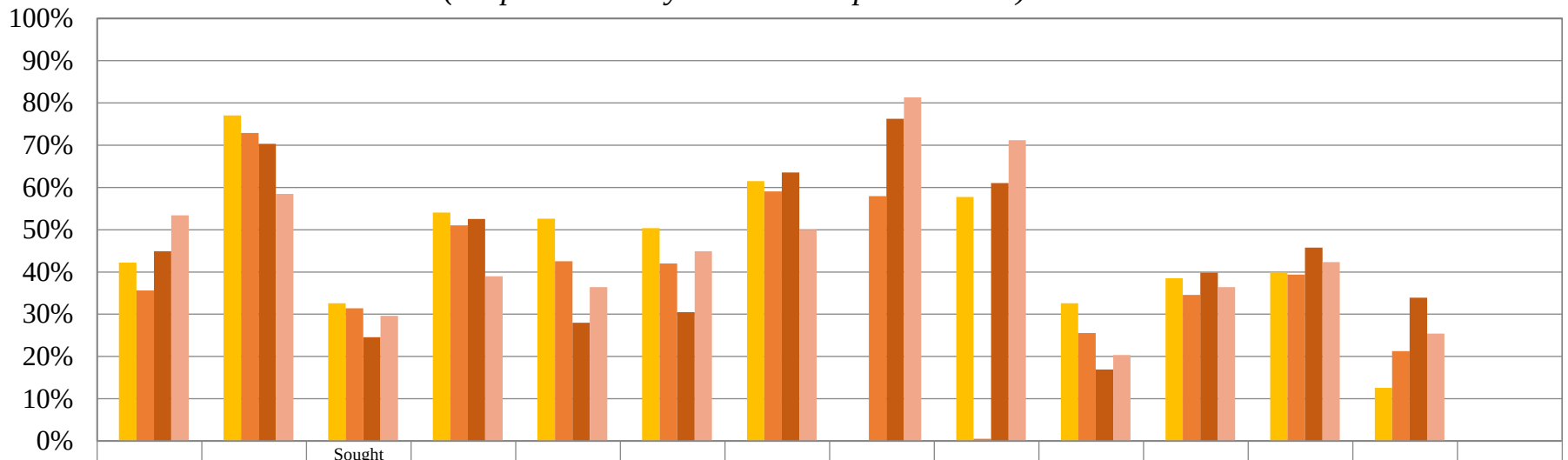
Staff Cultural Humility Survey

Comparison Between 2019, 2020, 2021 and 2022 Survey Results

Participation in Professional Development Activities (Past Six Months)

2019 White/ Caucasian Respondents (N=135) ***2020 White/ Caucasian Respondents (N=188)*** ***2021 White/ Caucasian Respondents (N=118)*** ***2022 White/ Caucasian Respondents (N=118)***

(Respondents may choose multiple answers.)



	Recognized a prejudice I have about certain people	Talked to a colleague about a cultural issue	Sought guidance about a cultural issue that arose during therapy/ service delivery	Attended a multi-cultural training seminar	Attended a cultural event	Attended an event in which most of the other people were not my race	Reflected on my racial identity and how it affects my work with clients	Read/ watched/ listened to media about multicultural issues	Learned something about a racial and/or cultural group other than my own	Sought supervision about multicultural issues	Talked to a friend about how our racial differences affect our relationship	Challenged a racist remark - my own or someone else's	Attended a training on Implicit Bias	Total Respondents
2019 # Respondents	57	104	44	73	71	68	83	0	78	44	52	54	17	135
2019 % Respondents	42%	77%	33%	54%	53%	50%	61%	0%	58%	33%	39%	40%	13%	100%
2020 # Respondents	67	137	59	96	80	79	111	109	1	48	65	74	40	188
2020 % Respondents	36%	73%	31%	51%	43%	42%	59%	58%	1%	26%	35%	39%	21%	100%
2021 # Respondents	53	83	29	62	33	36	75	90	72	20	47	54	40	118
2021 % Respondents	45%	70%	25%	53%	28%	31%	64%	76%	61%	17%	40%	46%	34%	100%
2022 # Respondents	63	69	35	46	43	53	59	96	84	24	43	50	30	118
2022 % Respondents	53%	58%	30%	39%	36%	45%	50%	81%	71%	20%	36%	42%	25%	100%

Fresno County Department of Behavioral Health

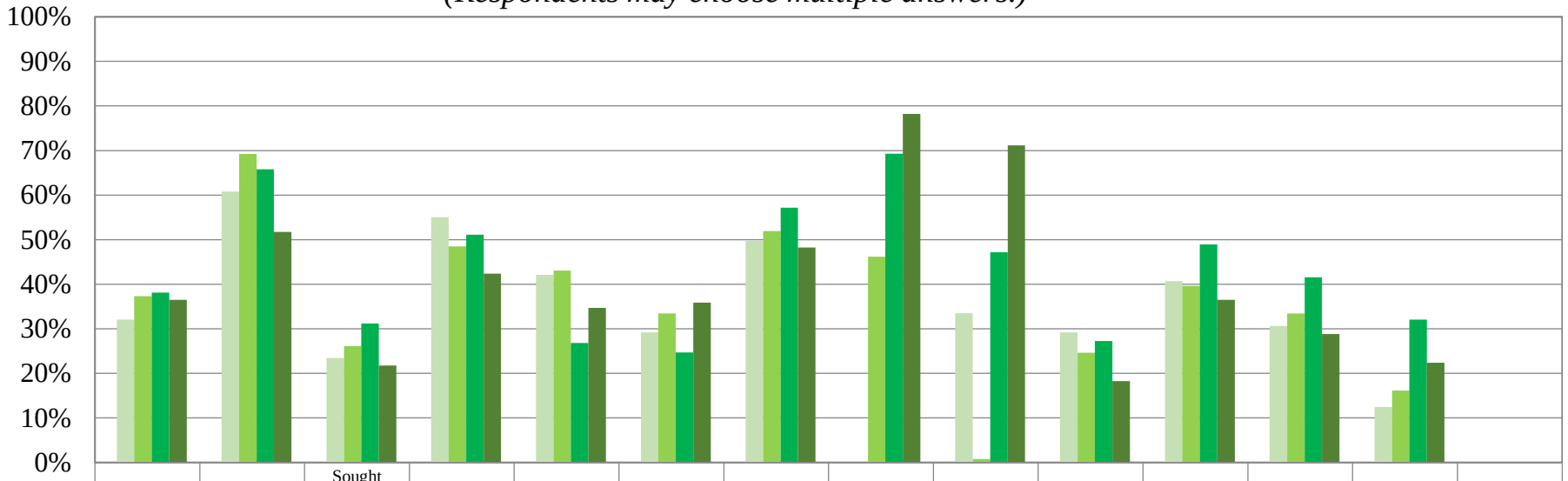
Staff Cultural Humility Survey

Comparison Between 2019, 2020, 2021 and 2022 Survey Results

Participation in Professional Development Activities (Past Six Months)

2019 Hispanic Respondents (N=209) ***2020 Hispanic Respondents (N=260)*** ***2021 Hispanic Respondents (N=231)*** ***2022 Hispanic Respondents (N=170)***

(Respondents may choose multiple answers.)



	Recognized a prejudice I have about certain people	Talked to a colleague about a cultural issue	Sought guidance about a cultural issue that arose during therapy/ service delivery	Attended a multi-cultural training seminar	Attended a cultural event	Attended an event in which most of the other people were not my race	Reflected on my racial identity and how it affects my work with clients	Read/ watched/ listened to media about multicultural issues	Learned something about a racial and/or cultural group other than my own	Sought supervision about multicultural issues	Talked to a friend about how our racial differences affect our relationship	Challenged a racist remark - my own or someone else's	Attended a training on Implicit Bias	Total Respondents
2019 # Respondents	67	127	49	115	88	61	104	0	70	61	85	64	26	209
2019 % Respondents	32%	61%	23%	55%	42%	29%	50%	0%	33%	29%	41%	31%	12%	100%
2020 # Respondents	97	180	68	126	112	87	135	120	2	64	103	87	42	260
2020 % Respondents	37%	69%	26%	48%	43%	33%	52%	46%	1%	25%	40%	33%	16%	100%
2021 # Respondents	88	152	72	118	62	57	132	160	109	63	113	96	74	231
2021 % Respondents	38%	66%	31%	51%	27%	25%	57%	69%	47%	27%	49%	42%	32%	100%
2022 # Respondents	62	88	37	72	59	61	82	133	121	31	62	49	38	170
2022 % Respondents	36%	52%	22%	42%	35%	36%	48%	78%	71%	18%	36%	29%	22%	100%

Fresno County Department of Behavioral Health

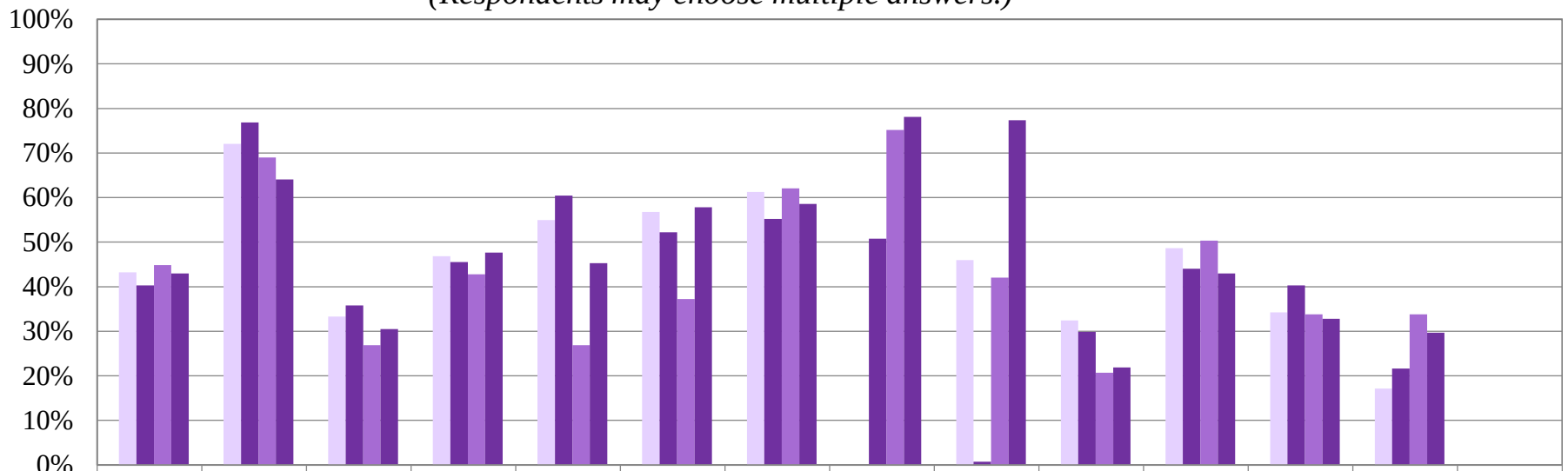
Staff Cultural Humility Survey

Comparison Between 2019, 2020, 2021 and 2022 Survey Results

Participation in Professional Development Activities (Past Six Months)

2019 Other Ethnicity Respondents (N=111) ***2020 Other Ethnicity Respondents (N=134)*** ***2021 Other Ethnicity Respondents (N=145)*** ***2022 Other Ethnicity Respondents (N=145)***

(Respondents may choose multiple answers.)



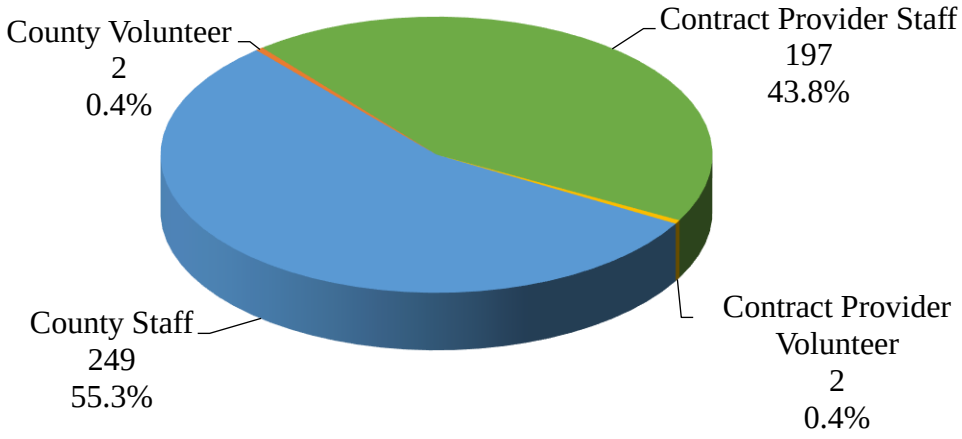
	Recognized a prejudice I have about certain people	Talked to a colleague about a cultural issue	Sought guidance about a cultural issue that arose during therapy/ service delivery	Attended a multi-cultural training seminar	Attended a cultural event	Attended an event in which most of the other people were not my race	Reflected on my racial identity and how it affects my work with clients	Read/ watched/ listened to media about multicultural issues	Learned something about a racial and/or cultural group other than my own	Sought supervision about multicultural issues	Talked to a friend about how our racial differences affect our relationship	Challenged a racist remark - my own or someone else's	Attended a training on Implicit Bias	Total Respondents
2019 # Respondents	48	80	37	52	61	63	68	0	51	36	54	38	19	111
2019 % Respondents	43%	72%	33%	47%	55%	57%	61%	0%	46%	32%	49%	34%	17%	100%
2020 # Respondents	54	103	48	61	81	70	74	68	1	40	59	54	29	134
2020 % Respondents	40%	77%	36%	46%	60%	52%	55%	51%	1%	30%	44%	40%	22%	100%
2021 # Respondents	65	100	39	62	39	54	90	109	61	30	73	49	49	145
2021 % Respondents	45%	69%	27%	43%	27%	37%	62%	75%	42%	21%	50%	34%	34%	100%
2022 # Respondents	55	82	39	61	58	74	75	100	99	28	55	42	38	128
2022 % Respondents	43%	64%	30%	48%	45%	58%	59%	78%	77%	22%	43%	33%	30%	100%

Fresno County Department of Behavioral Health

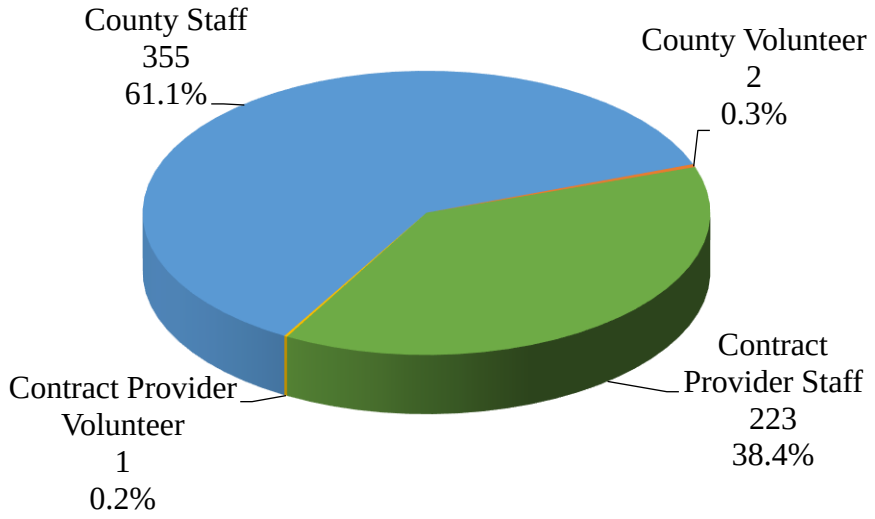
Staff Cultural Humility Survey

Comparison Between 2019, 2020, 2021 and 2022 Survey Results

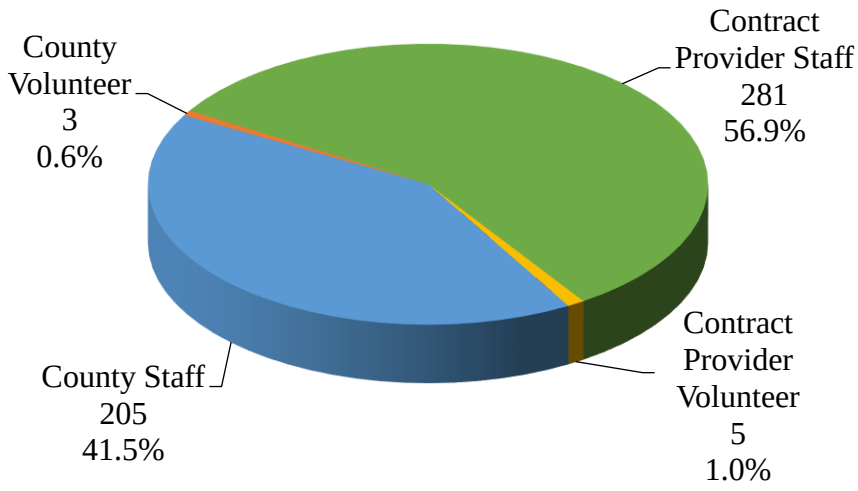
2019 Employment Status (N=450)



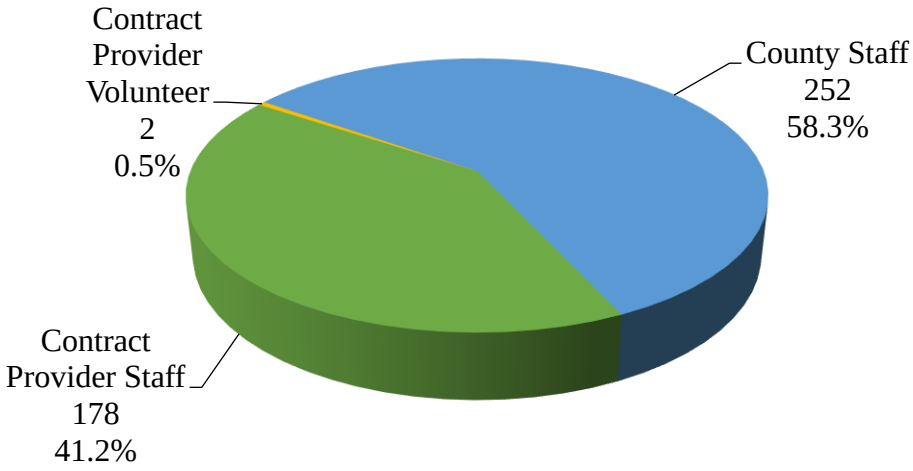
2020 Employment Status (N=581)



2021 Employment Status (N=494)



2022 Employment Status (N=432)

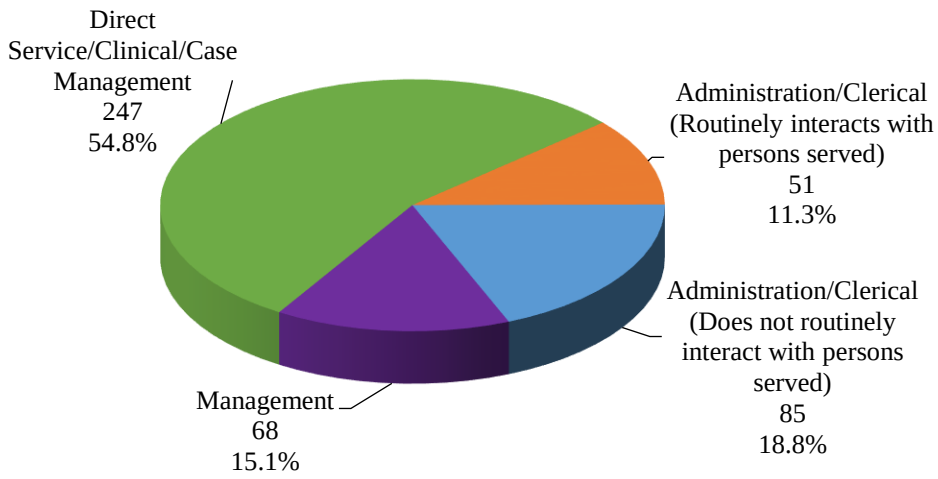


Fresno County Department of Behavioral Health

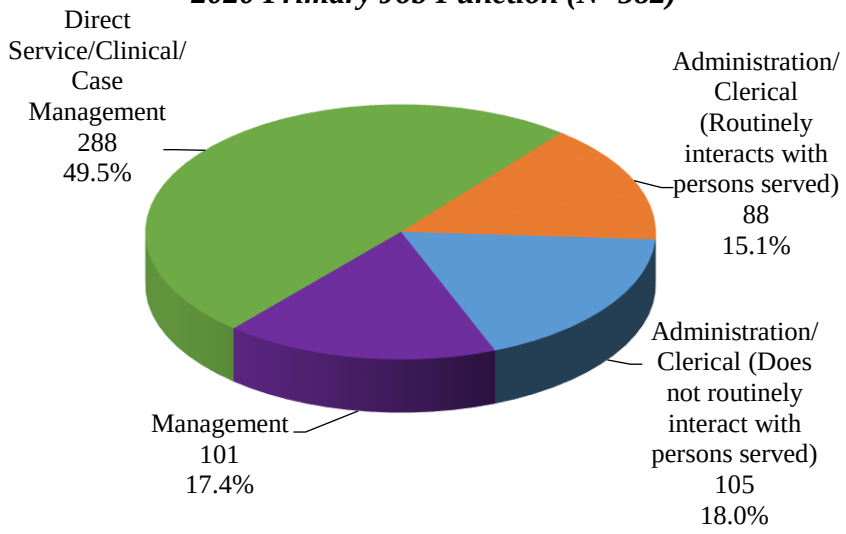
Staff Cultural Humility Survey

Comparison Between 2019, 2020, 2021 and 2022 Survey Results

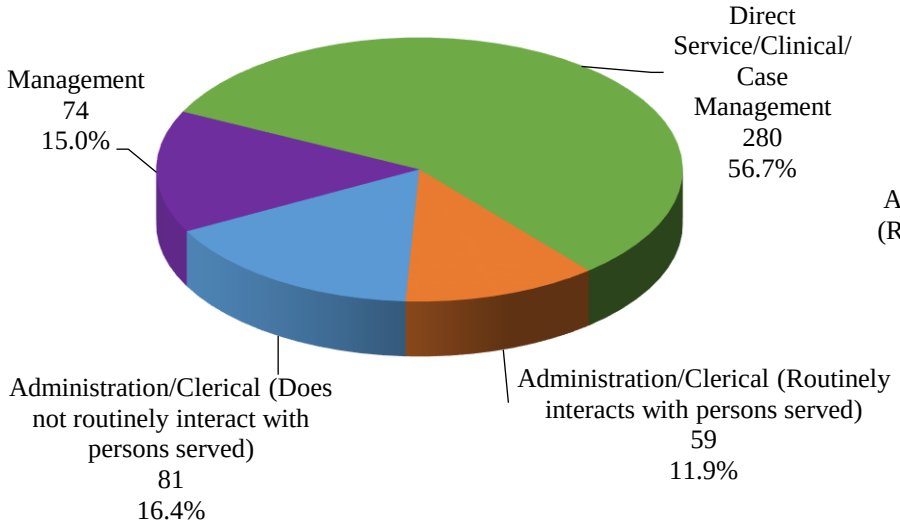
2019 Primary Job Function (N=451)



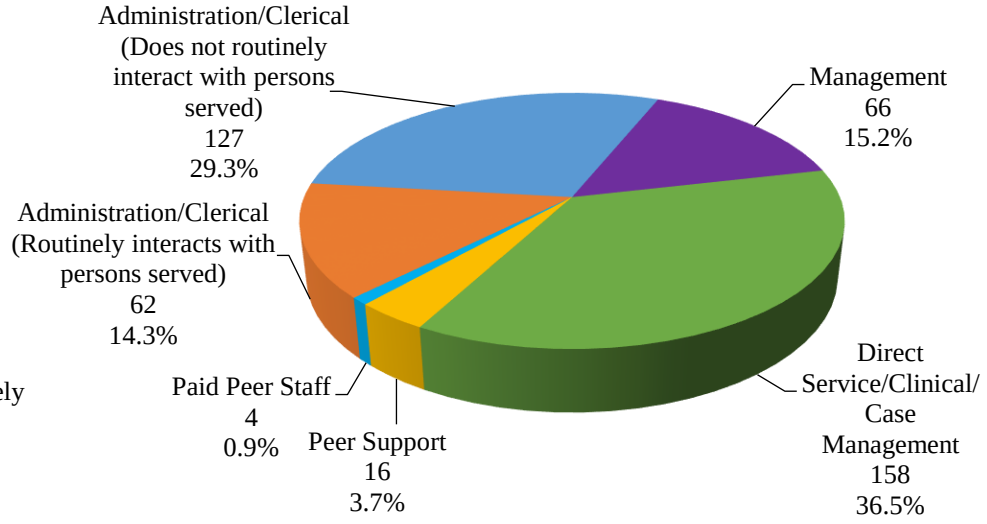
2020 Primary Job Function (N=582)



2021 Primary Job Function (N=494)



2022 Primary Job Function (N=433)

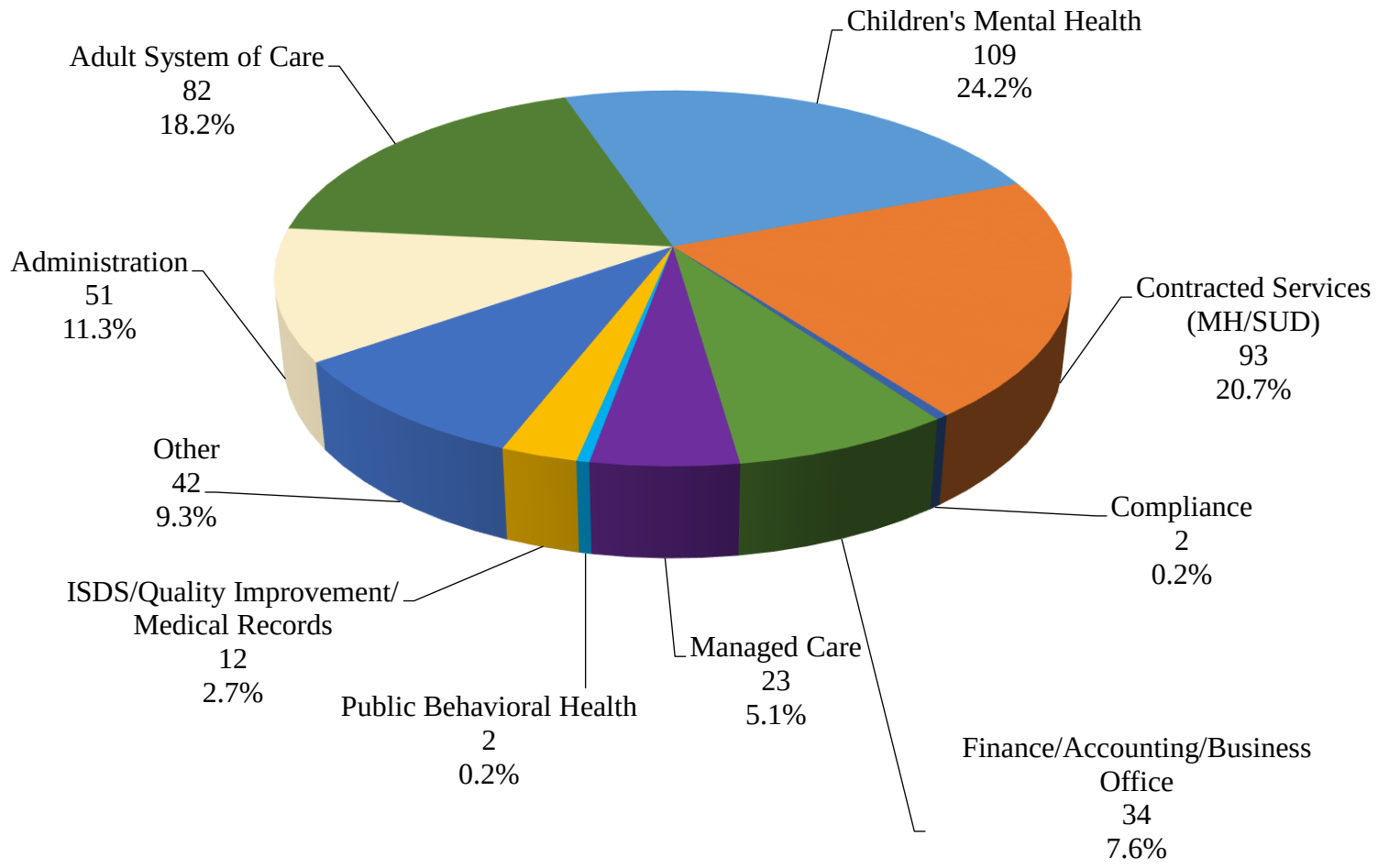


Fresno County Department of Behavioral Health

Staff Cultural Humility Survey

Comparison Between 2019, 2020, 2021 and 2022 Survey Results

2019 Department/Program (N=450)

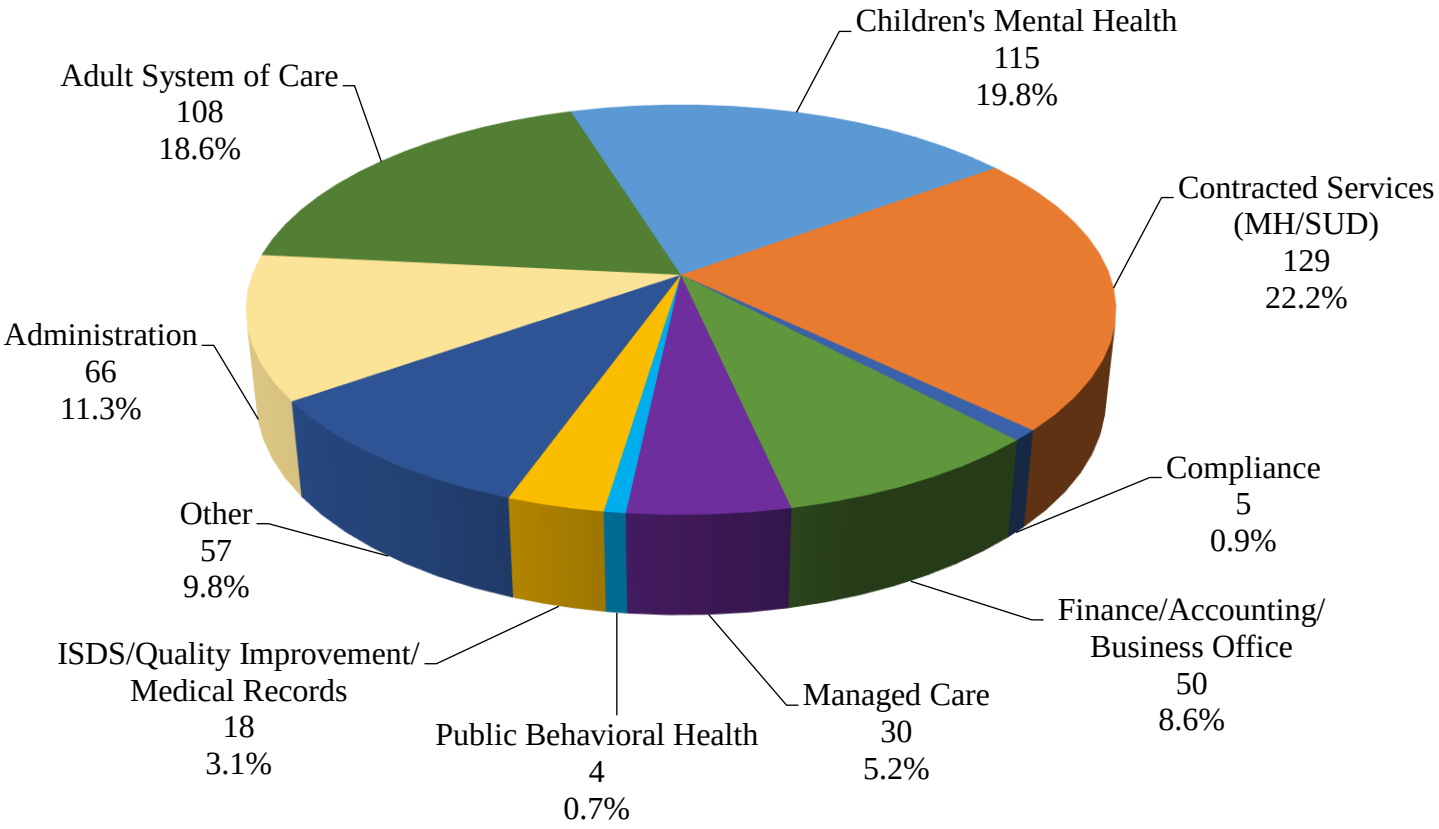


Fresno County Department of Behavioral Health

Staff Cultural Humility Survey

Comparison Between 2019, 2020, 2021 and 2022 Survey Results

2020 Department/Program (N=582)

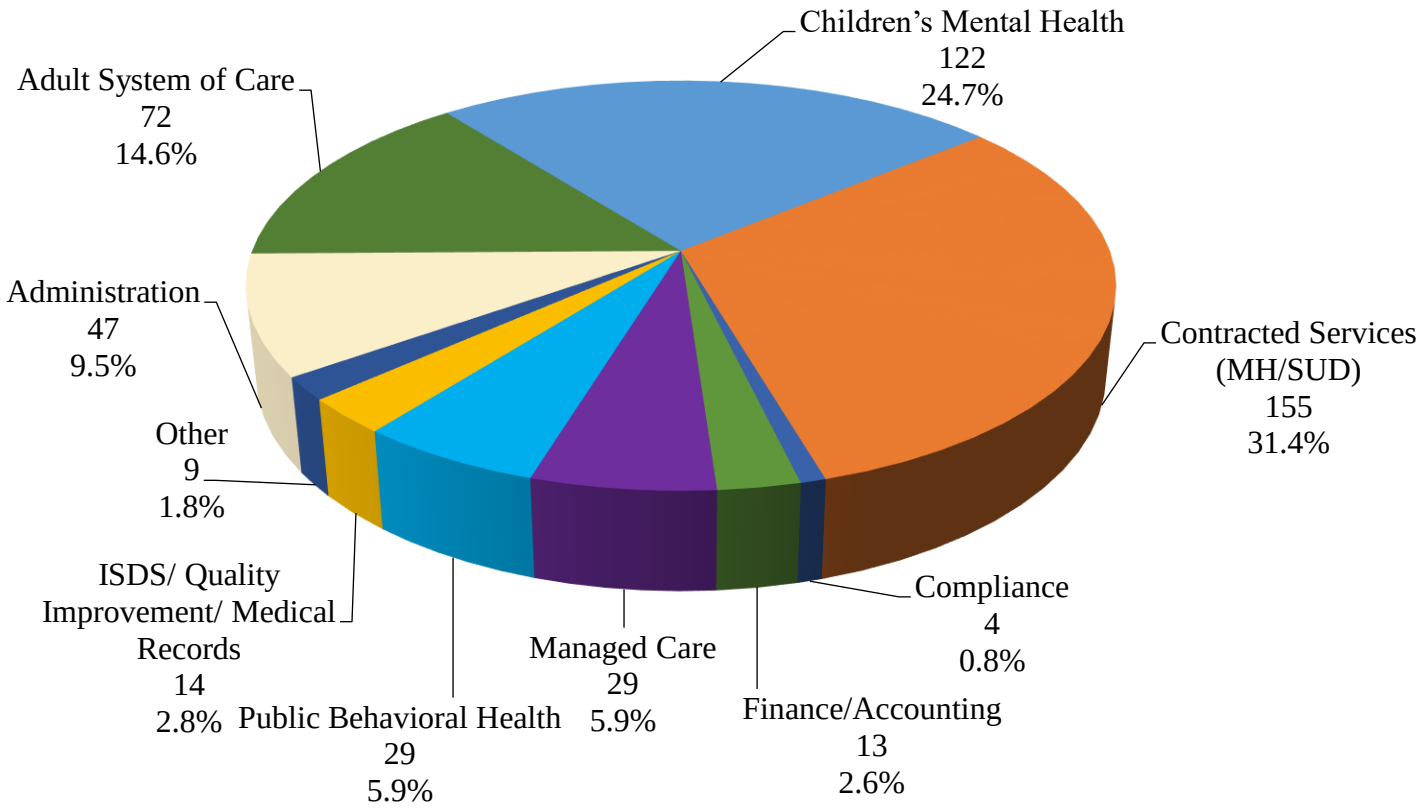


Fresno County Department of Behavioral Health

Staff Cultural Humility Survey

Comparison Between 2019, 2020, 2021 and 2022 Survey Results

2021 Department/Program (N=494)

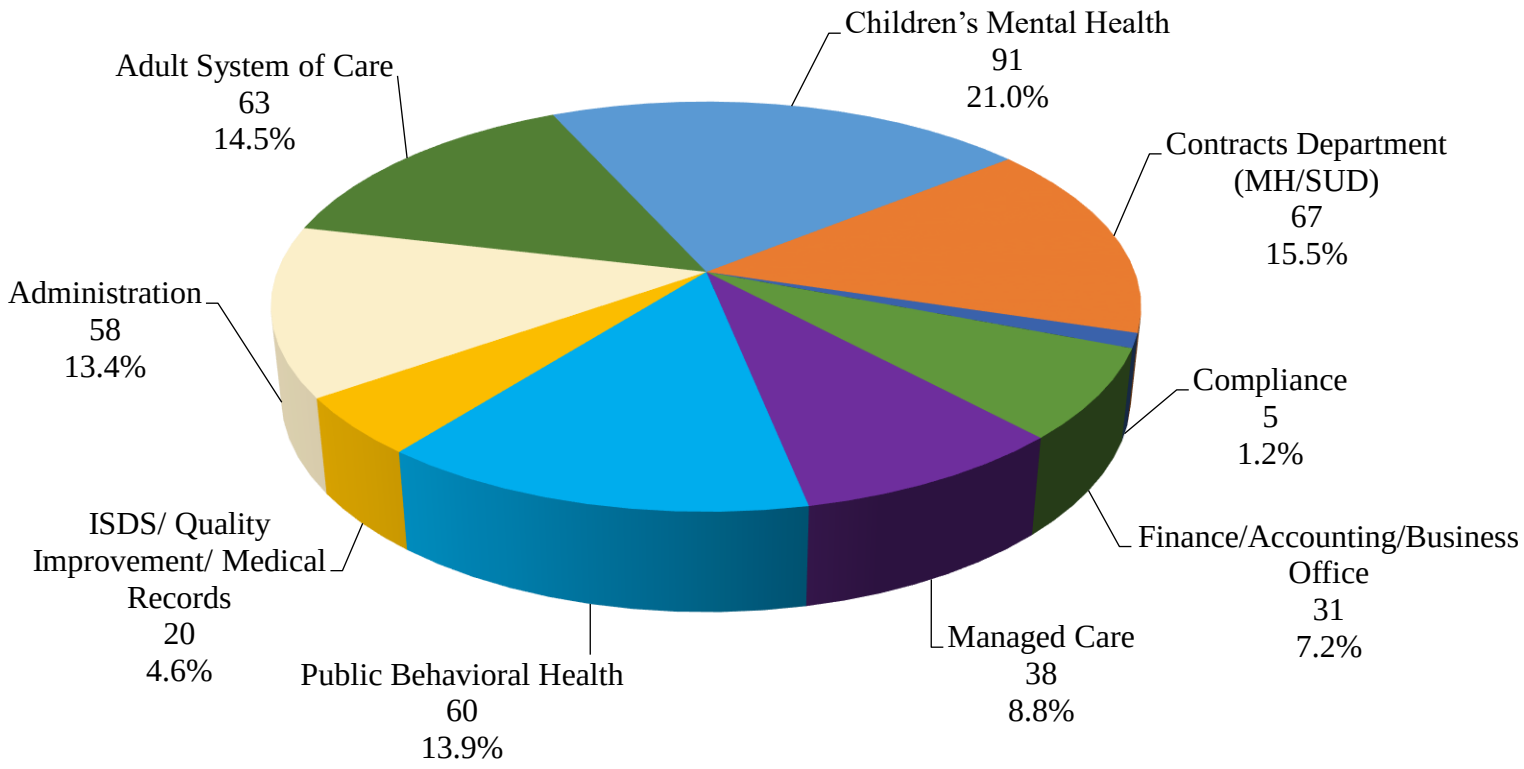


Fresno County Department of Behavioral Health

Staff Cultural Humility Survey

Comparison Between 2019, 2020, 2021 and 2022 Survey Results

2022 Department/Program (N=433)

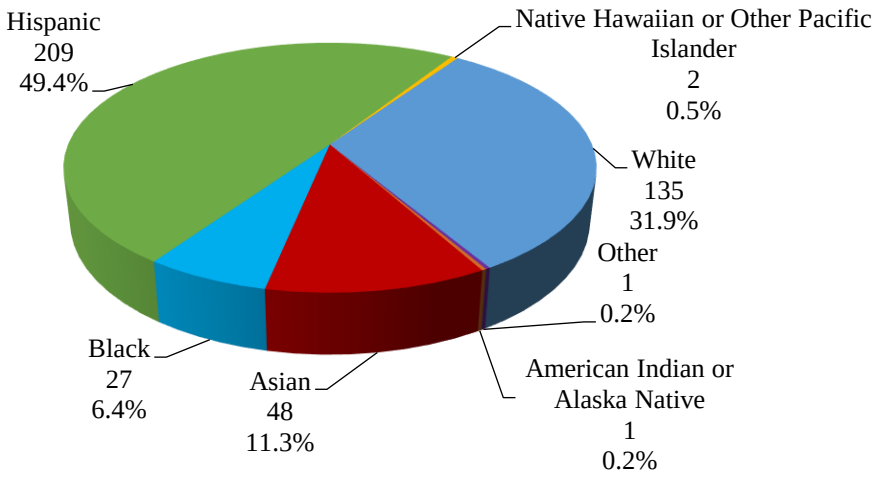


Fresno County Department of Behavioral Health

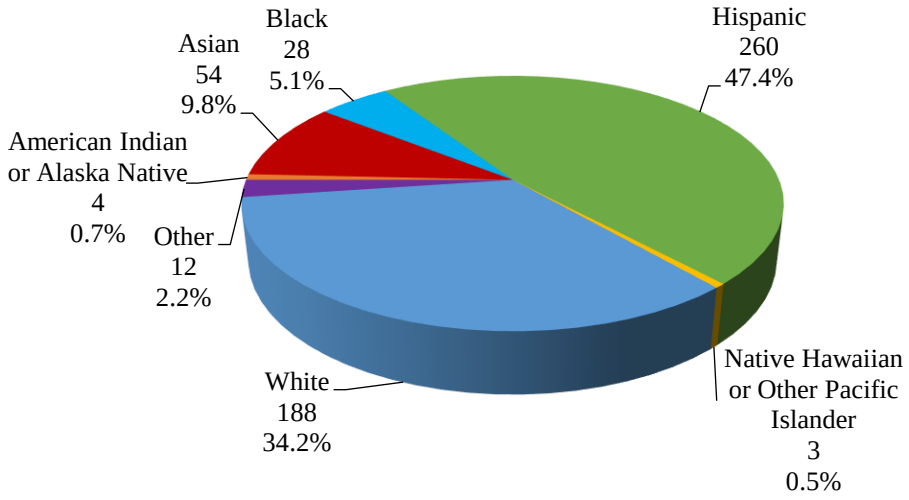
Staff Cultural Humility Survey

Comparison Between 2019, 2020, 2021 and 2022 Survey Results

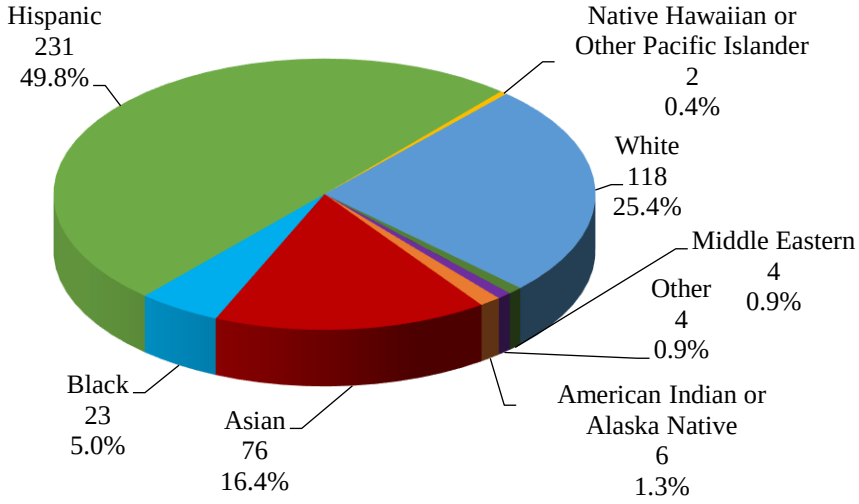
2019 Race/Ethnicity (N=423)



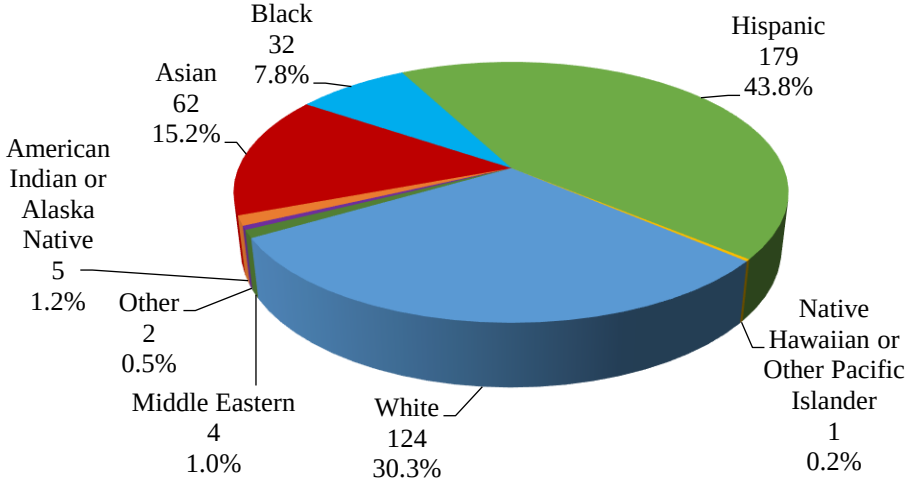
2020 Race/Ethnicity (N=549)



2021 Race/Ethnicity (N=464)



2022 Race/Ethnicity (N=409)

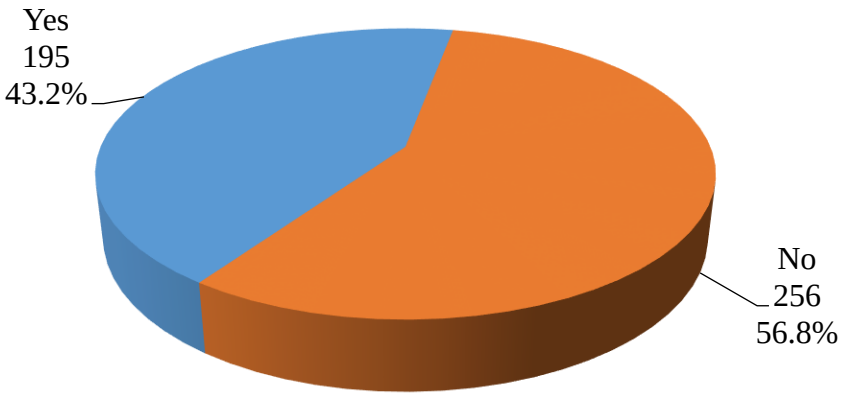


Fresno County Department of Behavioral Health

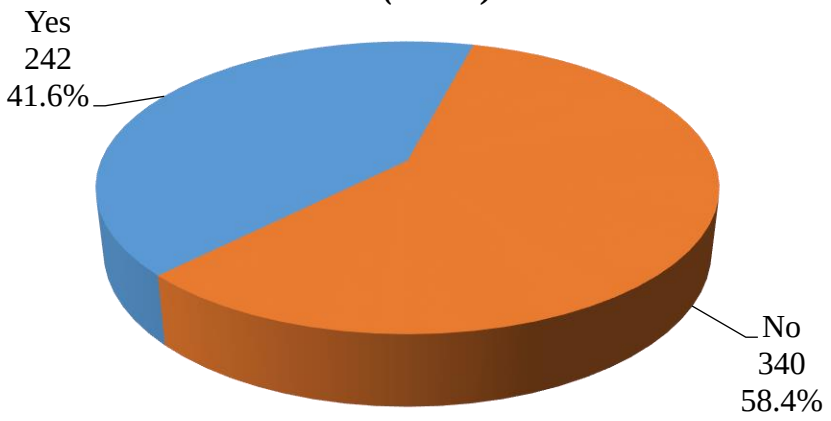
Staff Cultural Humility Survey

Comparison Between 2019, 2020, 2021 and 2022 Survey Results

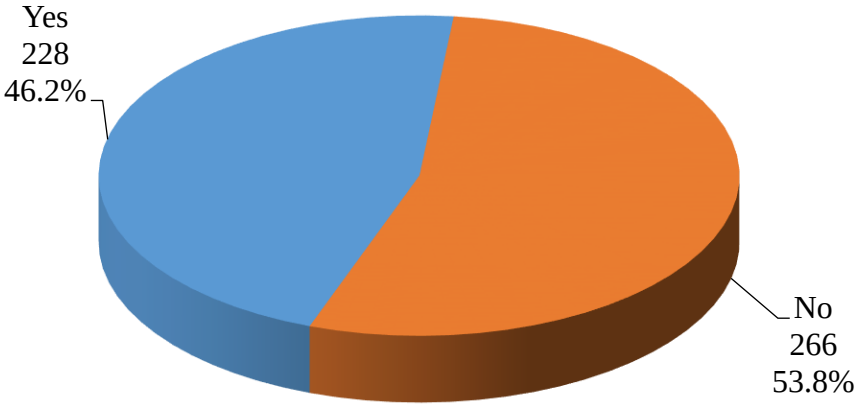
2019 Do you consider yourself Bilingual? (N=451)



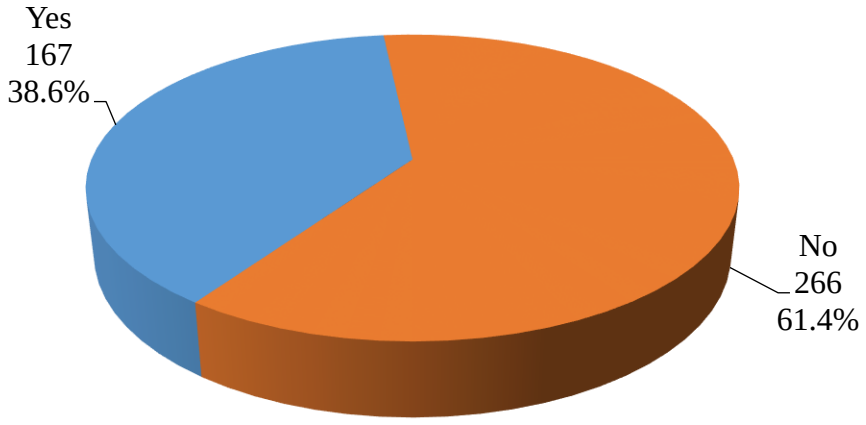
2020 Do you consider yourself Bilingual? (N=582)



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



2022 Do you consider yourself Bilingual? (N=433)



Fresno County Department of Behavioral Health

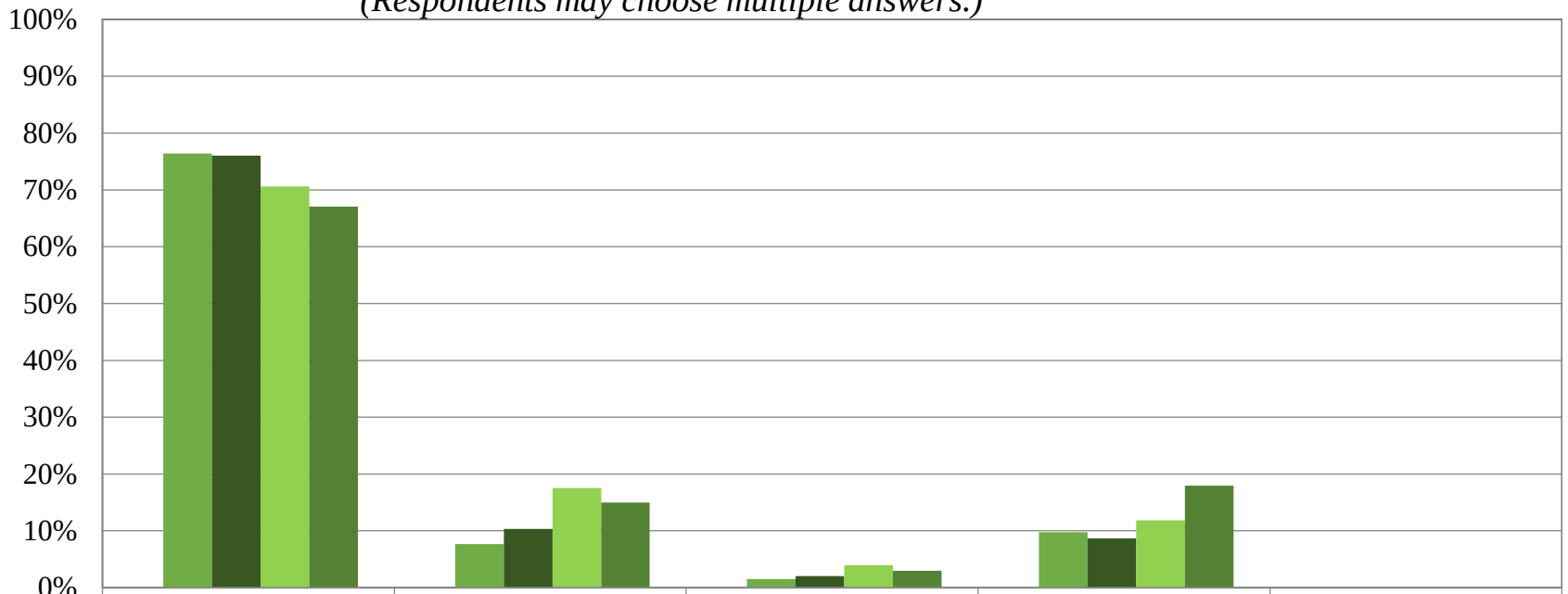
Staff Cultural Humility Survey

Comparison Between 2019, 2020, 2021 and 2022 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)*** ***2022 Bilingual Respondents (N=167)***

(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%
2022 # Respondents	112	25	5	30	167
2022 % Respondents	67%	15%	3%	18%	100%

Fresno County Department of Behavioral Health

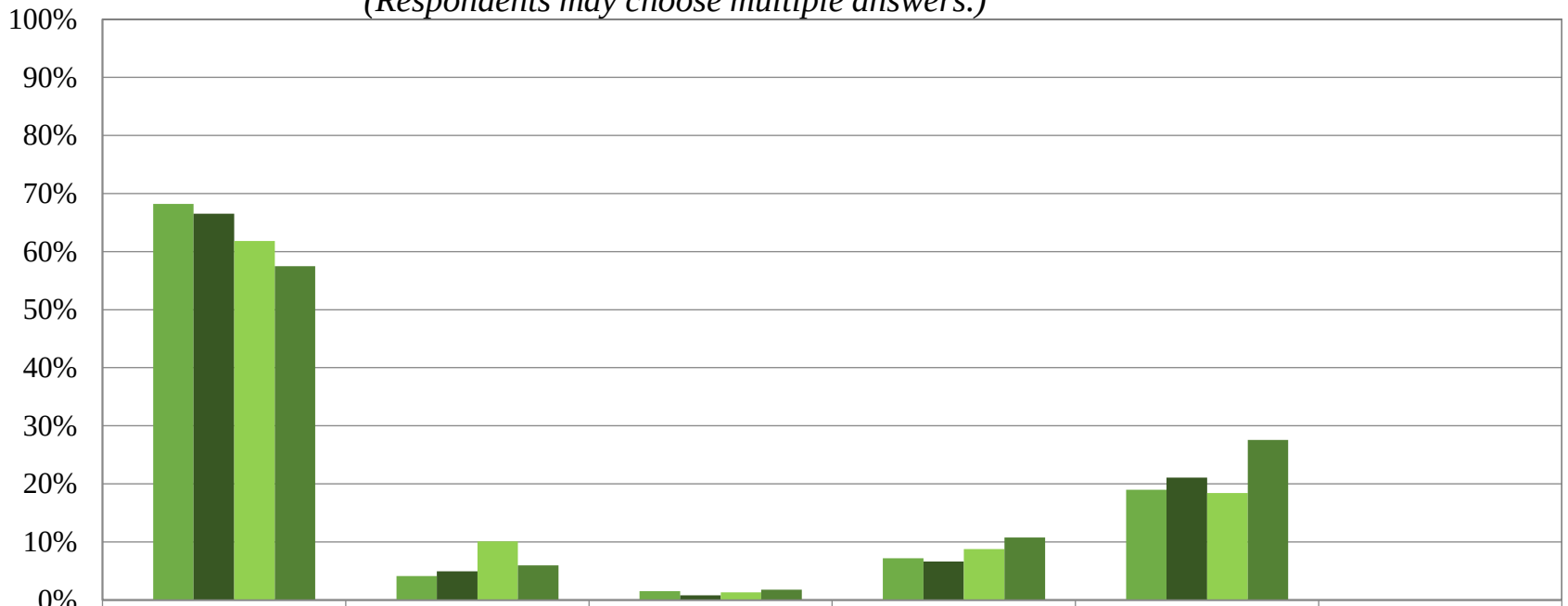
Staff Cultural Humility Survey

Comparison Between 2019, 2020, 2021 and 2022 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)*** ***2022 Bilingual Respondents (N=167)***

(Respondents may choose multiple answers.)



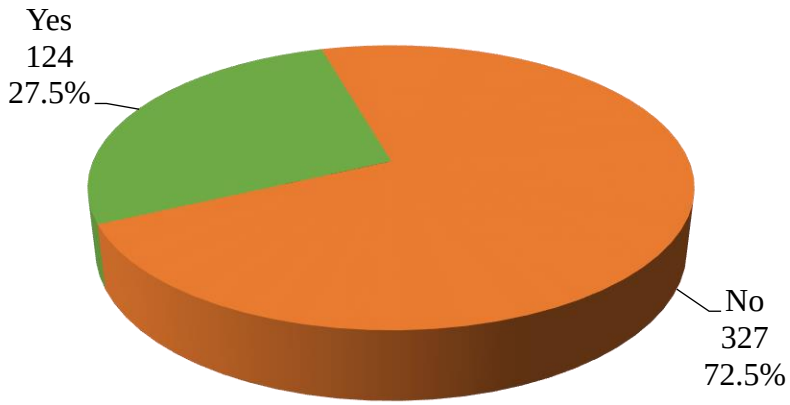
	Spanish	Hmong	Punjabi	Other	Not proficient	Total Bilingual
2019 # Respondents	133	8	3	14	37	195
2019 % Respondents	68%	4%	2%	7%	19%	100%
2020 # Respondents	161	12	2	16	51	242
2020 % Respondents	67%	5%	1%	7%	21%	100%
2021 # Respondents	141	23	3	20	42	228
2021 % Respondents	62%	10%	1%	9%	18%	100%
2022 # Respondents	96	10	3	18	46	167
2022 % Respondents	57%	6%	2%	11%	28%	100%

Fresno County Department of Behavioral Health

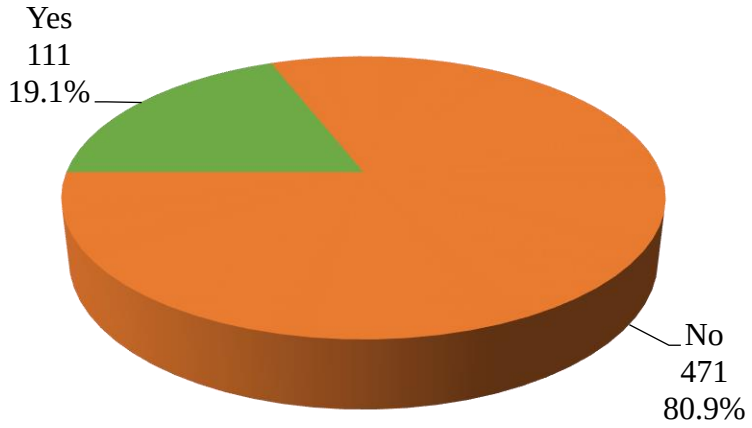
Staff Cultural Humility Survey

Comparison Between 2019, 2020, 2021 and 2022 Survey Results

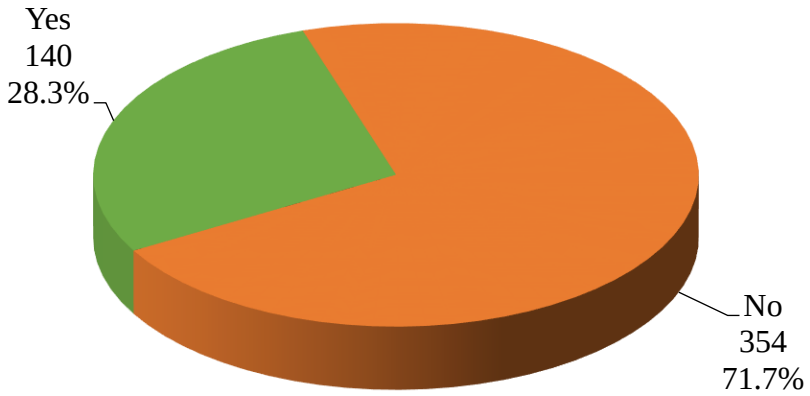
2019 Do you act as an Interpreter as part of your Job Function? (N=451)



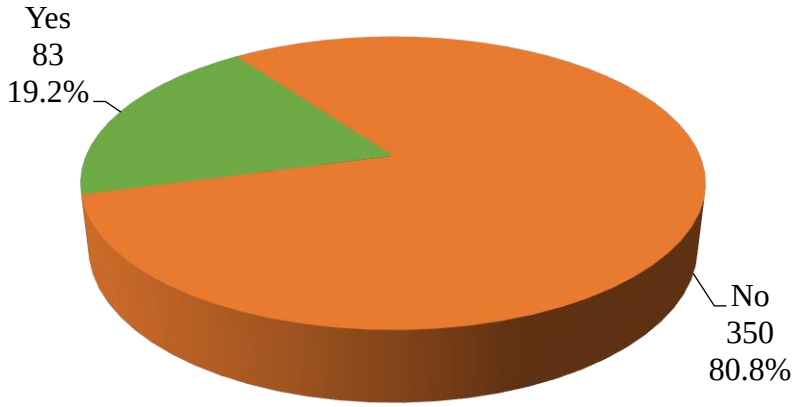
2020 Do you act as an Interpreter as part of your Job Function? (N=582)



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



2022 Do you act as an Interpreter as part of your Job Function? (N=433)

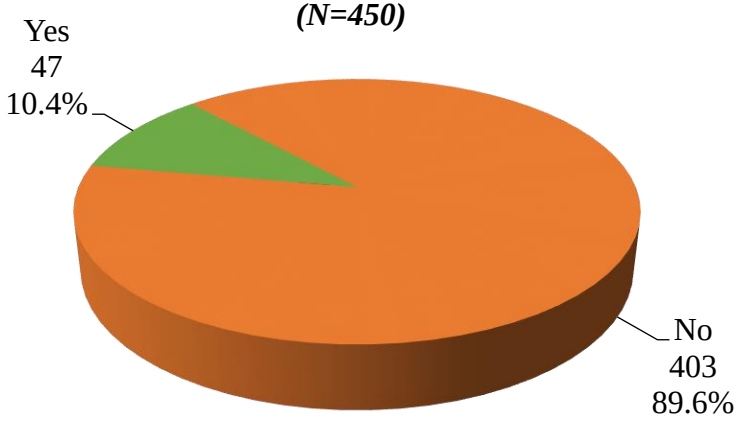


Fresno County Department of Behavioral Health

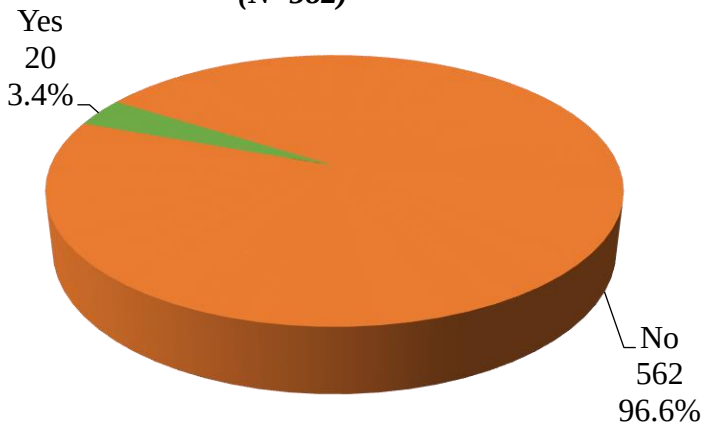
Staff Cultural Humility Survey

Comparison Between 2019, 2020, 2021 and 2022 Survey Results

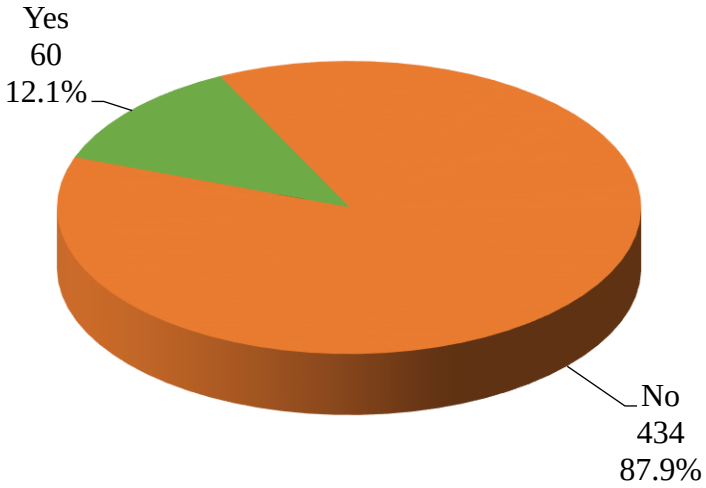
2019 Do you receive bilingual pay?
(N=450)



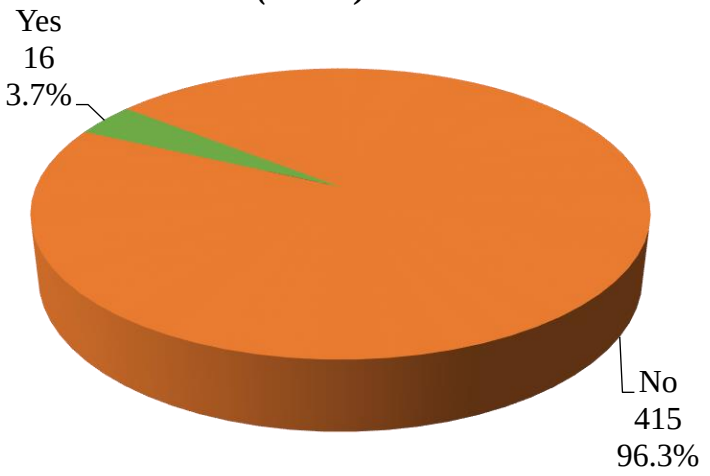
2020 Do you receive bilingual pay?
(N=582)



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



2022 Do you receive bilingual pay?
(N=431)

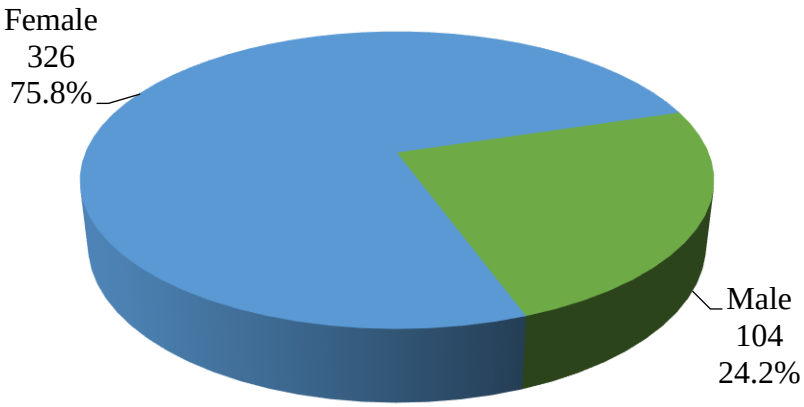


Fresno County Department of Behavioral Health

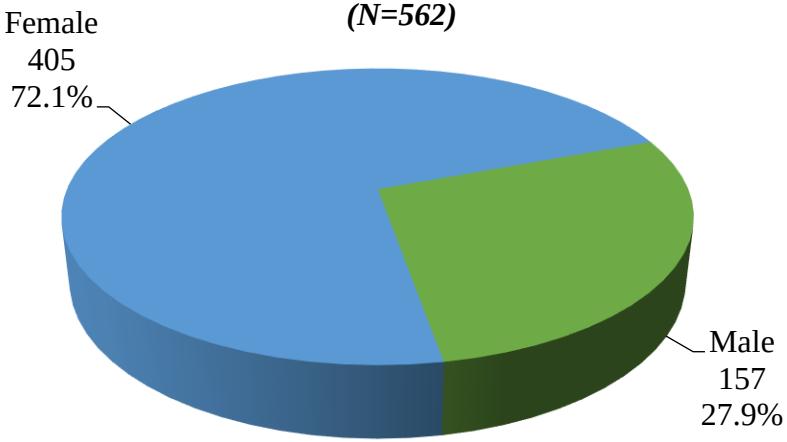
Staff Cultural Humility Survey

Comparison Between 2019, 2020, 2021 and 2022 Survey Results

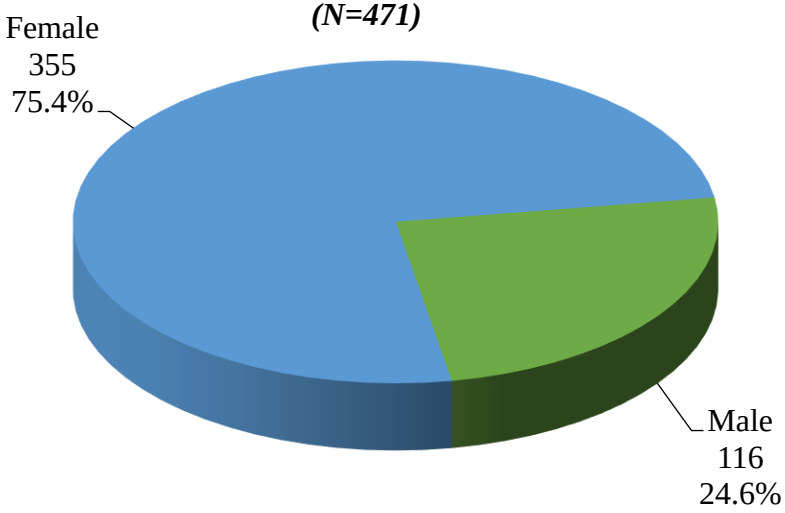
2019 Gender Assigned at Birth (N=430)



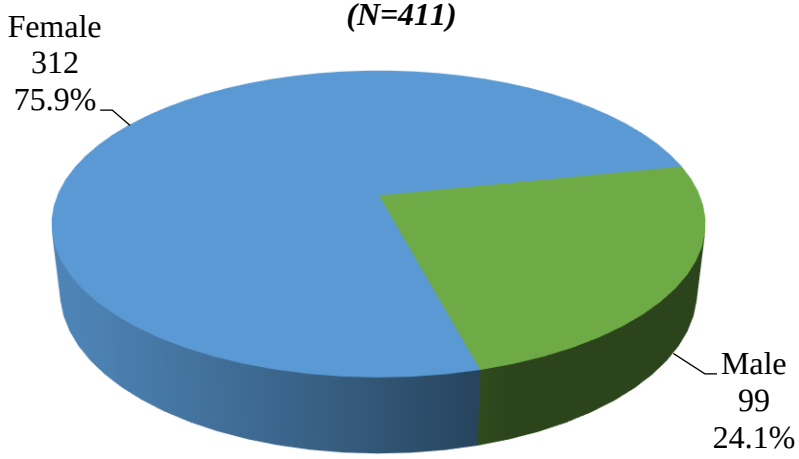
2020 Gender Assigned at Birth (N=562)



2021 Gender Assigned at Birth (N=471)



2022 Gender Assigned at Birth (N=411)

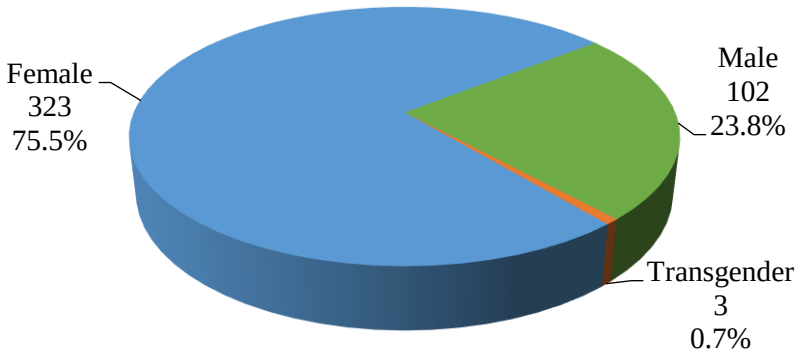


Fresno County Department of Behavioral Health

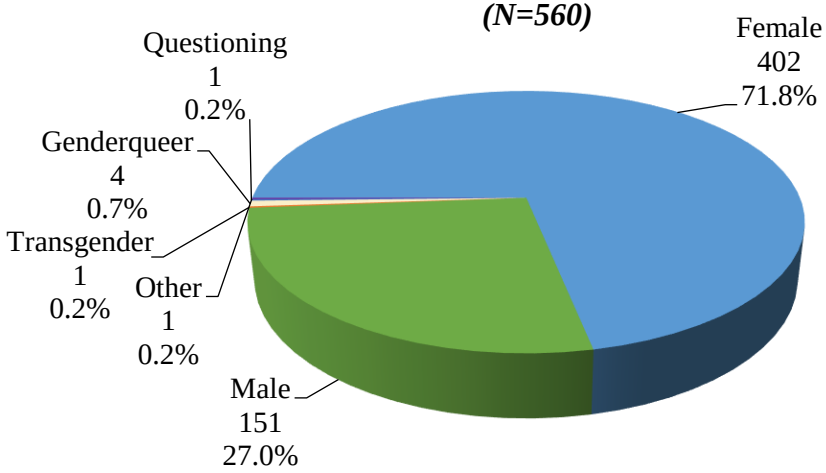
Staff Cultural Humility Survey

Comparison Between 2019, 2020, 2021 and 2022 Survey Results

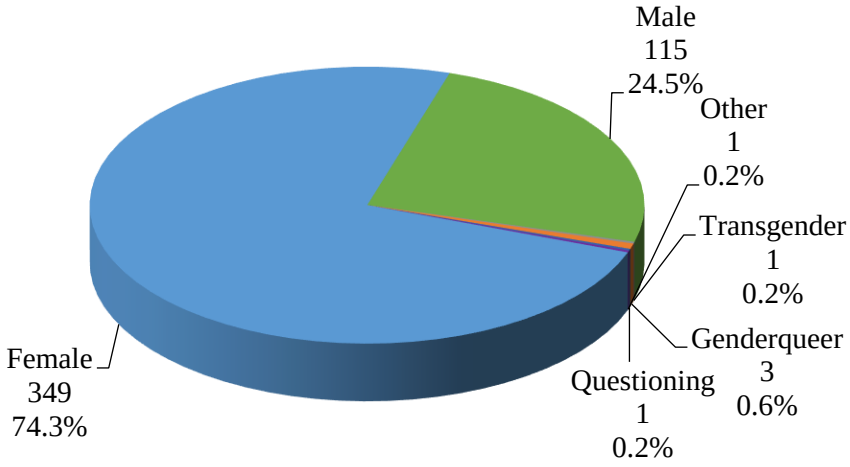
2019 Current Gender Identity
(N=428)



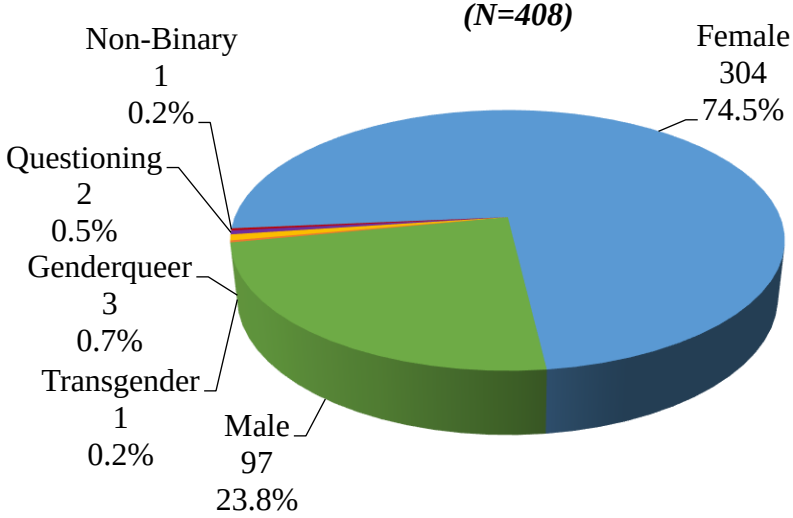
2020 Current Gender Identity
(N=560)



2021 Current Gender Identity
(N=470)



2022 Current Gender Identity
(N=408)

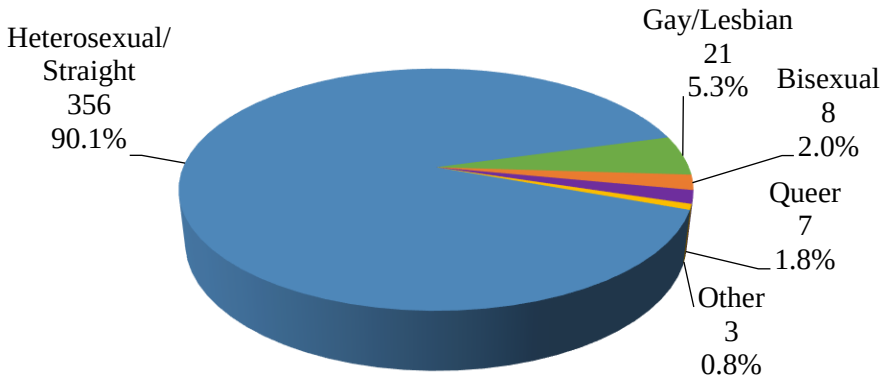


Fresno County Department of Behavioral Health

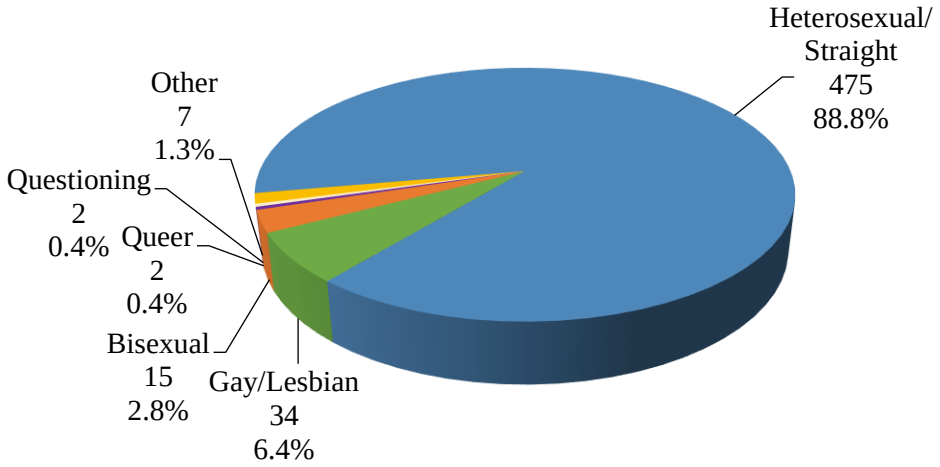
Staff Cultural Humility Survey

Comparison Between 2019, 2020, 2021 and 2022 Survey Results

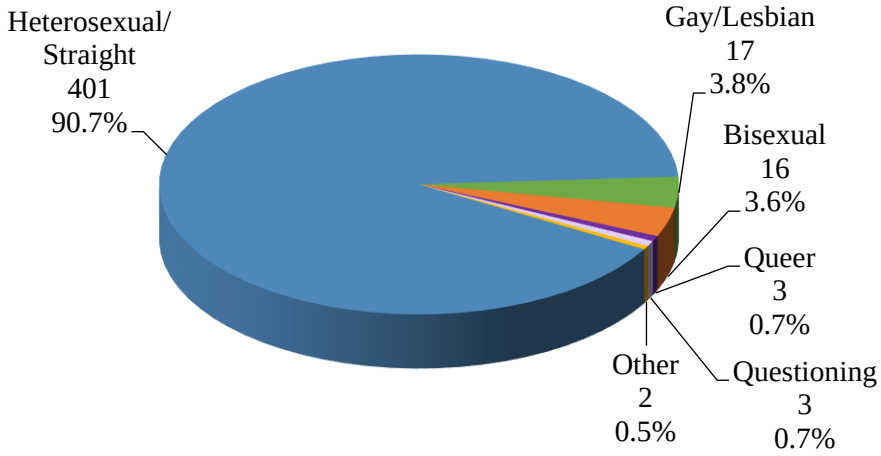
2019 Sexual Orientation (N=395)



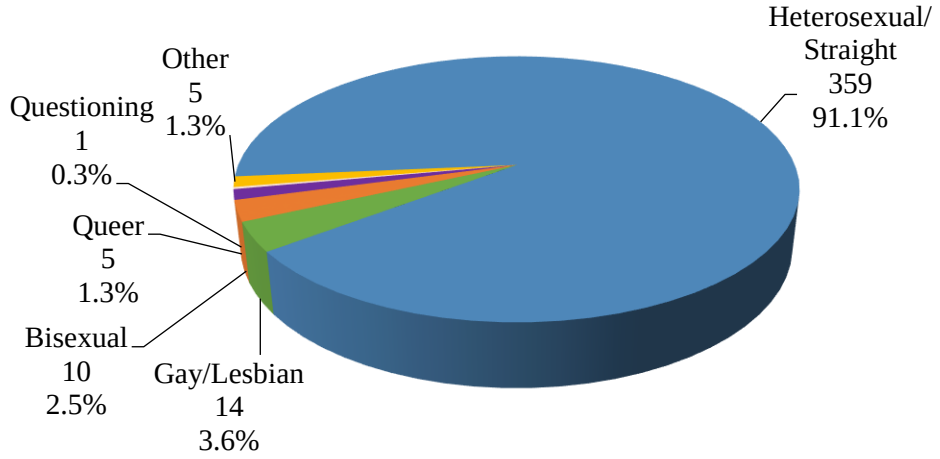
2020 Sexual Orientation (N=535)



2021 Sexual Orientation (N=442)



2022 Sexual Orientation (N=394)

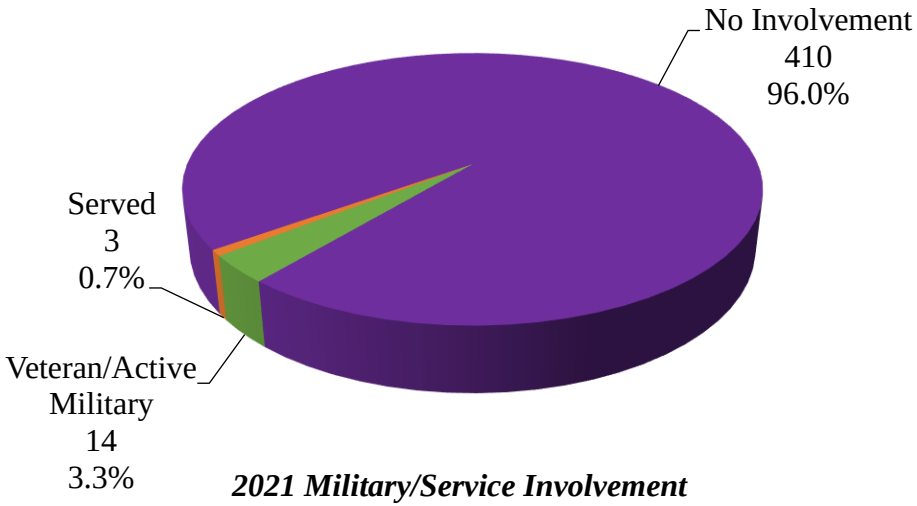


Fresno County Department of Behavioral Health

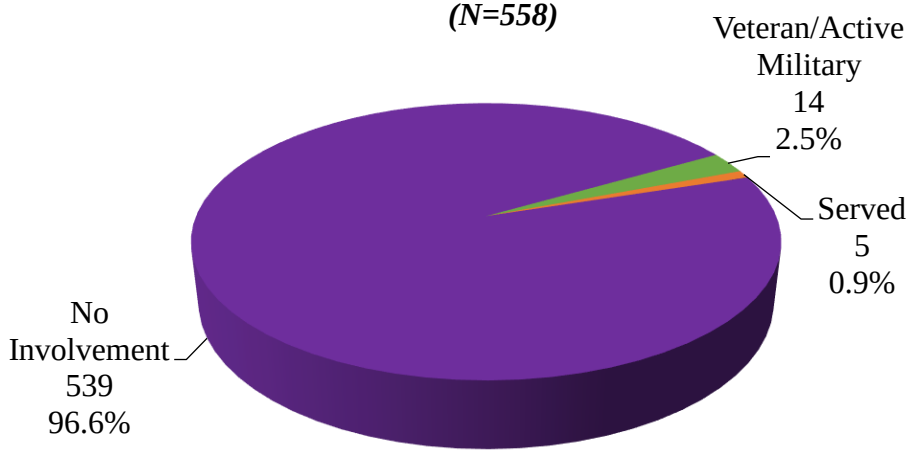
Staff Cultural Humility Survey

Comparison Between 2019, 2020, 2021 and 2022 Survey Results

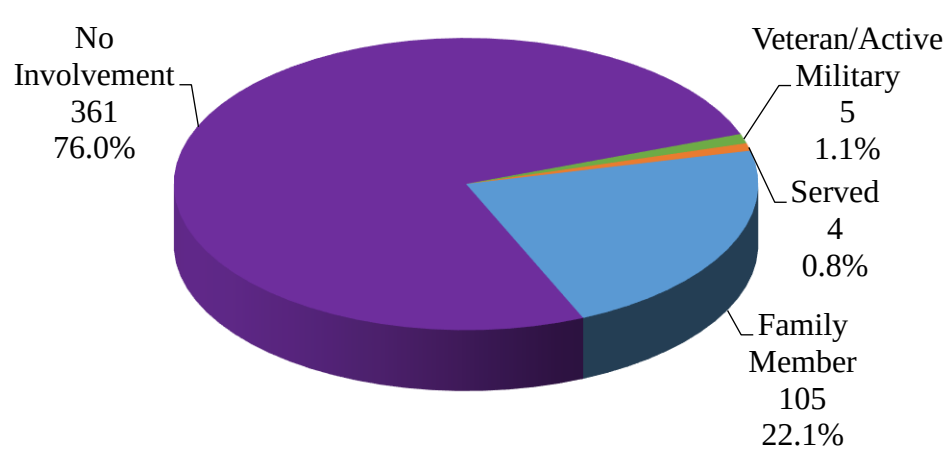
2019 Military/Service Involvement
(N=427)



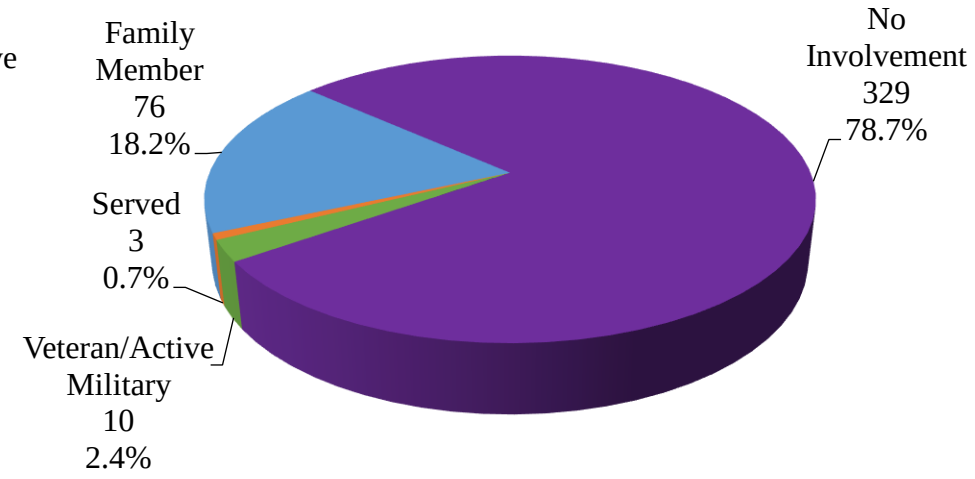
2020 Military/Service Involvement
(N=558)



2021 Military/Service Involvement
(N=475)



2022 Military/Service Involvement
(N=418)

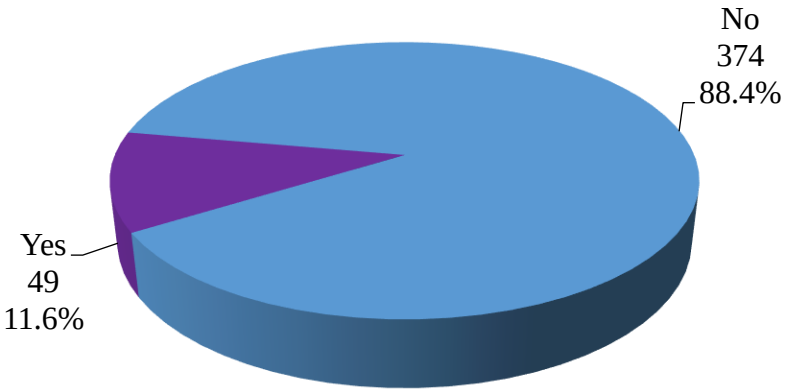


Fresno County Department of Behavioral Health

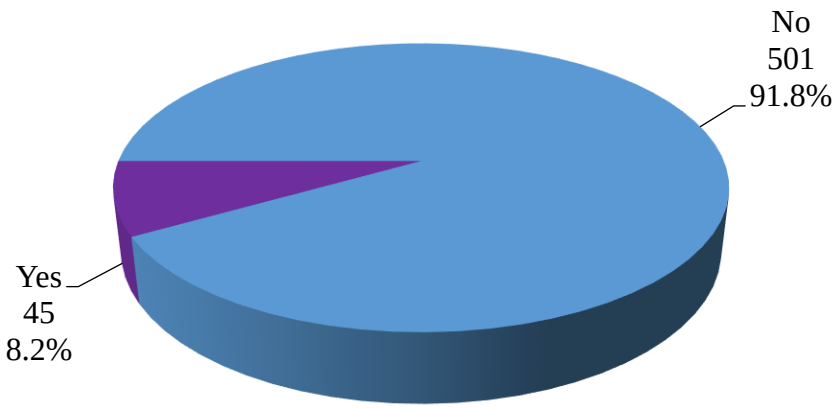
Staff Cultural Humility Survey

Comparison Between 2019, 2020, 2021 and 2022 Survey Results

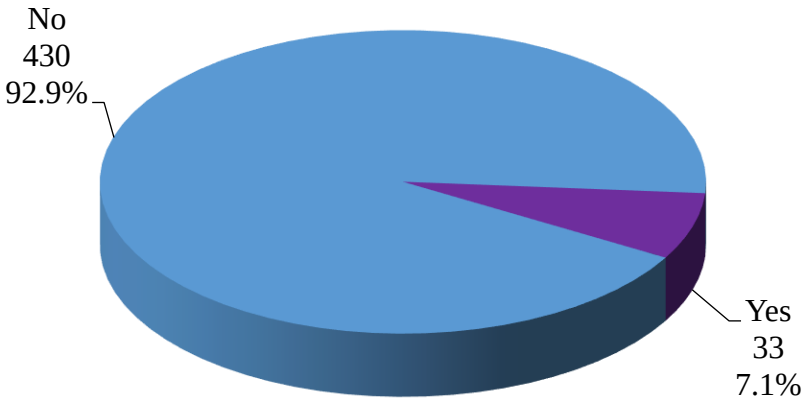
2019 Do you have a disability? (N=423)



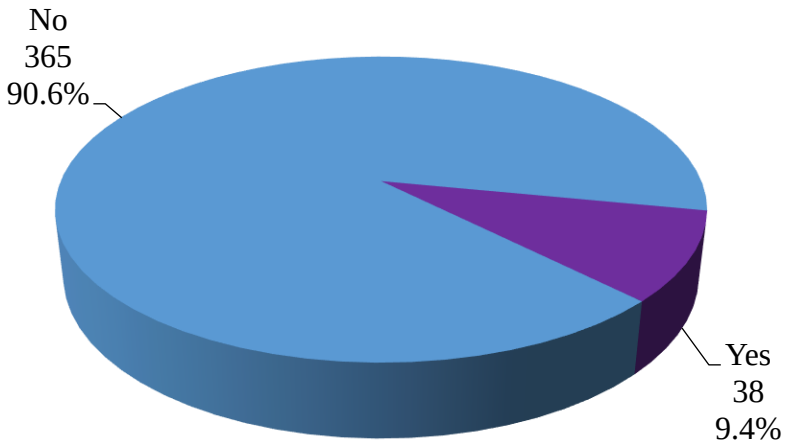
2020 Do you have a disability? (N=546)



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



2022 Do you have a disability? (N=403)

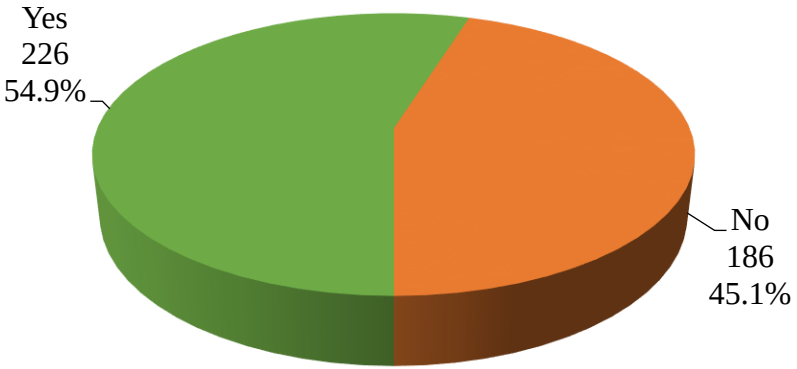


Fresno County Department of Behavioral Health

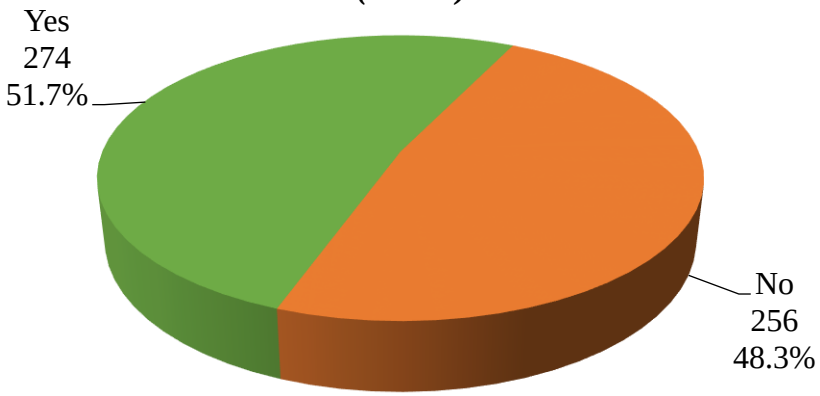
Staff Cultural Humility Survey

Comparison Between 2019, 2020, 2021 and 2022 Survey Results

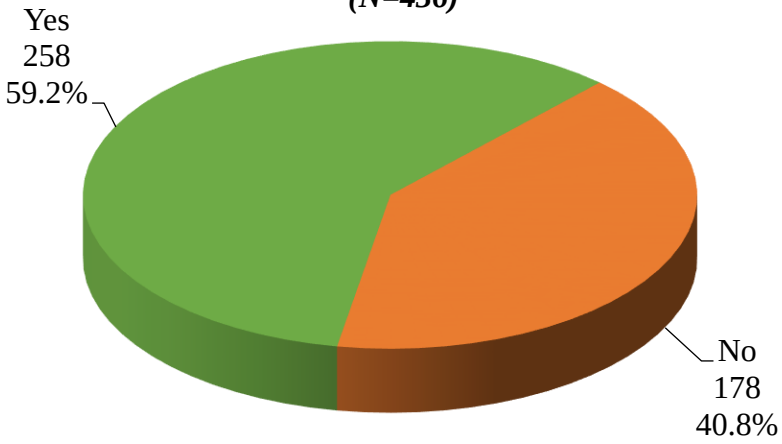
2019 Do you consider yourself to be a person with lived Mental Health experience? (N=412)



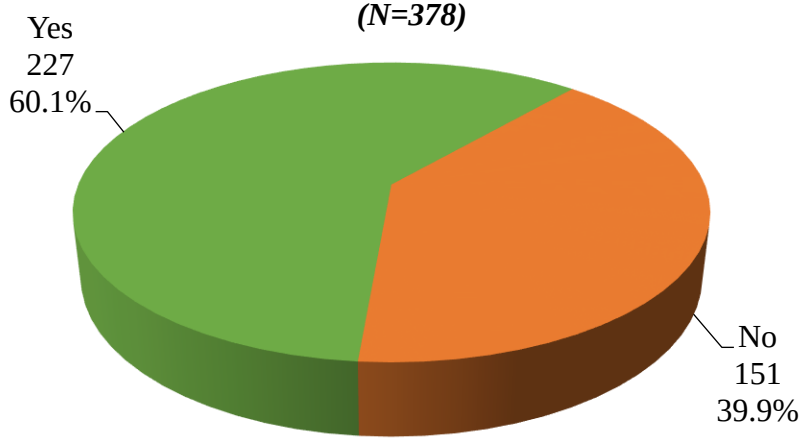
2020 Do you consider yourself to be a person with lived Mental Health experience? (N=530)



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



2022 Do you consider yourself to be a person with lived Mental Health experience? (N=378)

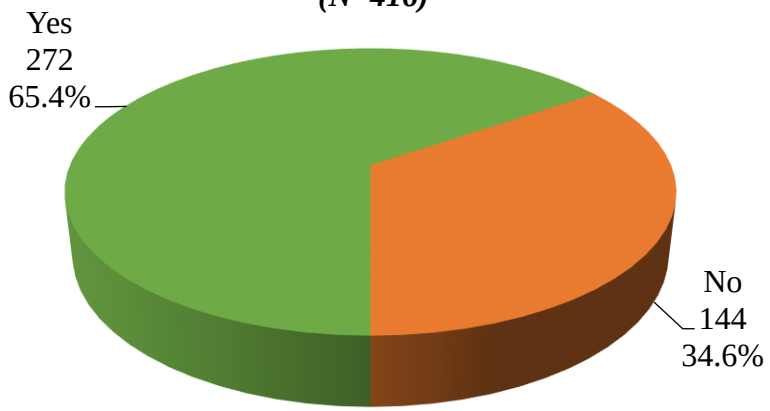


Fresno County Department of Behavioral Health

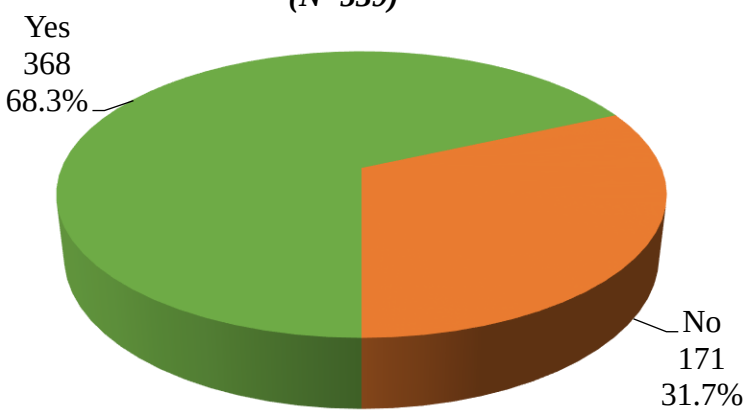
Staff Cultural Humility Survey

Comparison Between 2019, 2020, 2021 and 2022 Survey Results

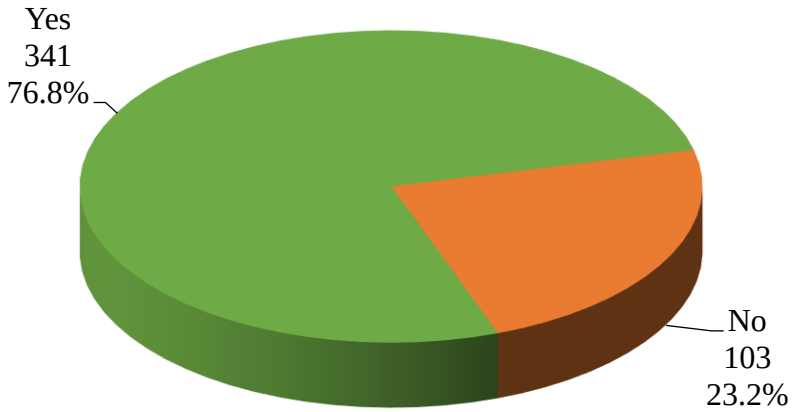
2019 Are you a family member of a person with lived Mental Health experience? (N=416)



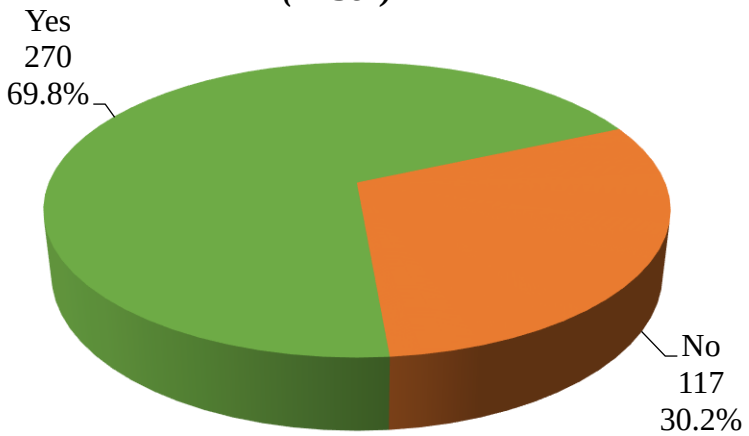
2020 Are you a family member of a person with lived Mental Health experience? (N=539)



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



2022 Are you a family member of a person with lived Mental Health experience? (N=387)

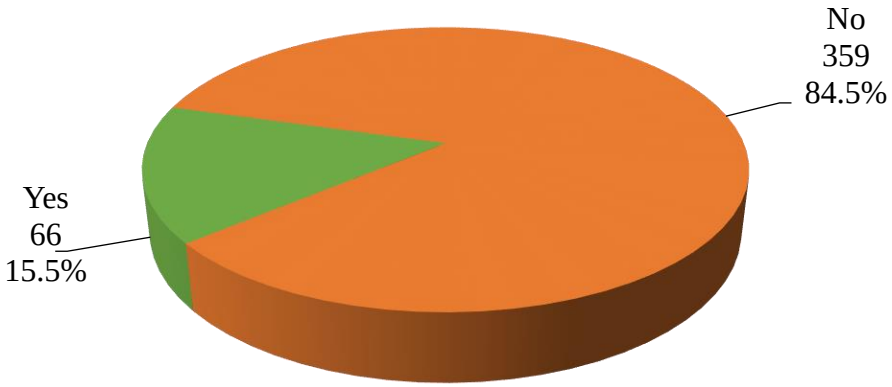


Fresno County Department of Behavioral Health

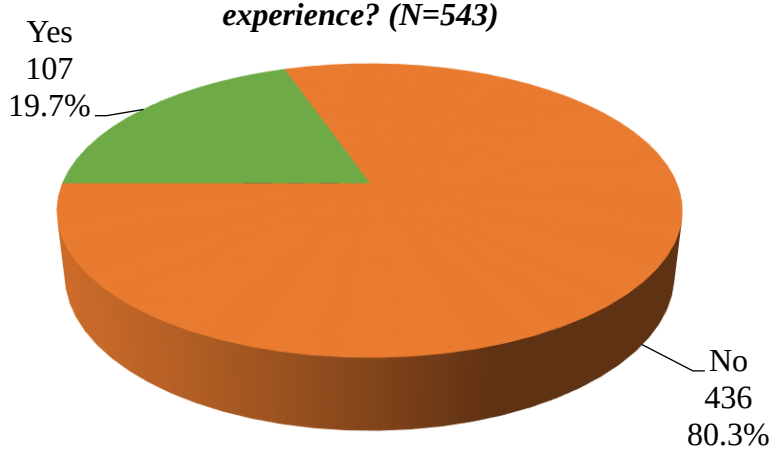
Staff Cultural Humility Survey

Comparison Between 2019, 2020, 2021 and 2022 Survey Results

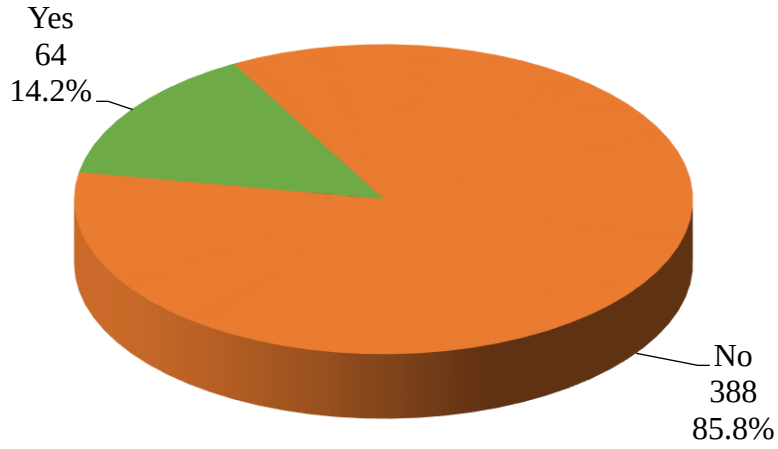
2019 Do you consider yourself to be a person with lived Substance Use Disorder experience? (N=425)



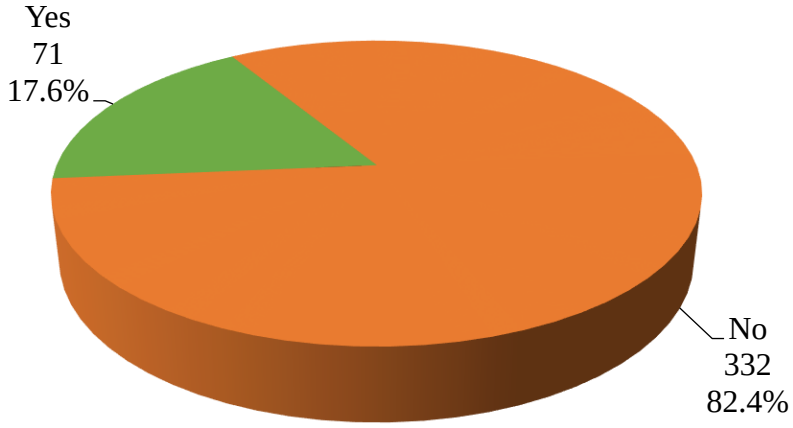
2020 Do you consider yourself to be a person with lived Substance Use Disorder experience? (N=543)



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



2022 Do you consider yourself to be a person with lived Substance Use Disorder experience? (N=403)

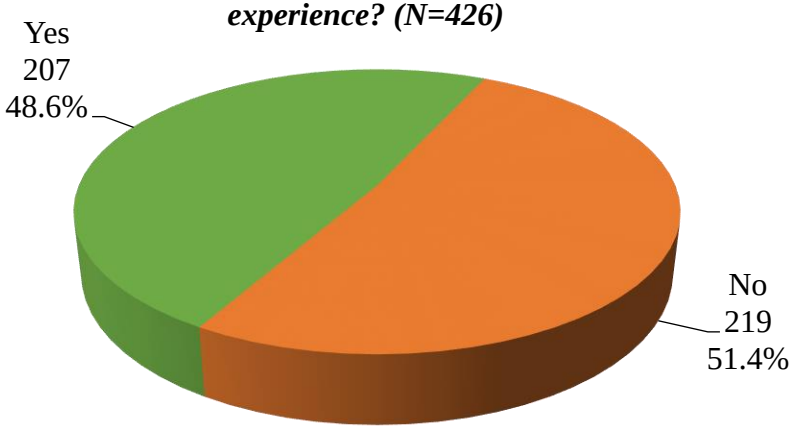


Fresno County Department of Behavioral Health

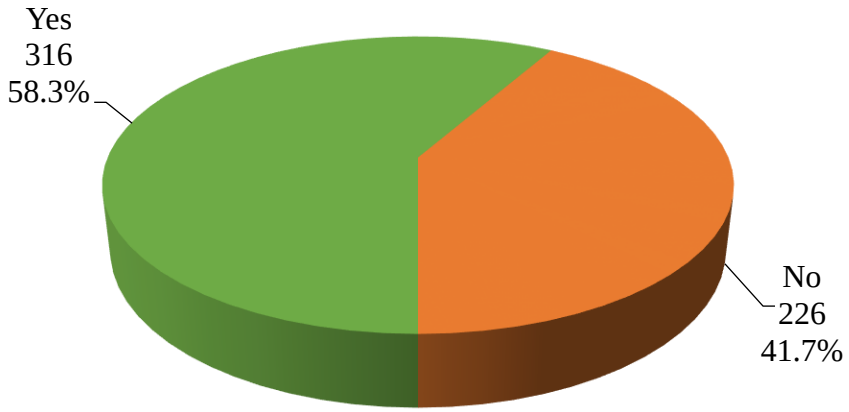
Staff Cultural Humility Survey

Comparison Between 2019, 2020, 2021 and 2022 Survey Results

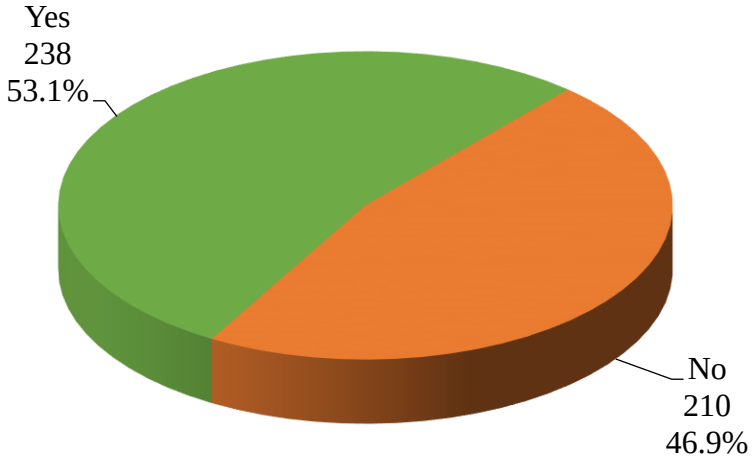
2019 Are you a family member of a person with lived Substance Use Disorder experience? (N=426)



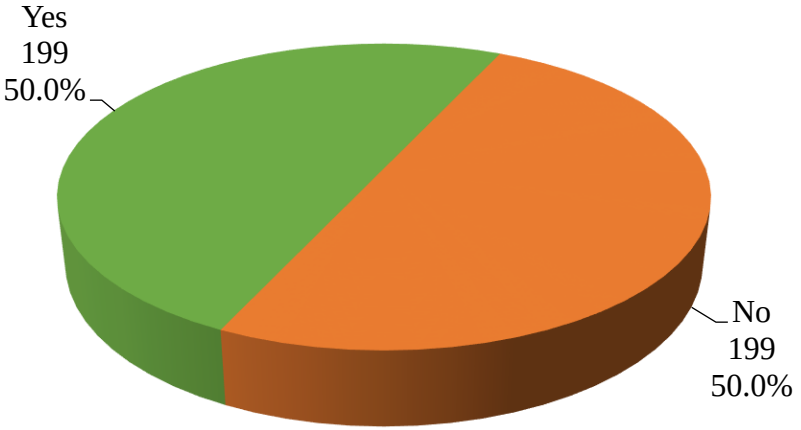
2020 Are you a family member of a person with lived Substance Use Disorder experience? (N=542)



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



2022 Are you a family member of a person with lived Substance Use Disorder experience? (N=398)

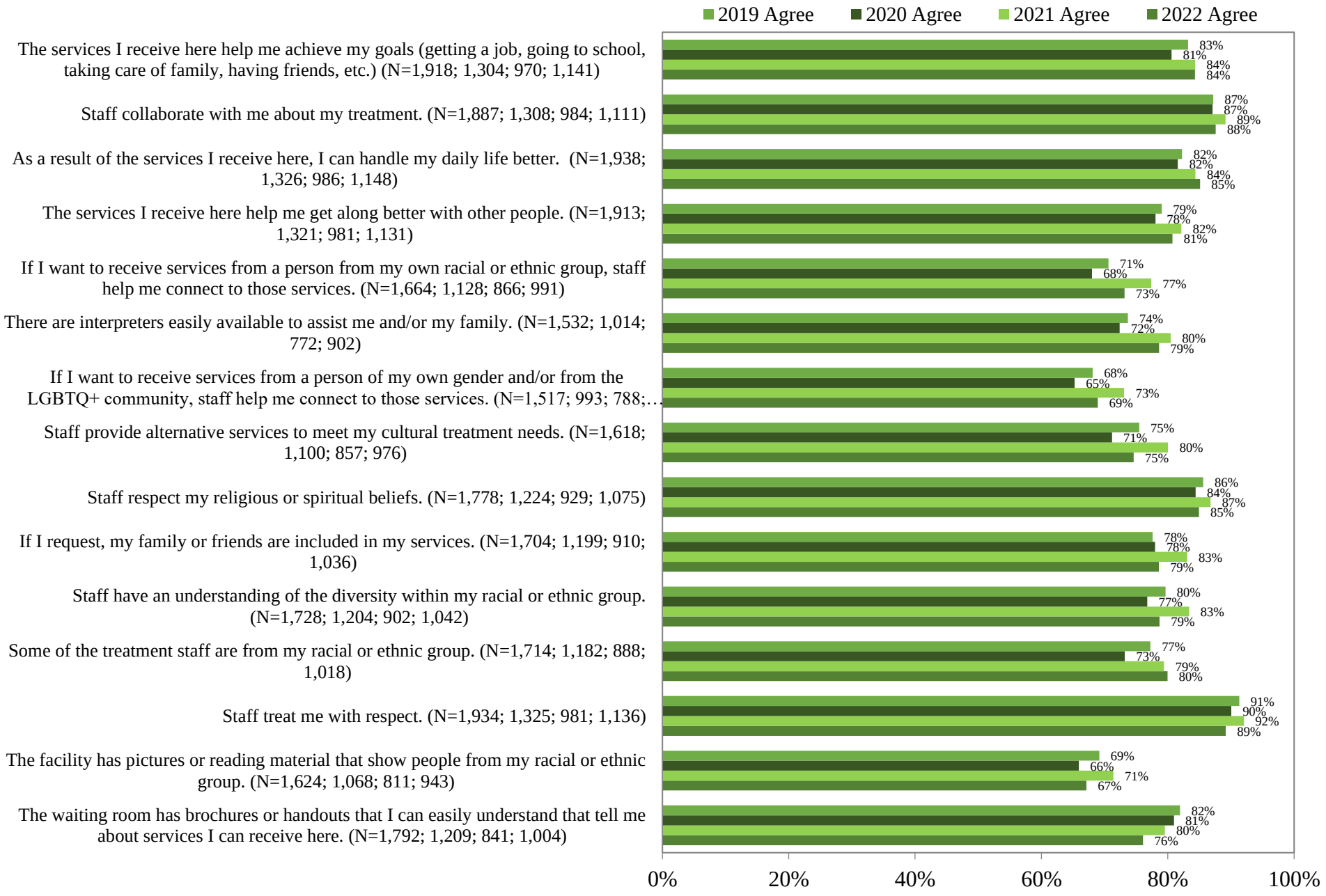


Attachment F: Client/Person Served Cultural Humility Survey Results

Fresno County Department of Behavioral Health

Client Cultural Humility Survey

Comparison Between 2019, 2020, 2021 and 2022 Survey Results

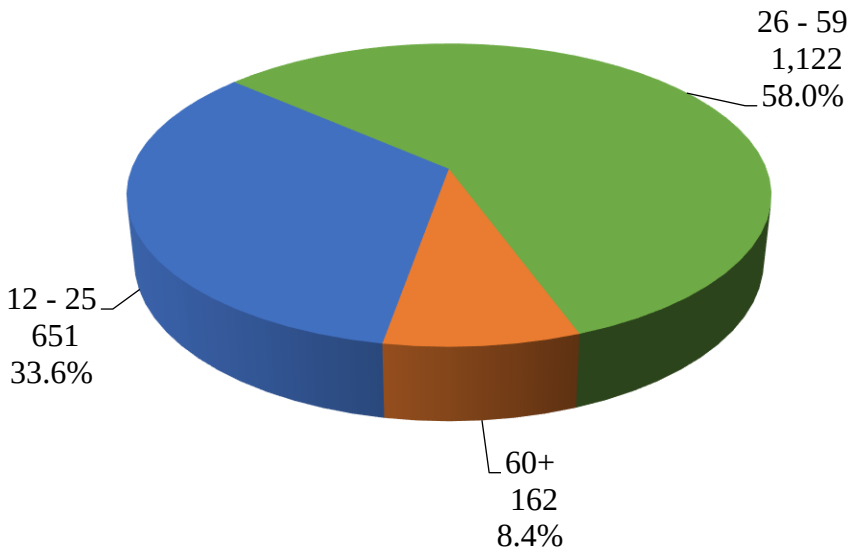


Fresno County Department of Behavioral Health

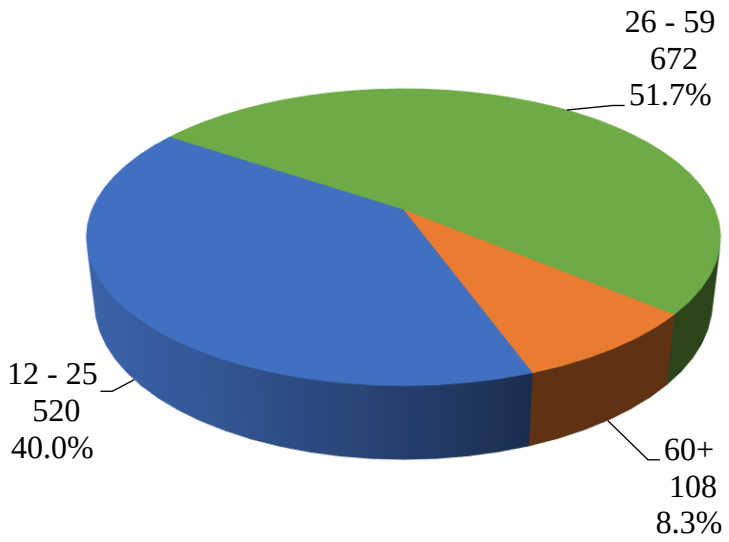
Client Cultural Humility Survey

Comparison Between 2019, 2020, 2021 and 2022 Survey Results

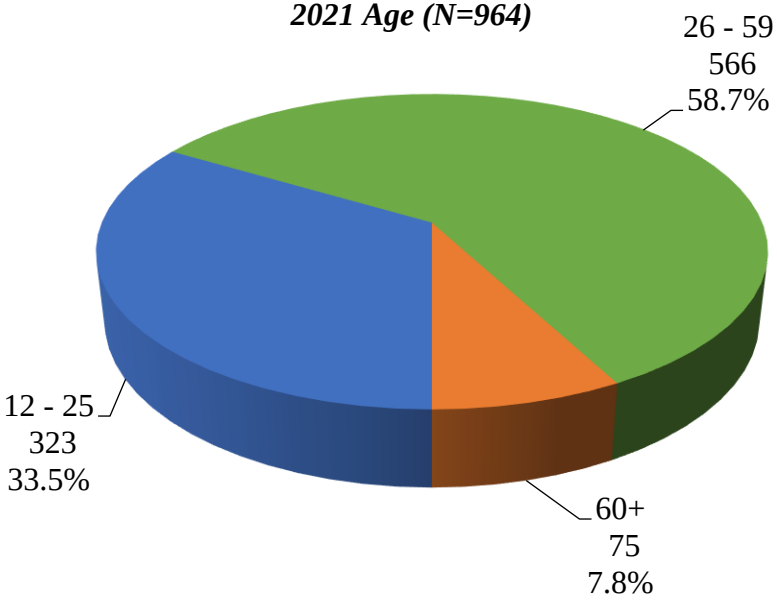
2019 Age (N=1,935)



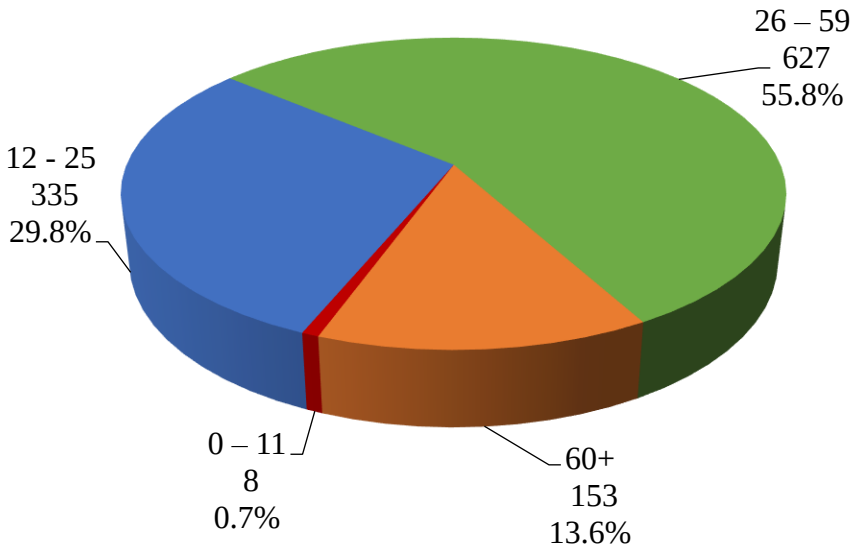
2020 Age (N=1,300)



2021 Age (N=964)



2022 Age (N=1,123)

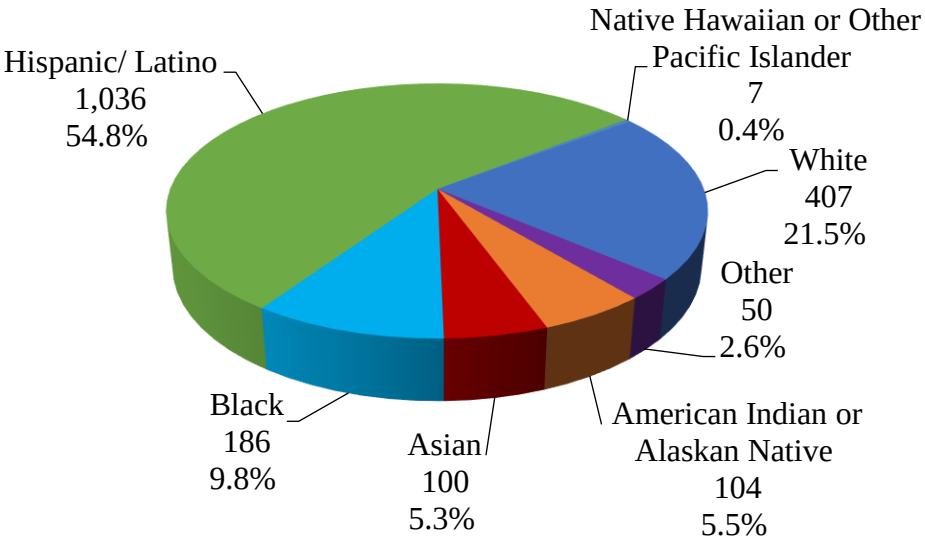


Fresno County Department of Behavioral Health

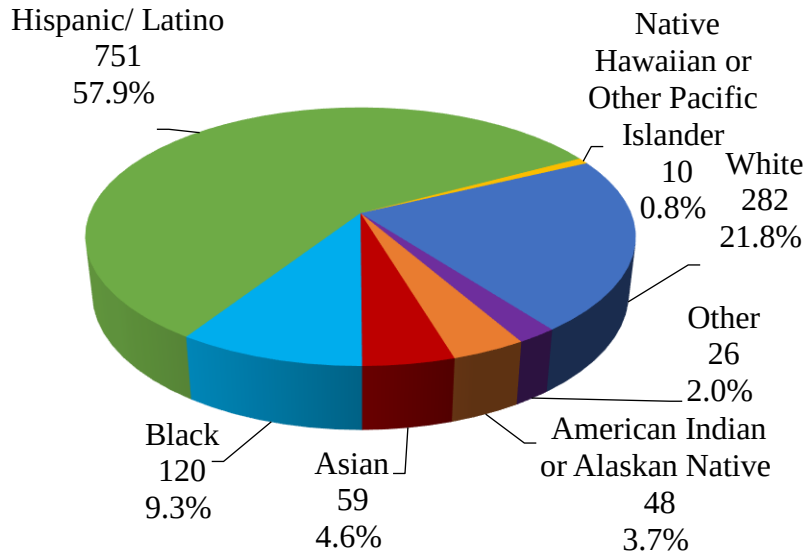
Client Cultural Humility Survey

Comparison Between 2019, 2020, 2021 and 2022 Survey Results

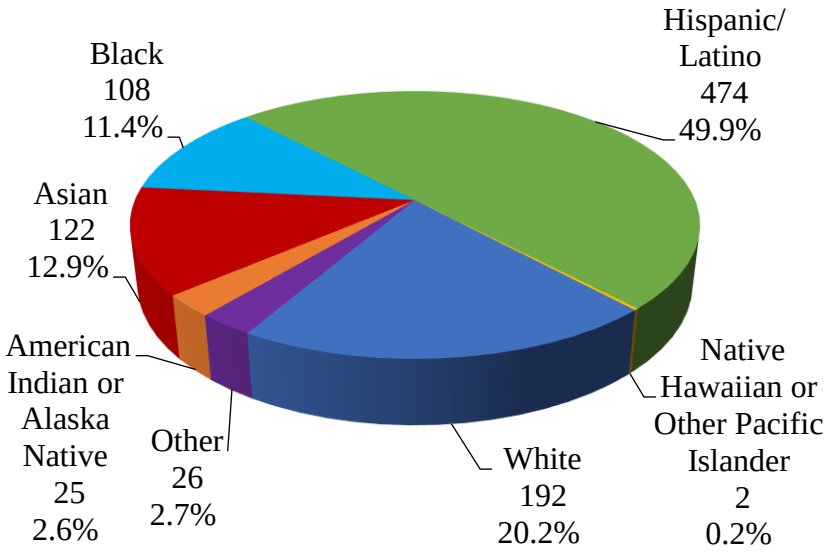
2019 Race/Ethnicity (N=1,890)



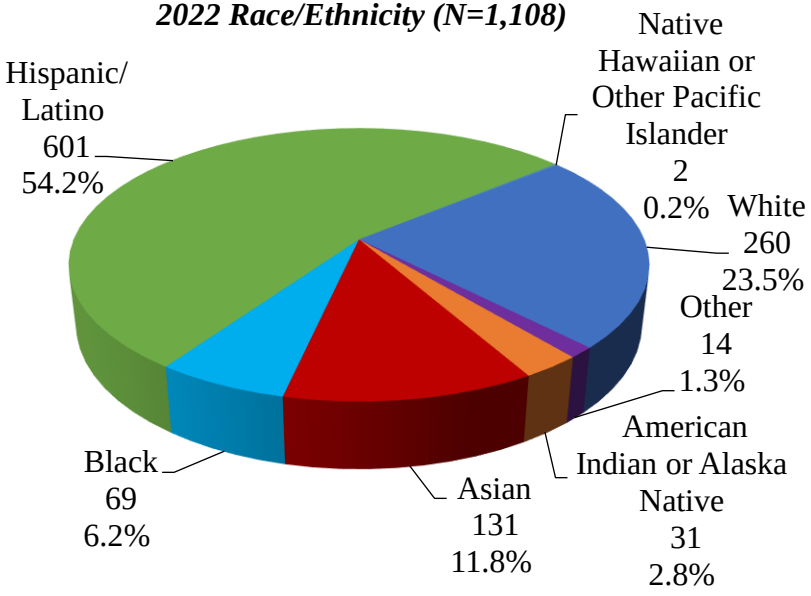
2020 Race/Ethnicity (N=1,296)



2021 Race/Ethnicity (N=949)



2022 Race/Ethnicity (N=1,108)

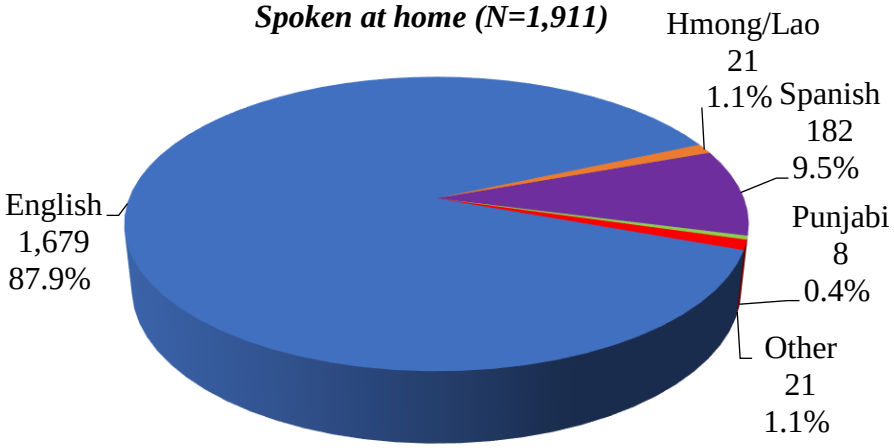


Fresno County Department of Behavioral Health

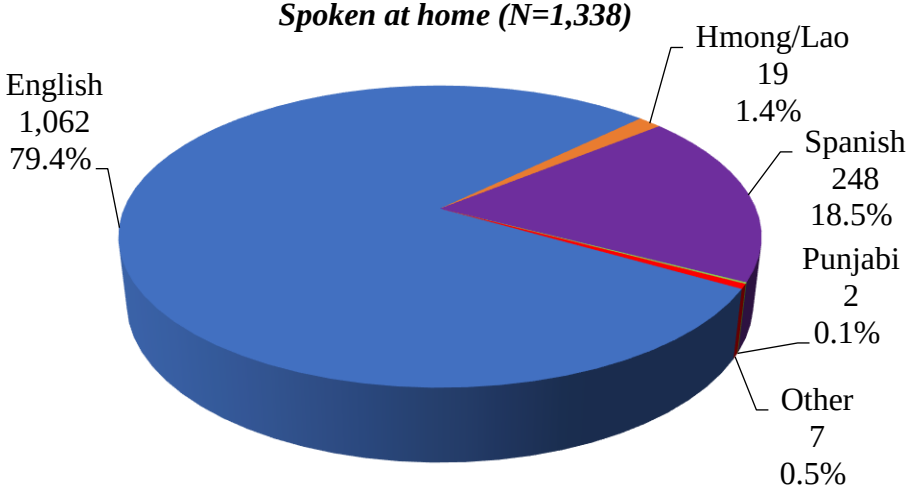
Client Cultural Humility Survey

Comparison Between 2019, 2020, 2021 and 2022 Survey Results

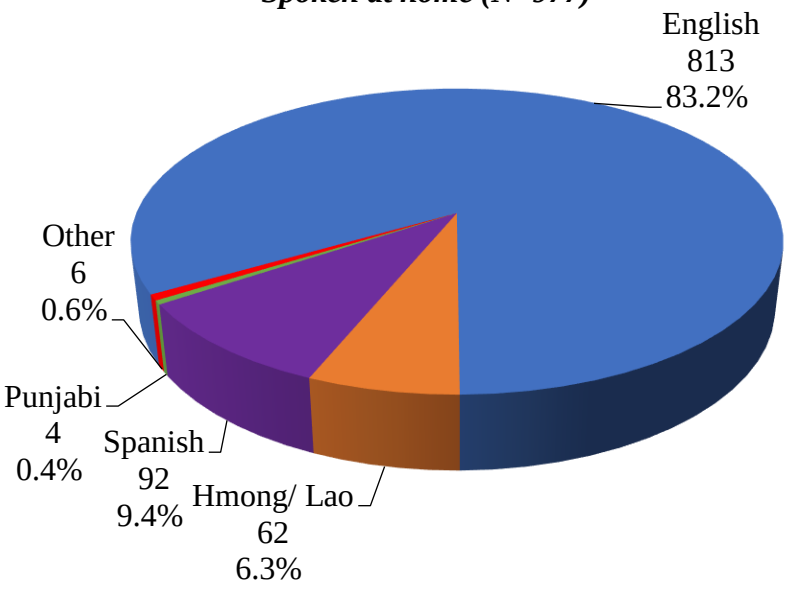
2019 Primary Language Spoken at home (N=1,911)



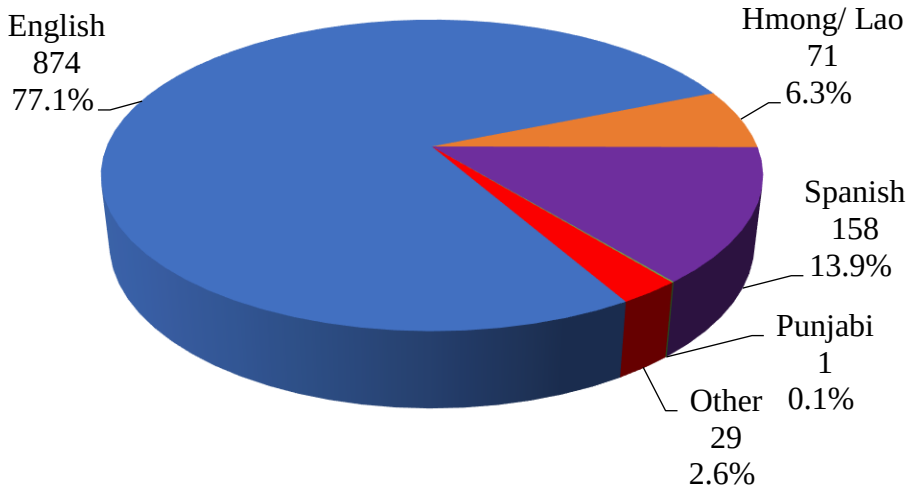
2020 Primary Language Spoken at home (N=1,338)



2021 Primary Language Spoken at home (N=977)



2022 Primary Language Spoken at home (N=1,133)

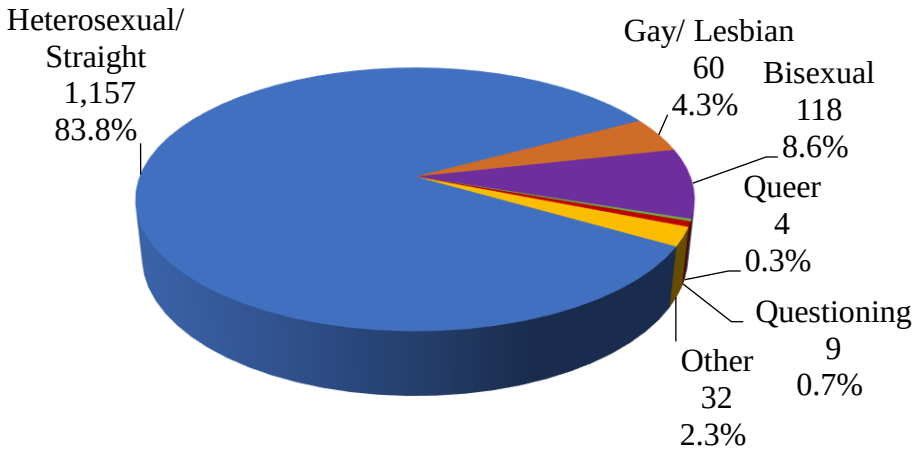


Fresno County Department of Behavioral Health

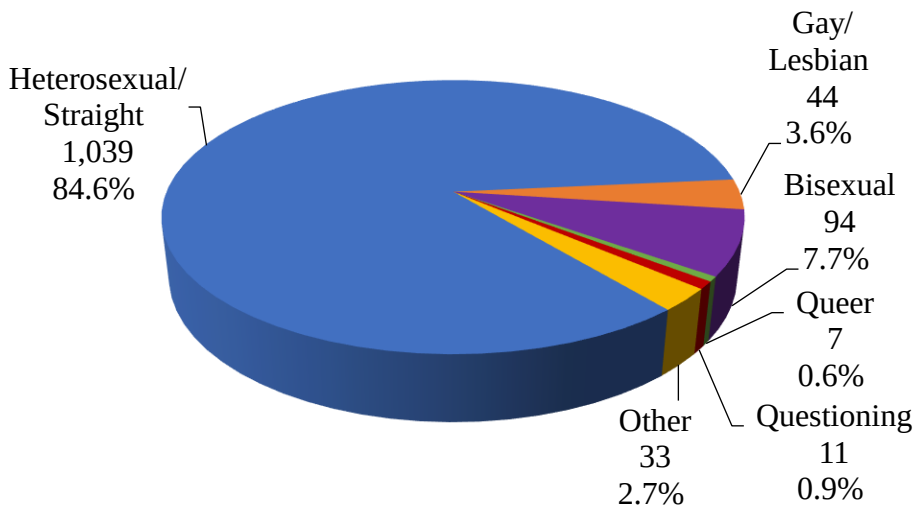
Client Cultural Humility Survey

Comparison Between 2019, 2020, 2021 and 2022 Survey Results

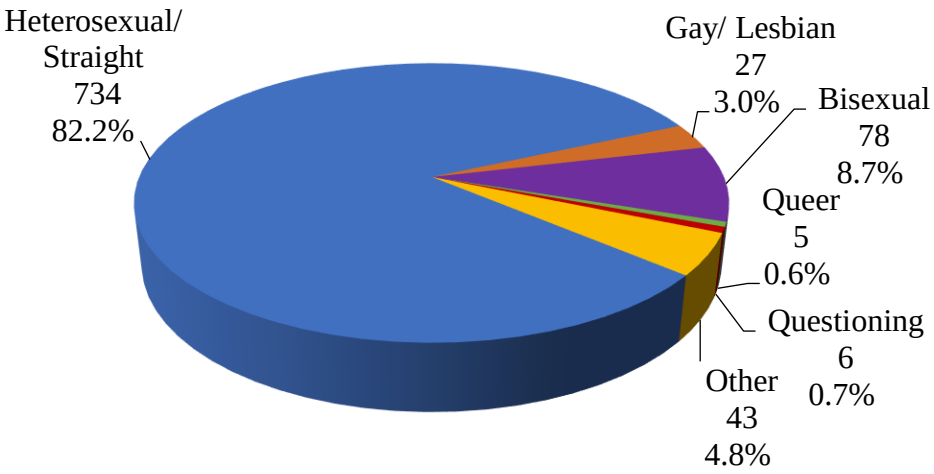
2019 Sexual Orientation (N=1,380)



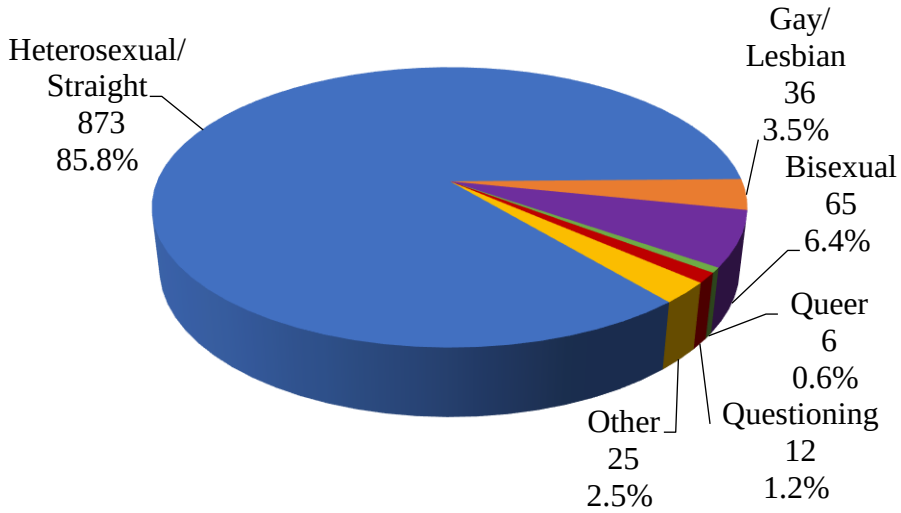
2020 Sexual Orientation (N=1,228)



2021 Sexual Orientation (N=893)



2022 Sexual Orientation (N=1,017)

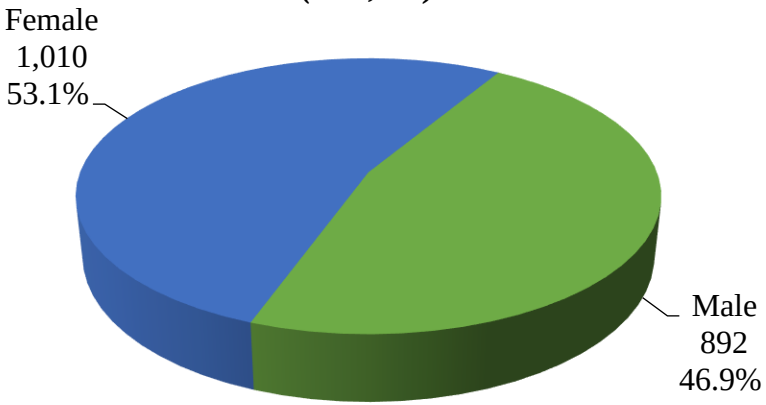


Fresno County Department of Behavioral Health

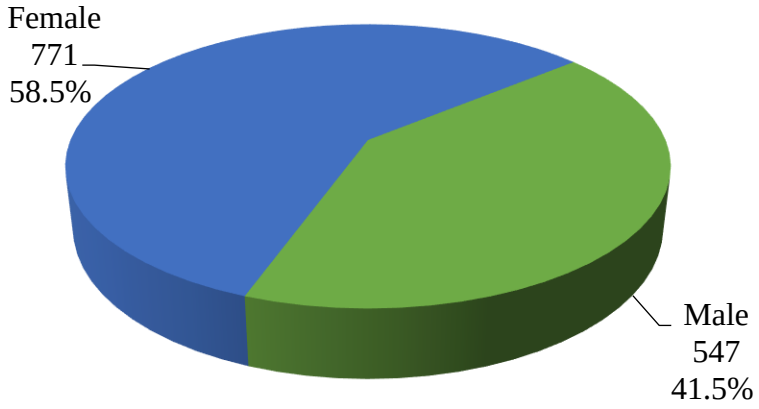
Client Cultural Humility Survey

Comparison Between 2019, 2020, 2021 and 2022 Survey Results

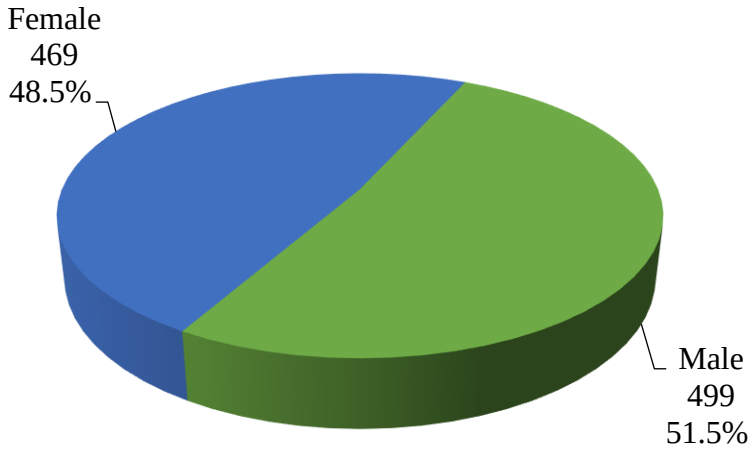
2019 Gender Assigned at Birth
(N=1,902)



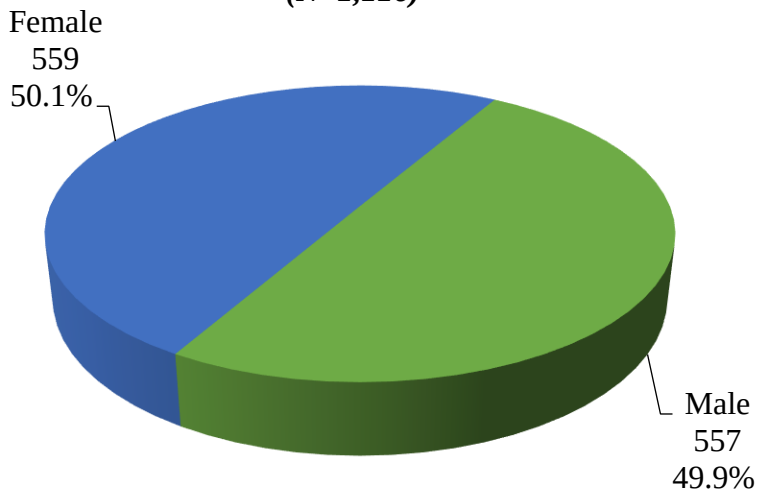
2020 Gender Assigned at Birth
(N=1,318)



2021 Gender Assigned at Birth
(N=968)



2022 Gender Assigned at Birth
(N=1,116)

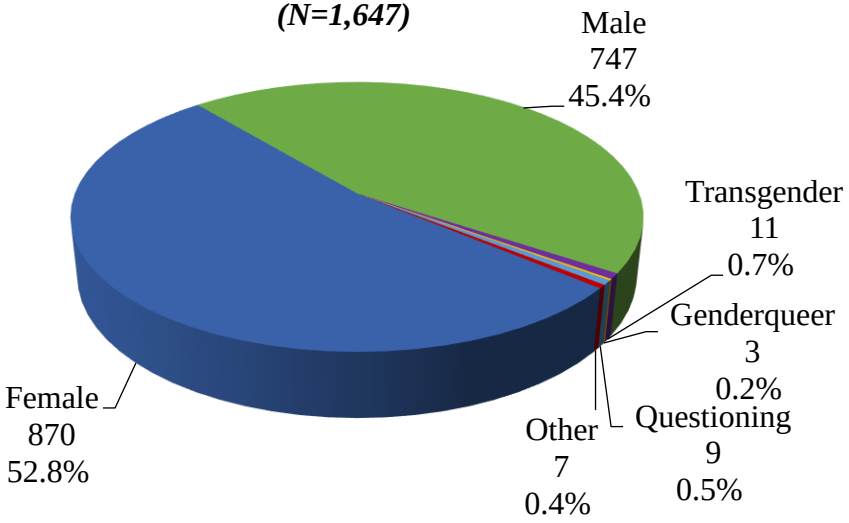


Fresno County Department of Behavioral Health

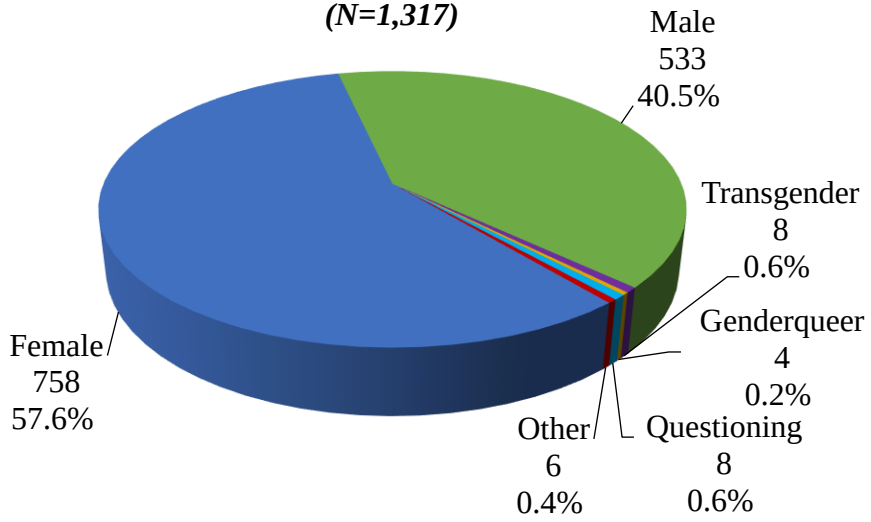
Client Cultural Humility Survey

Comparison Between 2019, 2020, 2021 and 2022 Survey Results

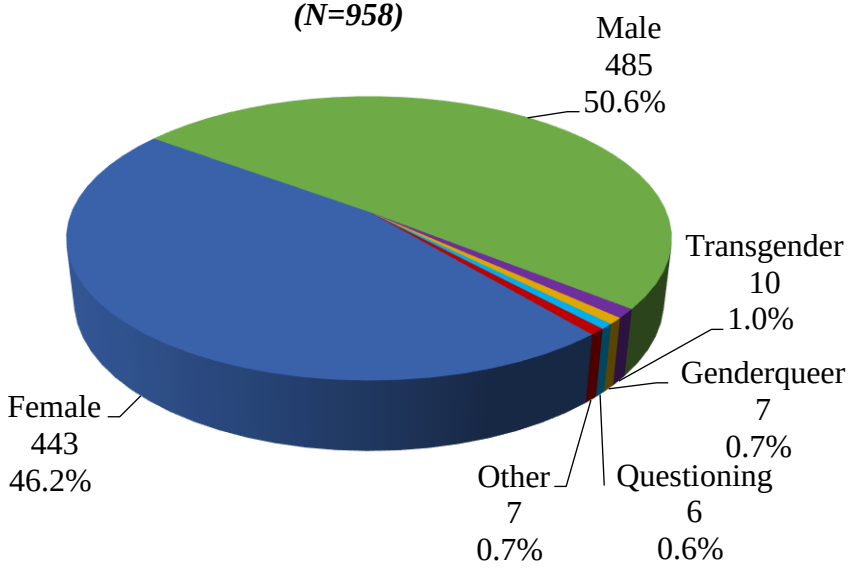
2019 Current Gender Identity
(N=1,647)



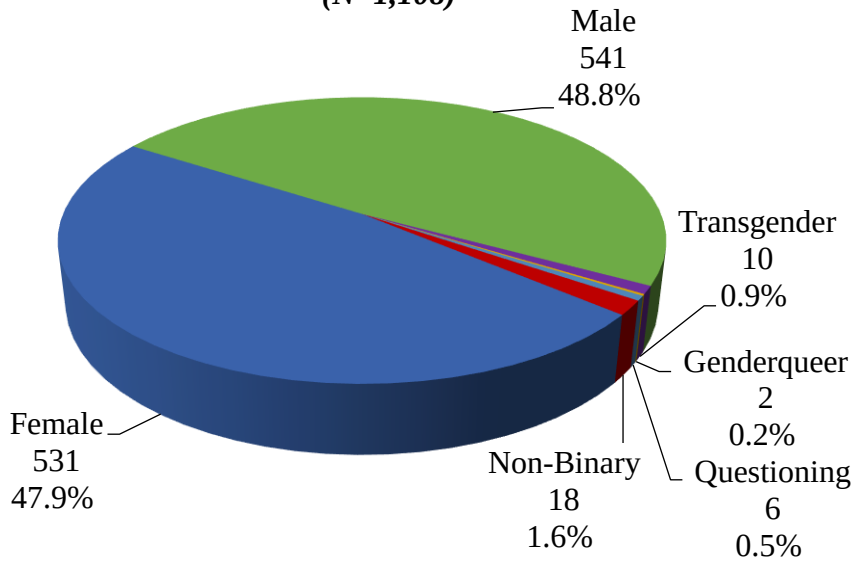
2020 Current Gender Identity
(N=1,317)



2021 Current Gender Identity
(N=958)



2022 Current Gender Identity
(N=1,108)

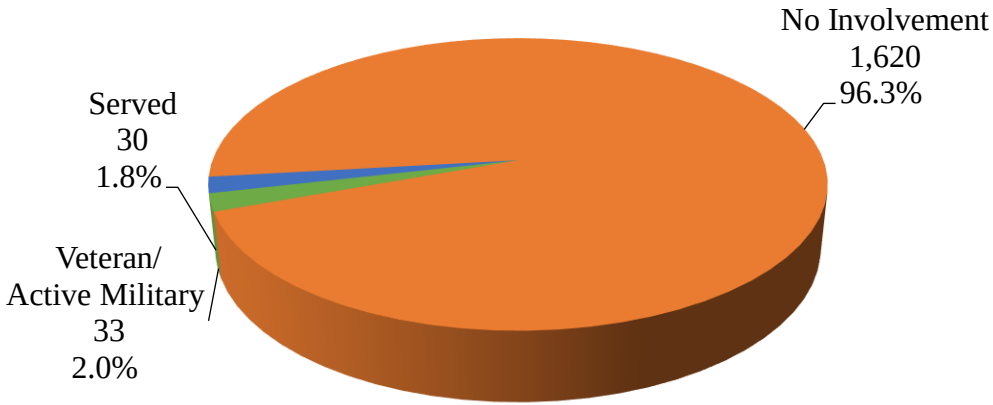


Fresno County Department of Behavioral Health

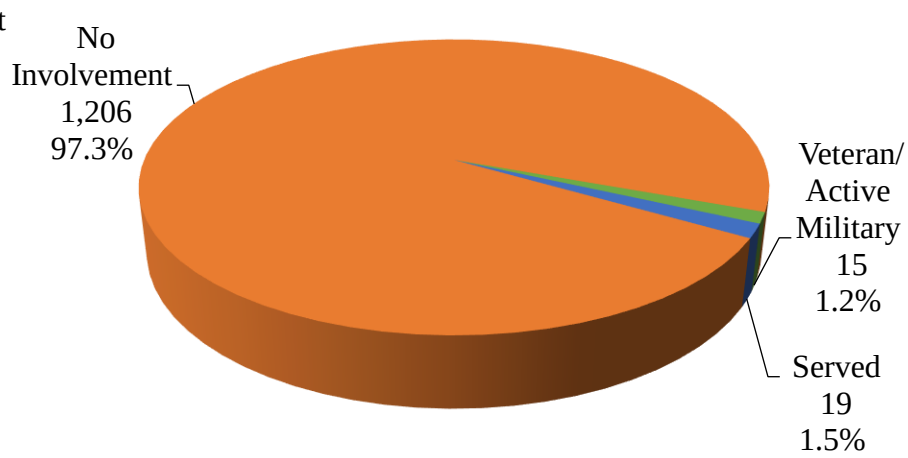
Client Cultural Humility Survey

Comparison Between 2019, 2020, 2021 and 2022 Survey Results

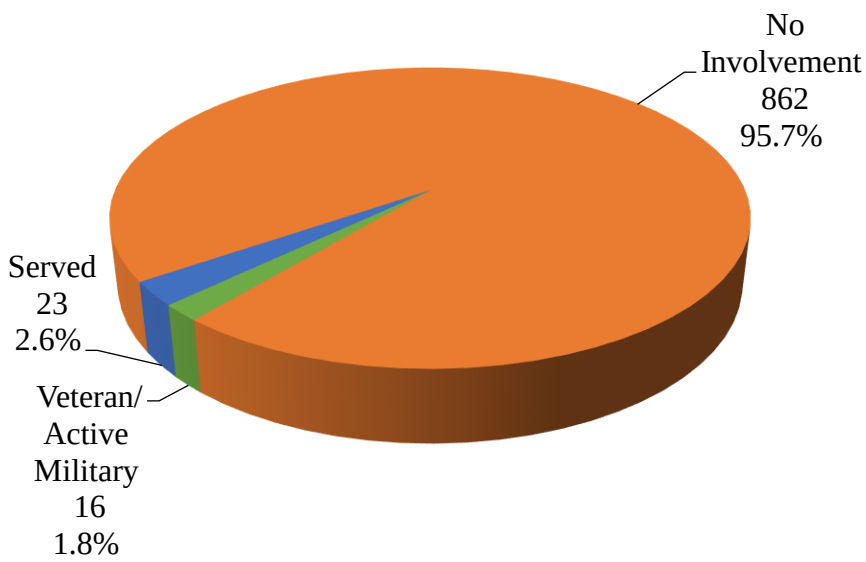
2019 Military/Service Involvement (N=1,683)



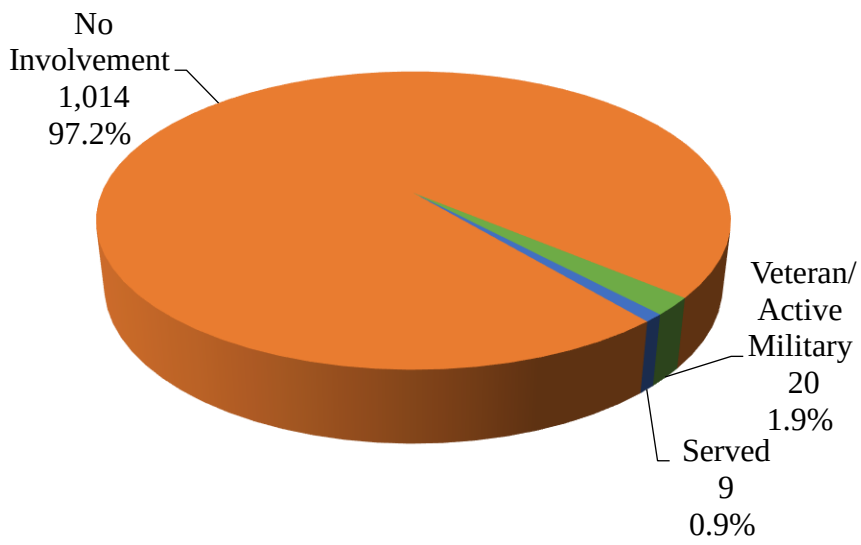
2020 Military/Service Involvement (N=1,240)



2021 Military/Service Involvement (N=901)



2022 Military/Service Involvement (N=1,043)

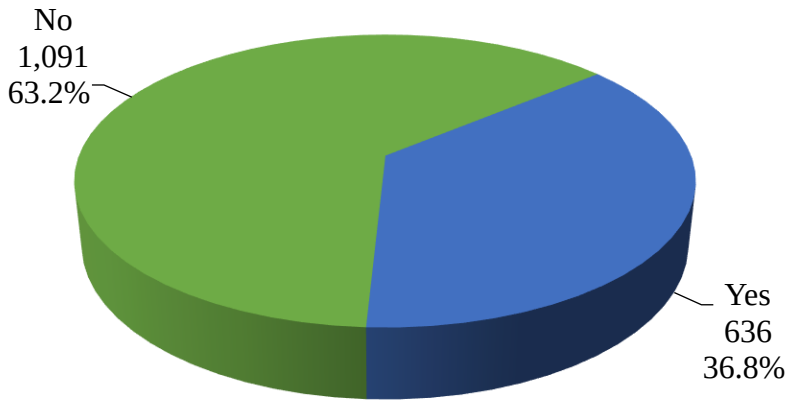


Fresno County Department of Behavioral Health

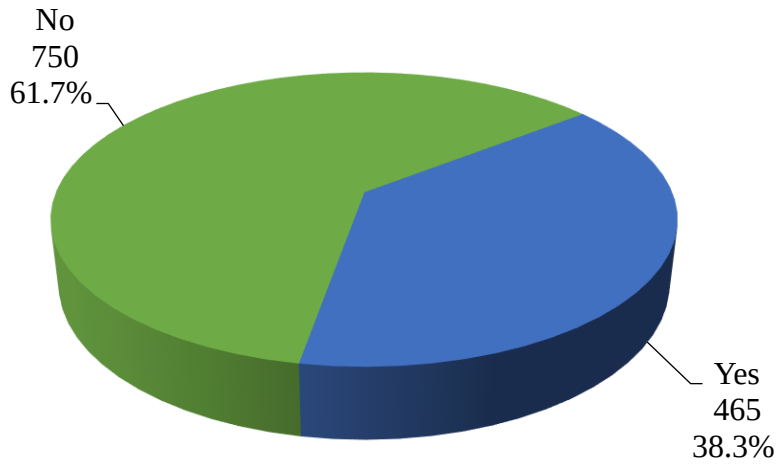
Client Cultural Humility Survey

Comparison Between 2019, 2020, 2021 and 2022 Survey Results

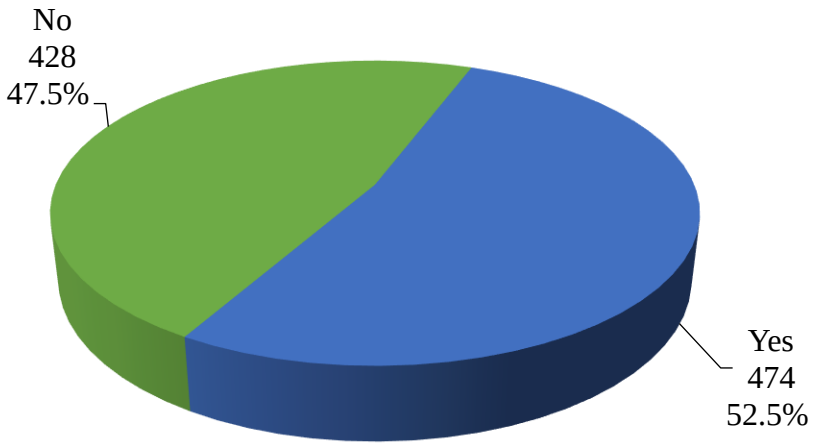
2019 Do you have a disability? (N=1,727)



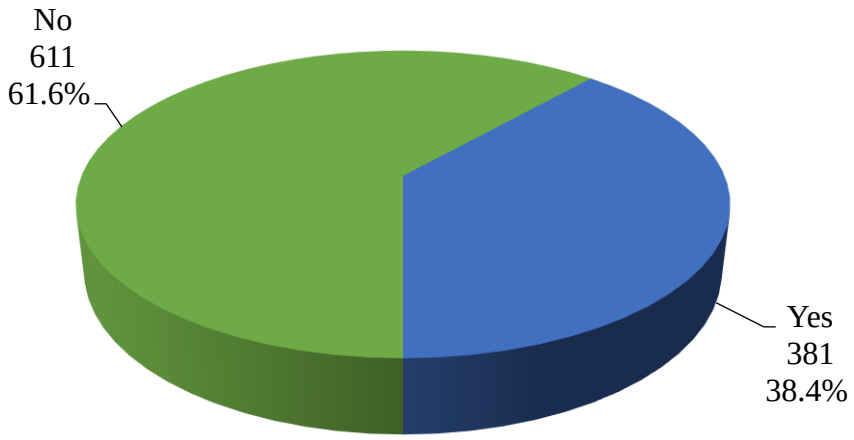
2020 Do you have a disability? (N=1,215)



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



2022 Do you have a disability? (N=992)

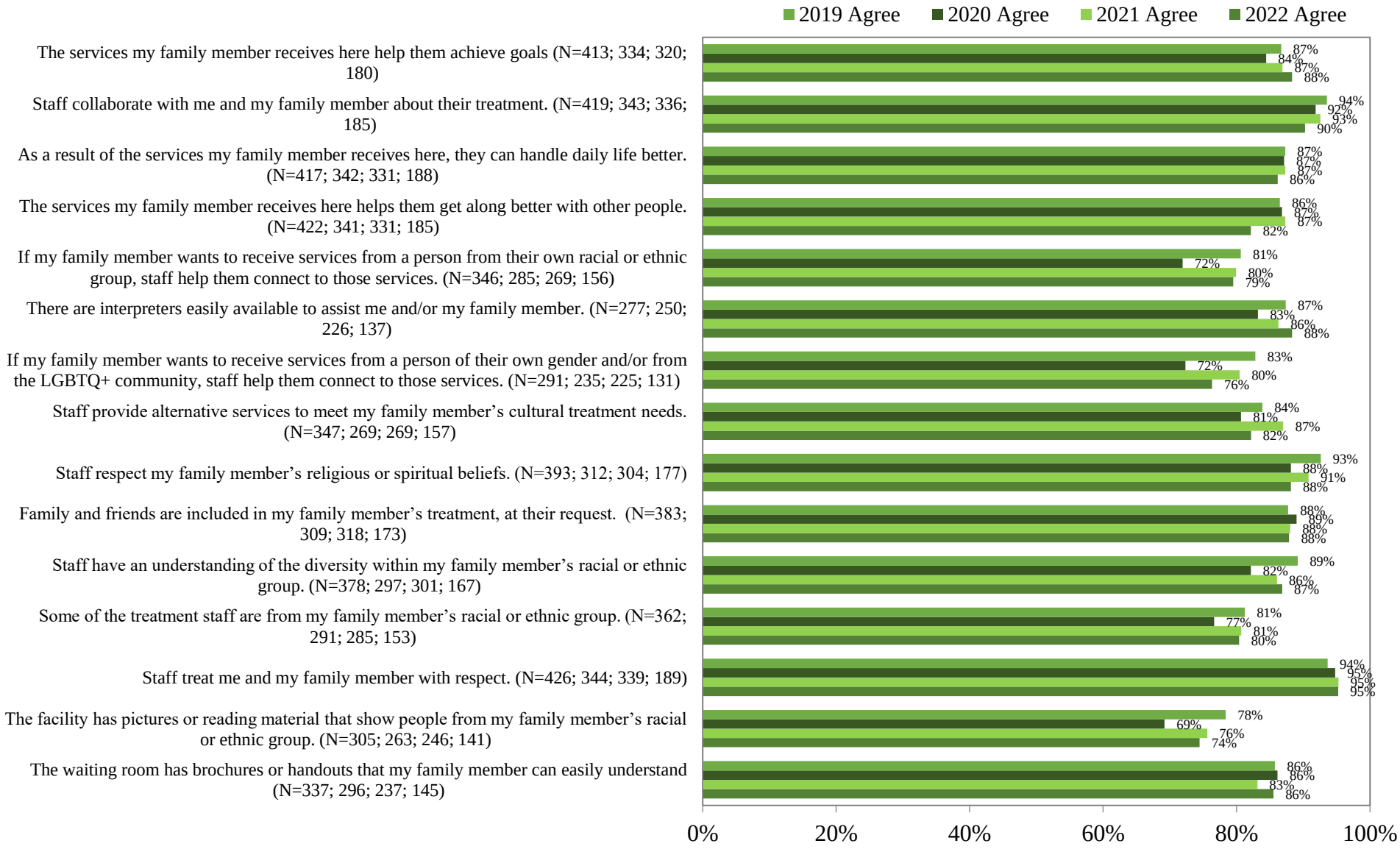


Attachment G: Family/Caregiver Cultural Humility Survey Results

Fresno County Department of Behavioral Health

Family/Caregiver Cultural Humility Survey

Comparison Between 2019, 2020, 2021 and 2022 Survey Results

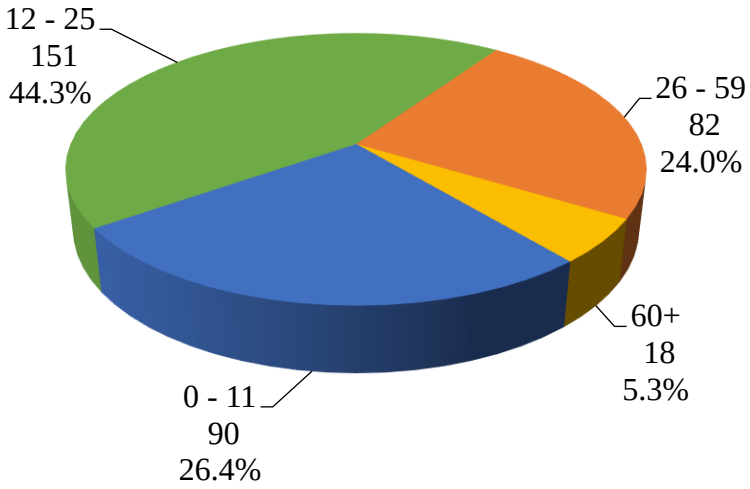


Fresno County Department of Behavioral Health

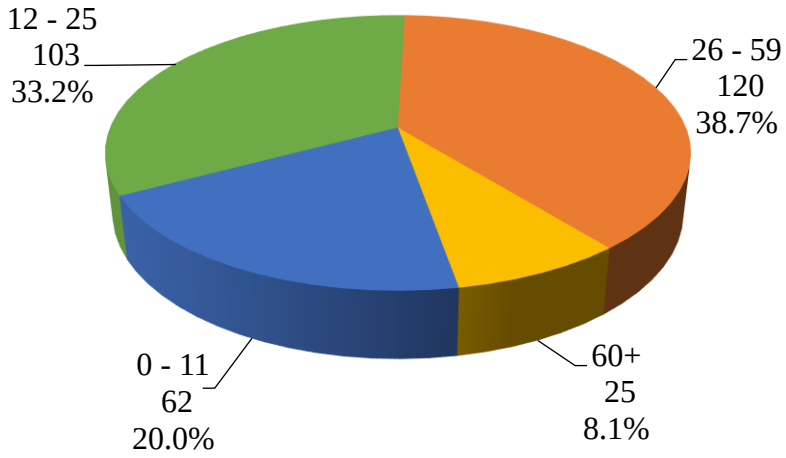
Family/Caregiver Cultural Humility Survey

Comparison Between 2019, 2020, 2021 and 2022 Survey Results

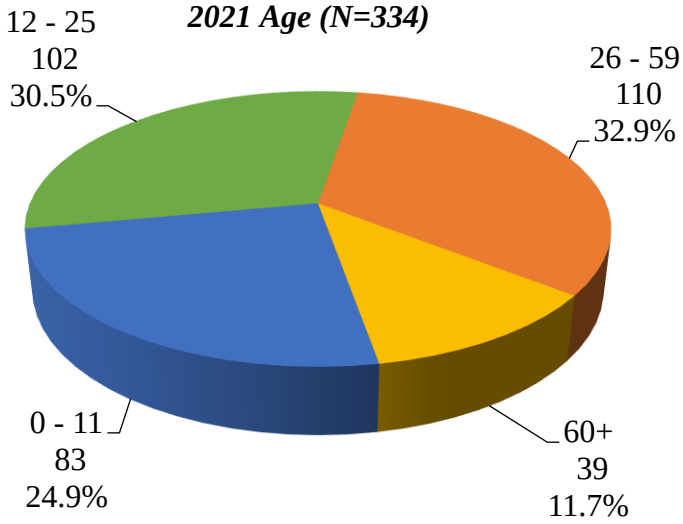
2019 Age (N=341)



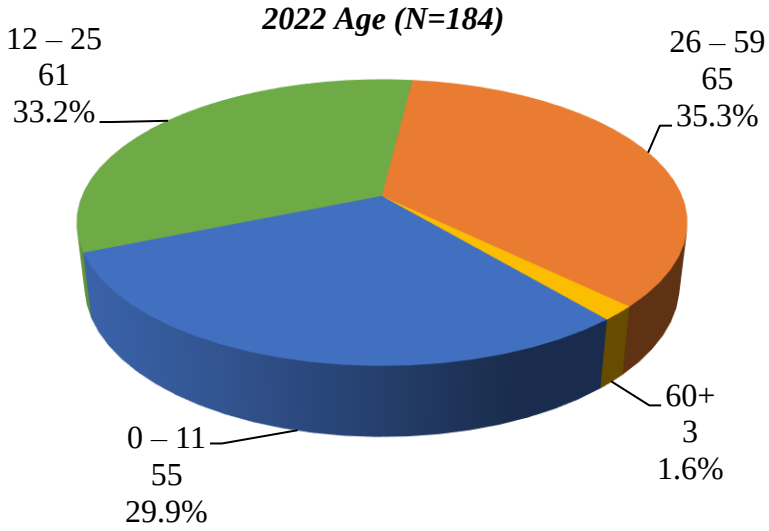
2020 Age (N=310)



2021 Age (N=334)



2022 Age (N=184)

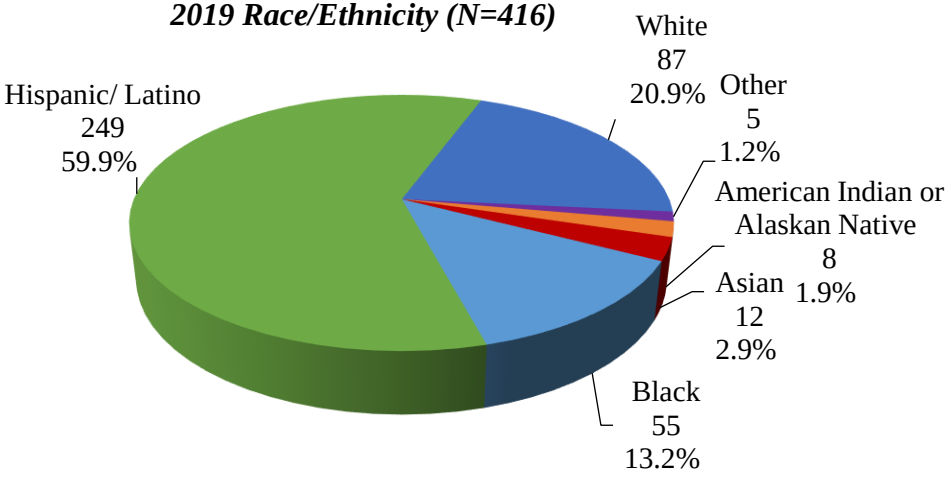


Fresno County Department of Behavioral Health

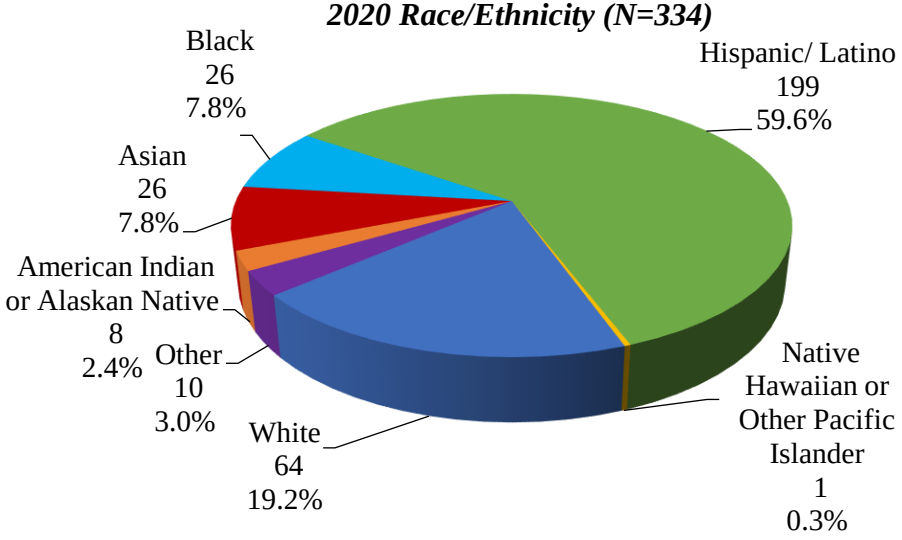
Family/Caregiver Cultural Humility Survey

Comparison Between 2019, 2020, 2021 and 2022 Survey Results

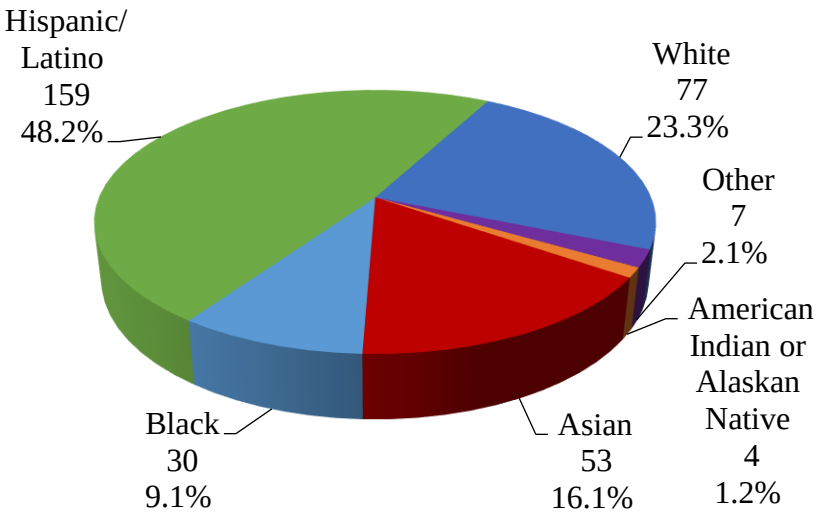
2019 Race/Ethnicity (N=416)



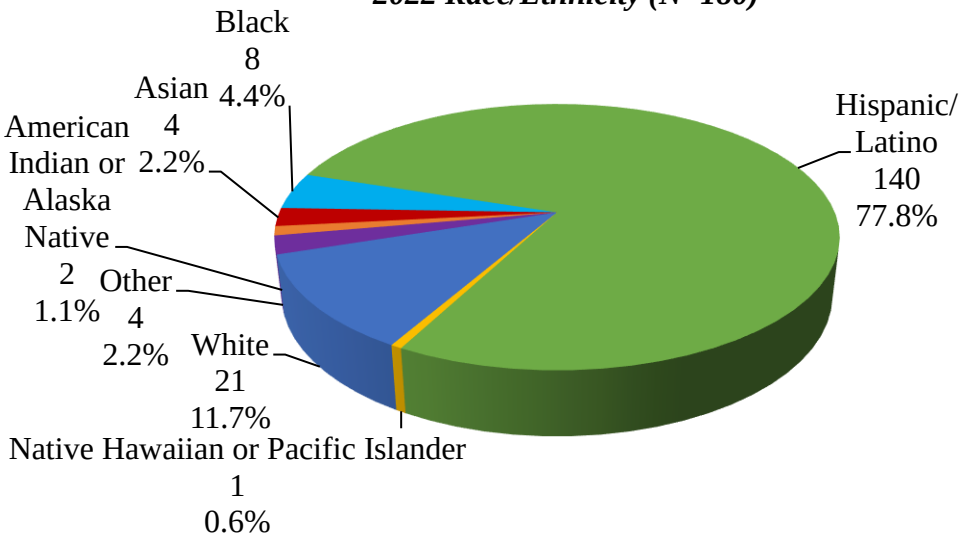
2020 Race/Ethnicity (N=334)



2021 Race/Ethnicity (N=330)



2022 Race/Ethnicity (N=180)

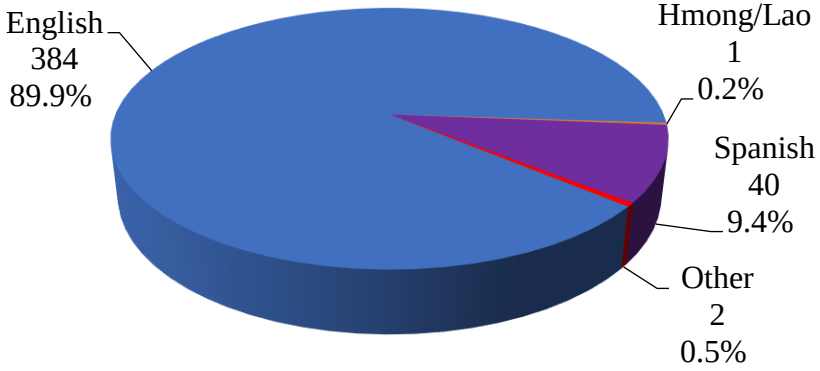


Fresno County Department of Behavioral Health

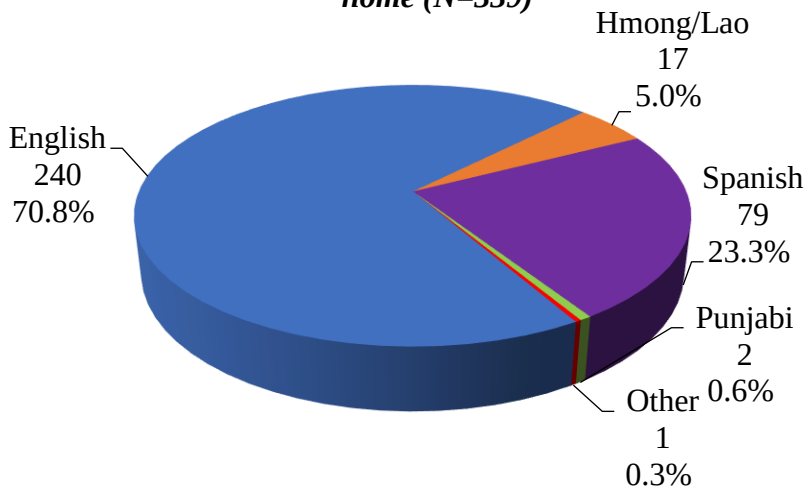
Family/Caregiver Cultural Humility Survey

Comparison Between 2019, 2020, 2021 and 2022 Survey Results

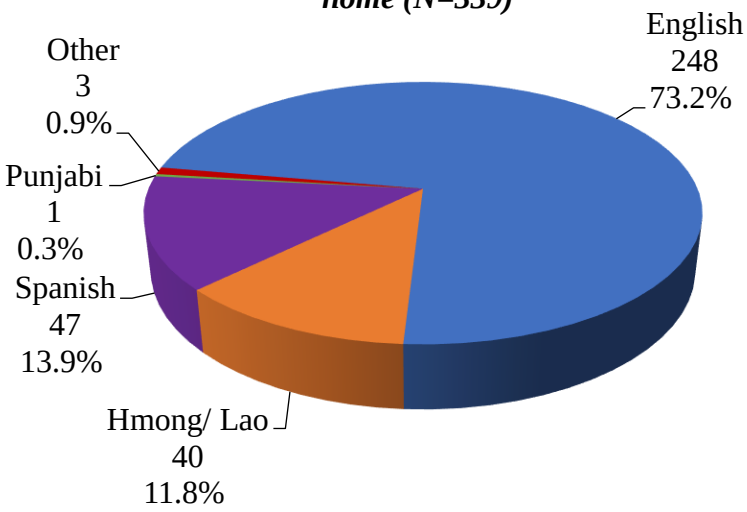
2019 Primary Language Spoken at home (N=427)



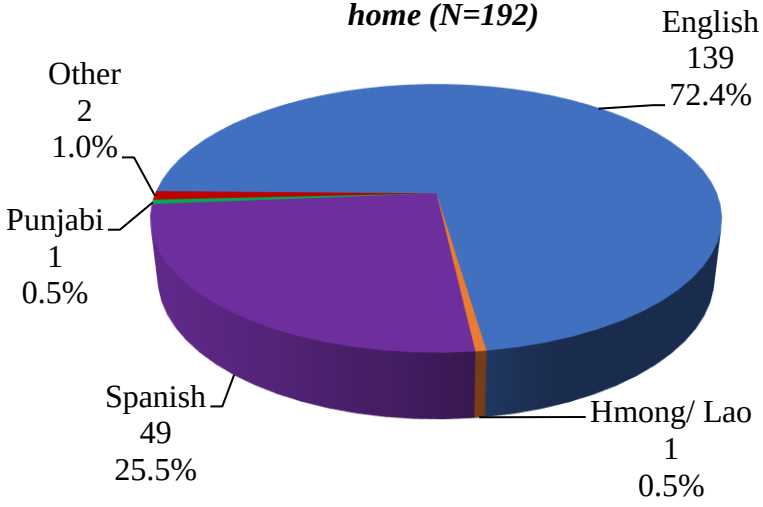
2020 Primary Language Spoken at home (N=339)



2021 Primary Language Spoken at home (N=339)



2022 Primary Language Spoken at home (N=192)

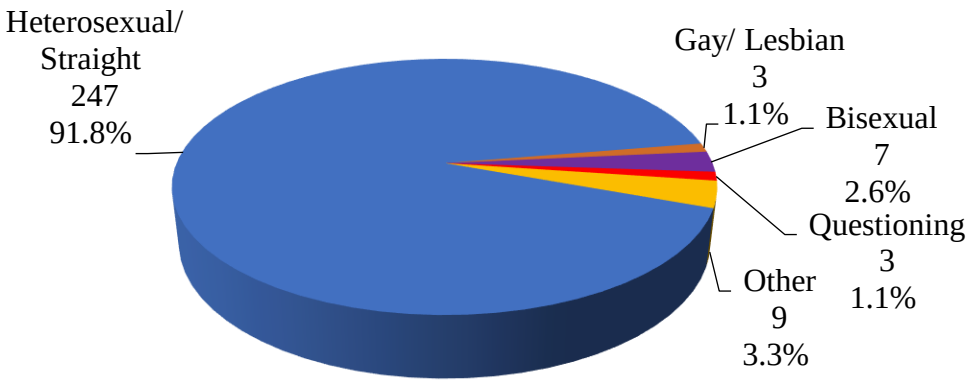


Fresno County Department of Behavioral Health

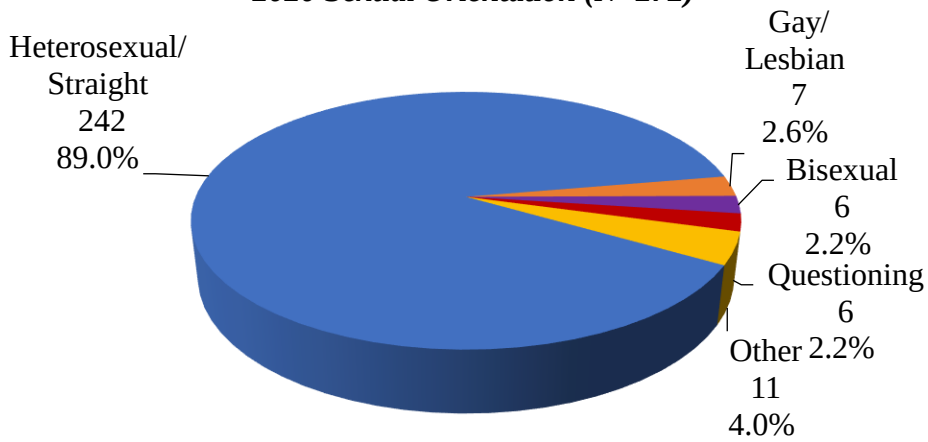
Family/Caregiver Cultural Humility Survey

Comparison Between 2019, 2020, 2021 and 2022 Survey Results

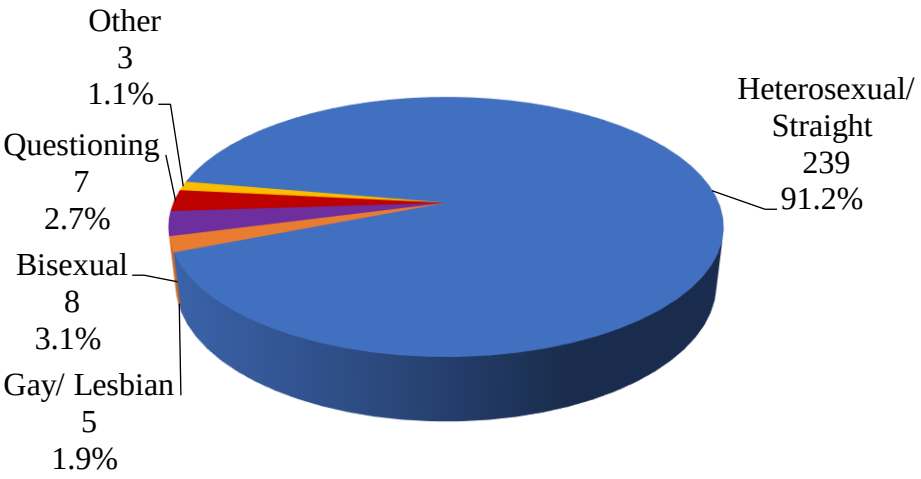
2019 Sexual Orientation (N=269)



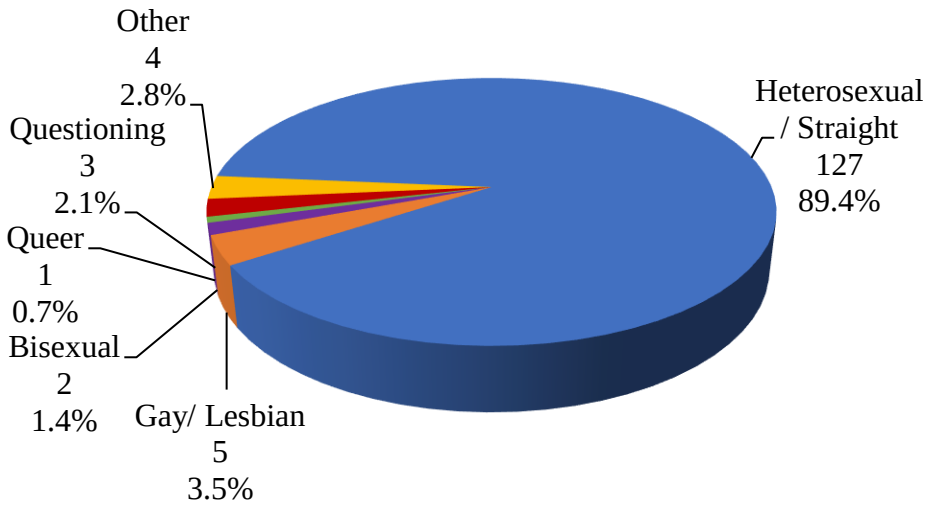
2020 Sexual Orientation (N=272)



2021 Sexual Orientation (N=262)



2022 Sexual Orientation (N=142)

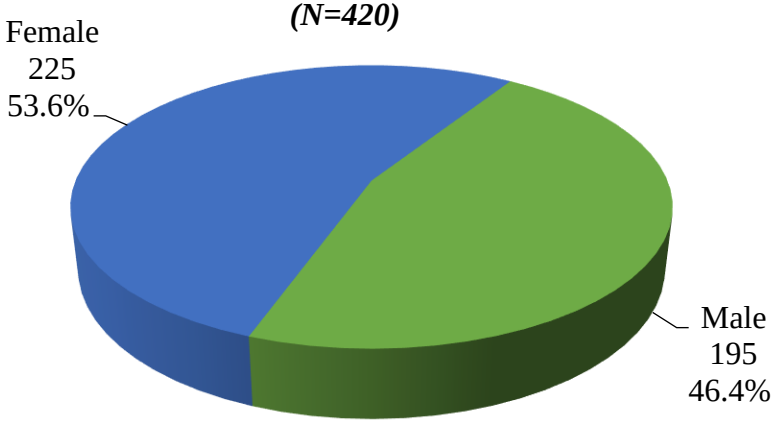


Fresno County Department of Behavioral Health

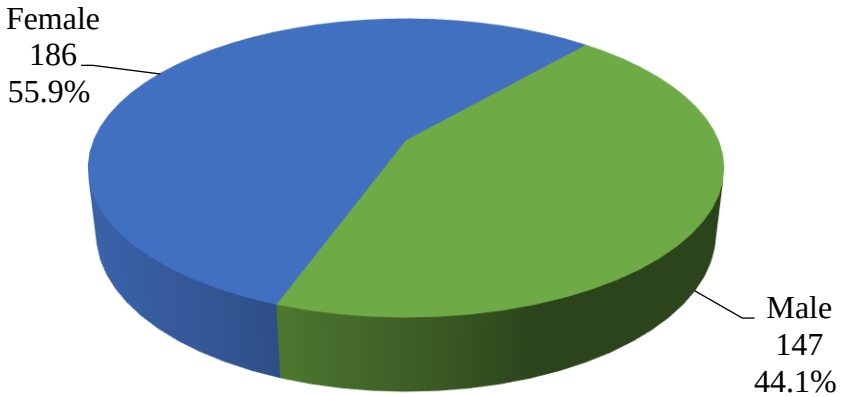
Family/Caregiver Cultural Humility Survey

Comparison Between 2019, 2020, 2021 and 2022 Survey Results

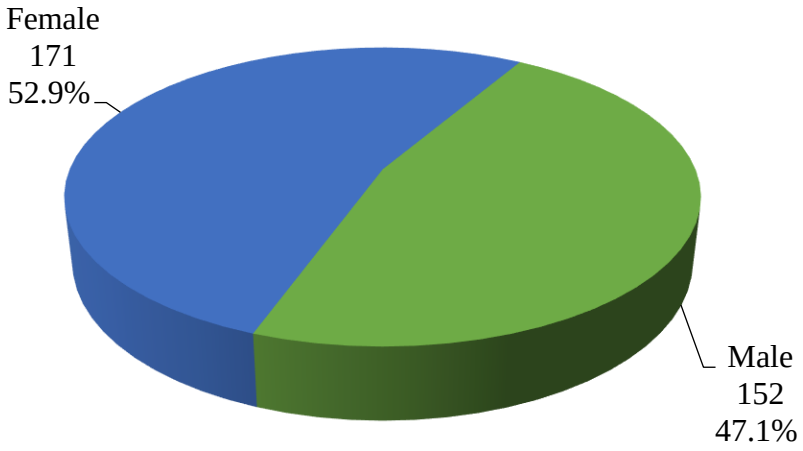
2019 Gender Assigned at Birth (N=420)



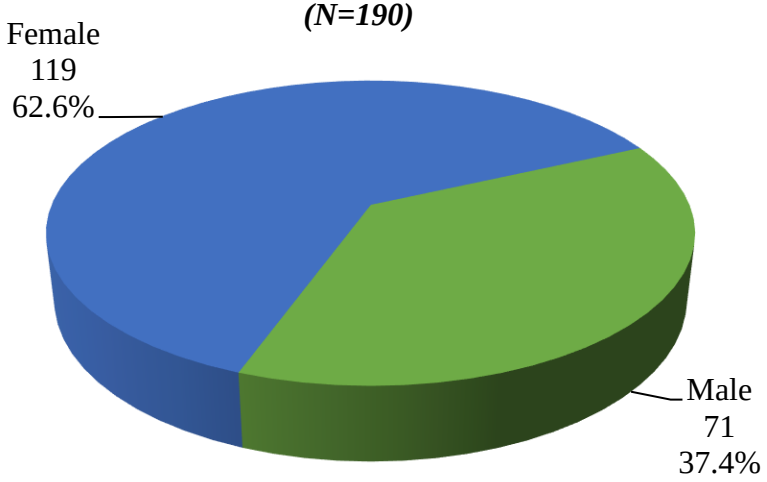
2020 Gender Assigned at Birth (N=333)



2021 Gender Assigned at Birth (N=323)



2022 Gender Assigned at Birth (N=190)

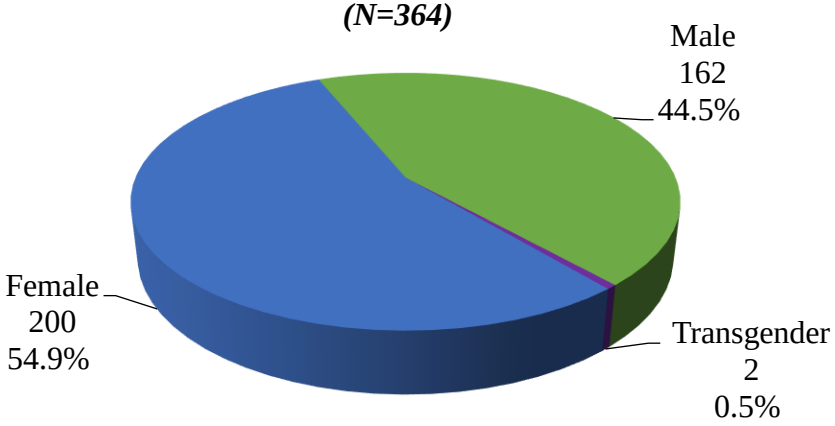


Fresno County Department of Behavioral Health

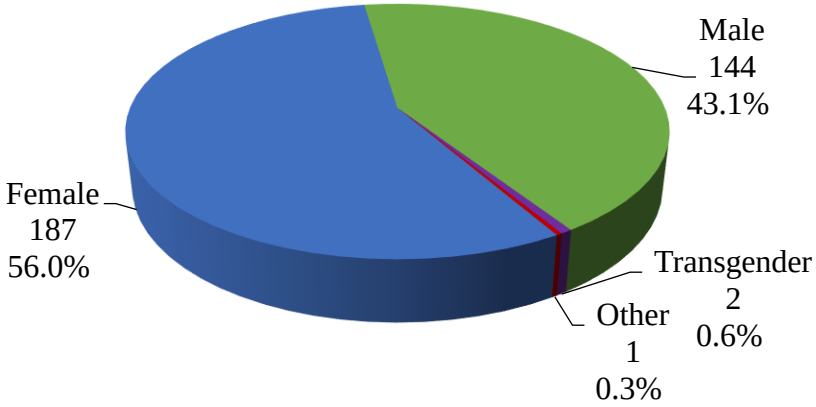
Family/Caregiver Cultural Humility Survey

Comparison Between 2019, 2020, 2021 and 2022 Survey Results

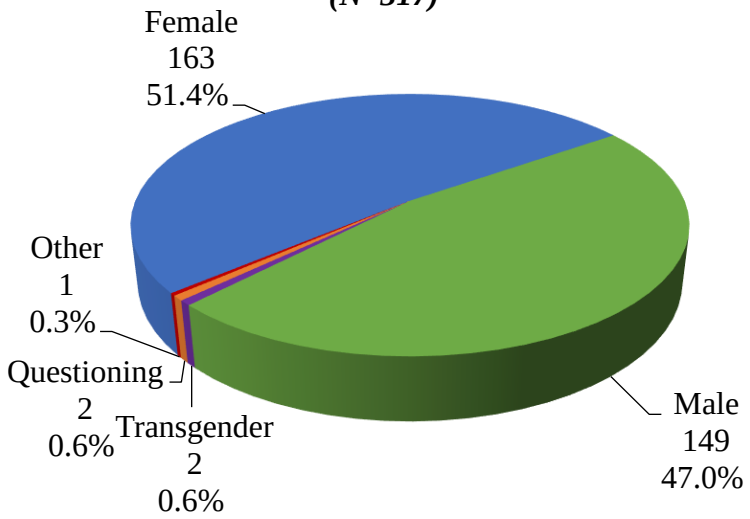
2019 Current Gender Identity
(N=364)



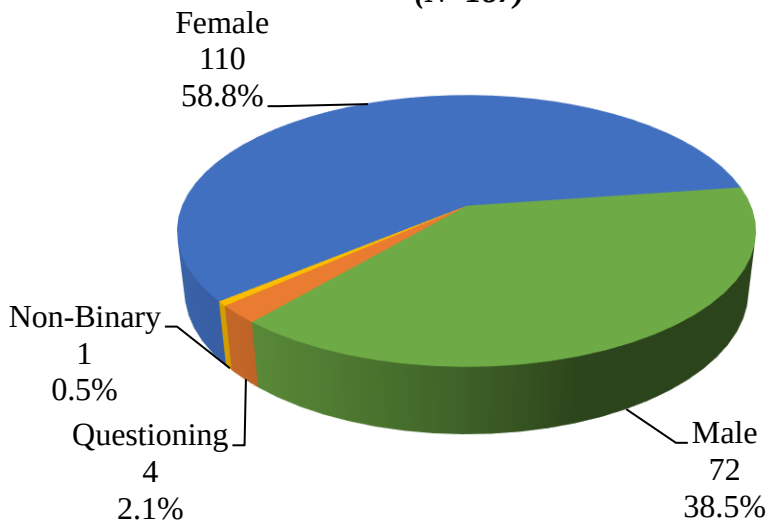
2020 Current Gender Identity
(N=334)



2021 Current Gender Identity
(N=317)



2022 Current Gender Identity
(N=187)

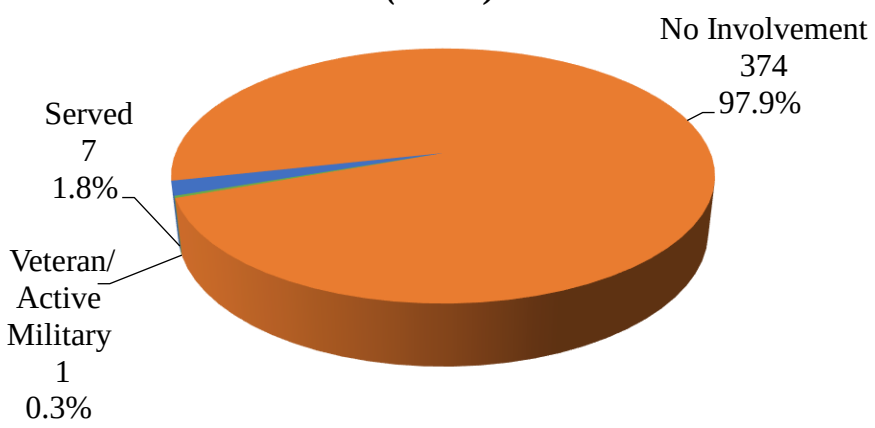


Fresno County Department of Behavioral Health

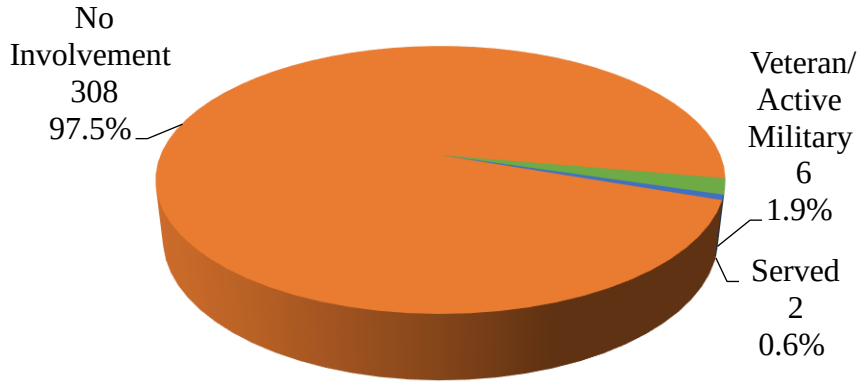
Family/Caregiver Cultural Humility Survey

Comparison Between 2019, 2020, 2021 and 2022 Survey Results

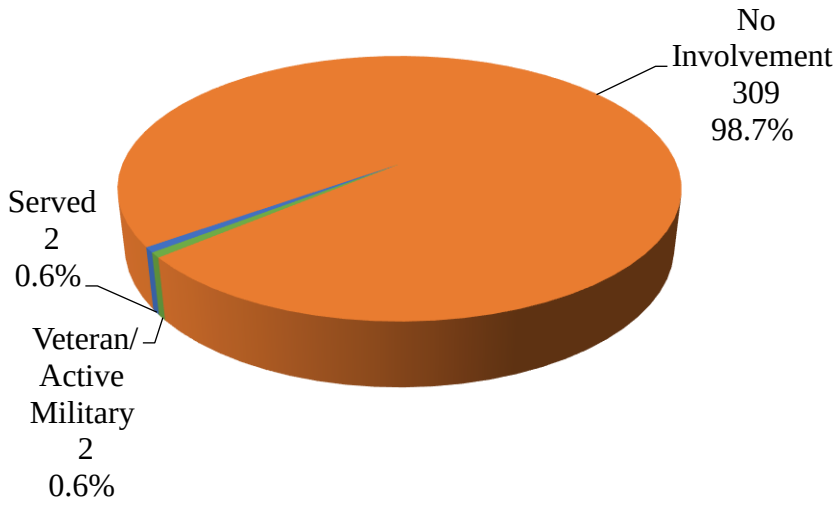
2019 Military/Service Involvement (N=382)



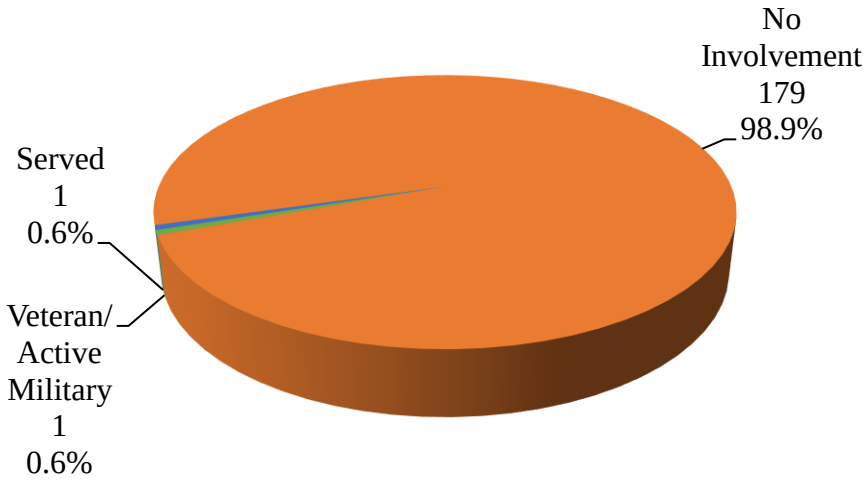
2020 Military/Service Involvement (N=316)



2021 Military/Service Involvement (N=313)



2022 Military/Service Involvement (N=181)

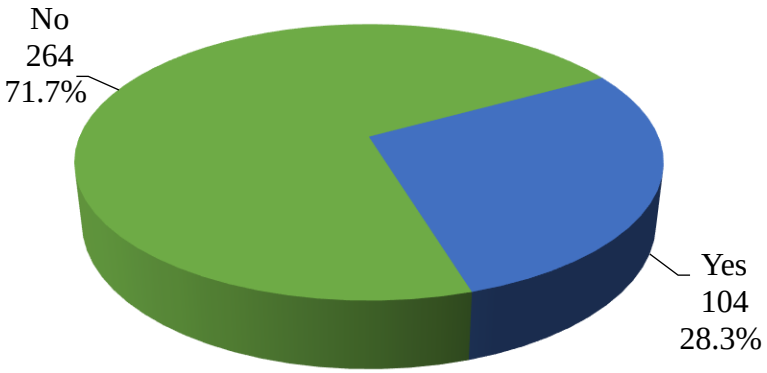


Fresno County Department of Behavioral Health

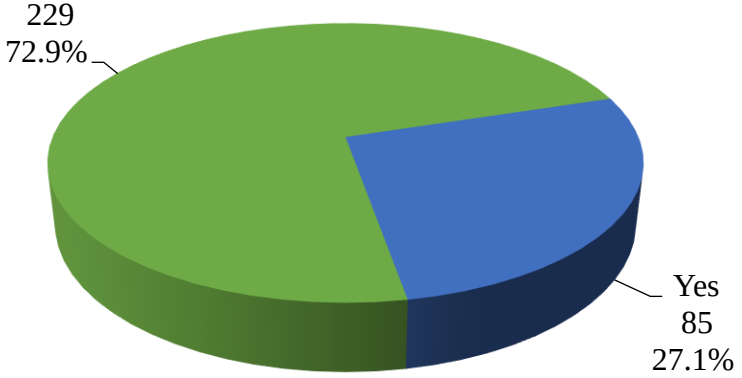
Family/Caregiver Cultural Humility Survey

Comparison Between 2019, 2020, 2021 and 2022 Survey Results

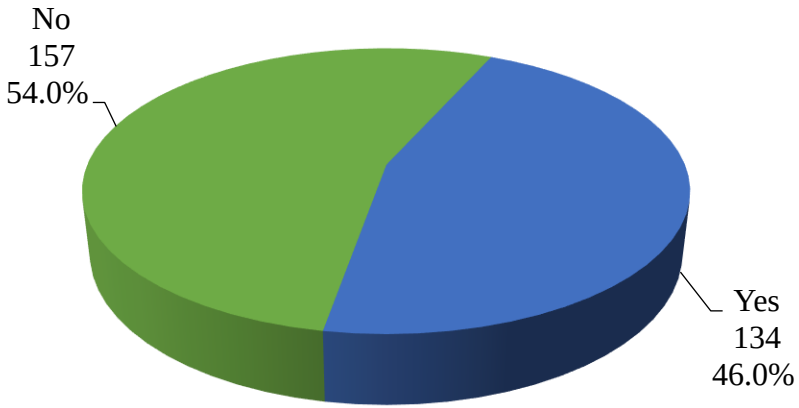
2019 Does your family member have a disability? (N=368)



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



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



2022 Does your family member have a disability? (N=182)