



# RACIAL EQUITY ANALYSIS



In November 2020, the [Board of Supervisors approved](#) the use of the Government Alliance on Race and Equity (GARE) Racial Equity Analysis toolkit for significant Board items, which provides the questions listed here for your exploration. To eliminate racial inequities in our communities, the County of Sonoma continues to integrate intentional and explicit consideration of racial equity in decisions and in the development of policies, programs, and budgets, in alignment with legal principles. Racial equity analyses help staff understand key community metrics and opportunities to advance racial equity and prompt them to develop strategies and actions that improve success for all communities.

## When should I do my Racial Equity Analysis?

**Policies & Ordinances:** In policy work, the Racial Equity Analysis (REA) should be applied **right from the outset of policy development**. This ensures that racial equity considerations are integrated into the policy design process, helping to identify and address potential disparities before they become entrenched. In addition, policies and ordinances that are found to produce inequities, should also be updated by applying a REA.

**Program Development:** For program development, it's crucial to employ the Racial Equity Analysis **from the inception of program planning**, as well as when updating program policies. This approach allows staff to incorporate equity principles throughout all phases, from program design to implementation and evaluation, resulting in programs that better serve the needs of communities that have been most negatively impacted by institutional racial inequities.

**Budget:** When it comes to budget work, the Racial Equity Analysis should be used **during the early stages of budget proposal development**, in addition to updating budget proposal items that have contributed to inequities. This enables decision-makers to allocate resources with key data metrics in mind to reduce disparate community outcomes, in alignment with their commitment to racial equity.

## How do I complete this Racial Equity Analysis (REA)?

**Review & Prepare:** Visit our **CAO Racial Equity Analysis Teams Channel: [SON-Communications | CAO-Racial Equity Analysis | Microsoft Teams](#)** and begin with the tab called, "Start Here." There you will find introductory resources, including the OOE Racial Equity Toolkit Training slides and recordings, direction from County Executive Officer Christina Rivera, Significant Item Calendars, and [Roles and Responsibilities](#) for the REA process.

Next, you can visit the "Resources" tab to find the full GARE Racial Equity Toolkit with more information to guide your analysis, this fillable REA template, other toolkit examples, and the OOE guiding resources for [Community Engagement](#) and [Intergovernmental Relations with Native Nations](#). There are also "Analysis Examples" from County departments and other jurisdictions, and local "Data Sources" under their respective tabs.

**Consult:** Most importantly, **engage in a consultation process with the Office of Equity (OOE) from the beginning**, and your department's equity group or Core Team member(s) if you have them. The Office of Equity will reach out to those who have been identified to complete an REA to provide guidance, technical assistance, and key recommendations, which will be documented in this analysis. The OOE analysis review process must be completed **before your initial submittal deadline** into Legistar.



# RACIAL EQUITY ANALYSIS



Use these questions as guiding considerations to explore what you know, what you don't know, and what you need to fill the gaps. This analysis is both a product and process. Answer each question to the best of your ability, and if there is a lack of data or information available, please note that.

**Tips:** Reference historical and current day **systemic and institutional barriers and advancements** to racial equity, use **clear, ethno-racial language** when relevant (Black/ African American, Latine/x, White, communities of color, etc.), and use [inclusive and accessible language](#) (ex. "systematically marginalized populations", "communities of color", "community members"), avoid terms like "vulnerable", "hard-to-reach populations", and "minorities."

<b>Board Item Date</b>	6/2/2026
<b>Board Item Name</b>	Proposition 1 Update (FY 2026-2029 Behavioral Health Services Act (BHSA) Integrated Plan)
<b>Department/Agency (Lead)</b> If this is an inter-departmental initiative, please identify a lead	Department of Health Services, Behavioral Health Division
<b>Contact Person(s) Completing Analysis</b>	Melissa Ladrech, BHSA Coordinator; Fabiola Espinosa, BHSA Analyst

## Step 1. Overview: Describe your program or policy and the desired results and outcomes?

- a. Who/what does this program, policy, or plan have an ability to impact?
 

<input checked="" type="checkbox"/> Children and youth	<input checked="" type="checkbox"/> Health
<input checked="" type="checkbox"/> Community engagement	<input checked="" type="checkbox"/> Housing
<input checked="" type="checkbox"/> Contracting equity	<input checked="" type="checkbox"/> Human services
<input checked="" type="checkbox"/> Criminal justice	<input checked="" type="checkbox"/> Jobs
<input checked="" type="checkbox"/> Economic development	<input type="checkbox"/> Parks and recreation
<input checked="" type="checkbox"/> Education	<input checked="" type="checkbox"/> Planning / development
<input checked="" type="checkbox"/> Environment	<input type="checkbox"/> Transportation
<input type="checkbox"/> Food access and affordability	<input checked="" type="checkbox"/> Utilities
<input checked="" type="checkbox"/> Government practices	<input checked="" type="checkbox"/> Workforce equity
<input type="checkbox"/> Other Click or tap here to enter text.	
- b. What is the program, policy, or plan? [Draft Sonoma BHSA Three Year Integrated Plan FY 26-29](#)
- c. What are the desired results (in the **community**) and outcomes (within your own **organization**)?
- d. What are the **indicators/performance measures** that would show if you were achieving those desired results? (How would you know?)

c. Sonoma County's Department of Health Services, Behavioral Health Division (DHS-BHD) has developed and released the first draft of the FY 2026–2029 Behavioral Health Services Act (BHSA) Integrated Plan (IP) for public and stakeholder review. The draft plan has been posted for community input and will be presented to the Sonoma County Board of Supervisors for review prior to final submission.

The BHSA Integrated Plan is a multi-year planning and budgeting document that outlines how the County will use BHSA funds to address behavioral health needs in the community. The plan identifies priority populations, describes the programs and services that will be implemented, and estimates the number of individuals who will be served. It also includes projected budgets, expected outcomes, and strategies designed to improve equity and expand access to behavioral health care.

The Integrated Plan is informed by community engagement, stakeholder feedback, and analysis of local and statewide data. It serves as Sonoma County's roadmap for implementing behavioral health services and evaluating their impact over the three-year planning period. As required by the Behavioral Health Services Act, the plan must be reviewed by stakeholders with an opportunity for public comment, approved by County leadership, and submitted to the California Department of Health Care Services (DHCS) by June 30, 2026.

Through this three-year plan, DHS-BHD aims to improve behavioral health, well-being, and stability for Sonoma County residents—particularly for communities that have historically experienced disparities, including Black, Indigenous, and People of Color (BIPOC), immigrants, rural residents, and low-income populations. The BHSA Integrated Plan seeks to strengthen a more effective, equitable, and coordinated behavioral health system that integrates mental health services, substance use treatment, and housing supports, while improving outcomes for individuals with the greatest needs.

Sonoma County's FY 2026–2029 BHSA Integrated Plan prioritizes increasing equitable access to culturally and linguistically responsive behavioral health services while strengthening prevention and early intervention supports for youth and families. Desired community-level outcomes include increased awareness of behavioral health resources, reduced barriers to accessing care, and improved outcomes related to mental health, substance use, and housing stability. The plan also aims to reduce disparities in crisis system involvement, psychiatric hospitalizations, and justice system contact, while strengthening trust and engagement between underserved communities and the behavioral health system.

Additional community-level outcomes include fewer individuals experiencing homelessness related to behavioral health needs, fewer children entering foster care due to untreated behavioral health conditions, reduced suicide deaths—particularly among populations at elevated risk—and improved long-term recovery and stability for individuals receiving services.

Within DHS-BHD, the desired organizational outcomes focus on strengthening the behavioral health system to ensure services are equitable, coordinated, and effective. These efforts include improving the collection and analysis of disaggregated data to better identify and

address disparities across racial and ethnic groups, expanding partnerships with culturally specific and community-based providers, and strengthening internal practices that promote accountability for reducing disparities in service access and outcomes.

DHS-BHD will also increase the number of staff and contracted providers participating in foundational equity and Anti-Racist Results-Based Accountability (AR-RBA) trainings and incorporate AR-RBA outcome measures into service contracts to ensure measurable progress toward equity goals. Community engagement will remain a central component of the planning and implementation process by providing meaningful opportunities for residents and stakeholders to participate through the BHSA Steering Committee, community town halls, and stakeholder feedback sessions.

Additional organizational priorities include expanding workforce diversity and increasing cultural responsiveness training for staff and contracted providers. Together, these efforts will help ensure that programs funded through the BHSA Integrated Plan are implemented in ways that advance equity, strengthen service delivery, and improve behavioral health outcomes for residents across Sonoma County.

d. DHS-BHD will continue to track, analyze, and collaborate with key stakeholders on a range of indicators and performance measures to ensure progress toward advancing equity, improving service delivery, and supporting better outcomes for Sonoma County residents. DHS-BHD will monitor a combination of statewide goals and indicators, local performance measures, and Anti-Racist Results-Based Accountability (AR-RBA) outcomes. These indicators focus on increasing access to care, reducing disparities, strengthening prevention and crisis response systems, and improving overall behavioral health outcomes across the county.

Key performance measures related to access to care include increases in Specialty Mental Health Services (SMHS) and Non-Specialty Mental Health Services (NSMHS) penetration rates for both adults and youth, reductions in wait times for services, and improved initiation of substance use disorder treatment. DHS-BHD will also monitor whether individuals from historically underserved communities—including Black, Indigenous, and People of Color (BIPOC), immigrants, rural residents, and low-income populations—are accessing behavioral health services at higher rates. Data will be disaggregated by race, ethnicity, gender, and geography to identify disparities and evaluate whether access to care is improving across populations.

For statewide goals related to homelessness, institutionalization, and justice involvement, DHS-BHD will track indicators such as reductions in the Point-in-Time (PIT) count of individuals experiencing homelessness, increases in housing placements for people with behavioral health conditions, and decreases in involuntary detentions, psychiatric hospitalizations, and conservatorships. Additional measures include reductions in arrest and recidivism rates among individuals with behavioral health needs—particularly among BIPOC populations—and increased diversion from the justice system into treatment and supportive services. For children and families, DHS-BHD will monitor improvements in access to mental health services for youth involved in child welfare systems, as well as indicators related to

family stability and reduced foster care placements associated with untreated behavioral health conditions.

In alignment with the additional statewide behavioral health goal of suicide prevention, DHS-BHD will track reductions in the county suicide death rate per 100,000 residents, with the goal of lowering Sonoma County's current rate (16.0 per 100,000) closer to or below the California statewide rate. Performance measures will also include reductions in suicide disparities among high-risk populations, particularly men and adults ages 45–64 and 65–84, as well as veterans and individuals who identify as LGBTQ+. Additional indicators include increased utilization of crisis services such as the Mobile Support Team (MST), Crisis Stabilization Unit, and the 988 Suicide and Crisis Lifeline, increased participation in suicide prevention trainings, and improved follow-up care and engagement with behavioral health services after a crisis event.

Using an AR-RBA framework, DHS-BHD will track indicators that answer three core questions: How much did we do? How well did we do it? Is anyone better off? "How much" indicators include the number of individuals receiving culturally responsive behavioral health services, the number of outreach and engagement activities conducted, the number of staff and contractors completing foundational equity and AR-RBA trainings, and the number of contracts that incorporate AR-RBA outcome measures. "How well" indicators include client satisfaction, timely access to services, and the delivery of culturally and linguistically appropriate care. "Is anyone better off" indicators focus on outcomes such as improved mental health and substance use recovery, reduced crises and hospitalizations, increased housing stability, and improved overall quality of life for individuals receiving services. Progress will also be evaluated through reductions in racial and ethnic disparities across behavioral health outcomes.

Together, these indicators combined with disaggregated data, ongoing community engagement, and AR-RBA performance monitoring will allow DHS-BHD to evaluate whether its programs and partnerships are effectively improving behavioral health outcomes, reducing inequities, and strengthening the behavioral health system for residents of Sonoma County.

## **Step 2. Data Collection & Analysis: What's the data? What does the data tell us?**

Local Data Sources to Consider: [Portrait of Sonoma](#), [Sonoma County Census Data](#), [County of Sonoma Human Resources Employee Demographic Dashboard](#), [the State of Black Housing in Sonoma County](#), [Sonoma County Queer Needs Assessment Report](#), [Sonoma County Youth Truth Survey Results](#), [National Equity Atlas: Policing in Sonoma County Schools](#), [Bay Area Equity Atlas](#), [California Communities Environmental Health Screening Tool](#)

- a. **Geographic Impact:** Will the program, policy, or plan have impacts in specific geographic areas (neighborhoods, areas, or regions)? What are the racial demographics of those living in the area? Who is the **most negatively impacted** in your analysis?
- b. **Community Insights:** What does **population level** (this is community level data) data, including quantitative (the numbers) and qualitative (the stories) data, tell you about existing racial inequities? What does it tell you about root causes or factors influencing racial inequities?

- c. **Program, Policy, Plan Insights:** What **performance level** data (this is your department's/County level data) do you have available for your program, policy, or plan? This should include data associated with existing programs or policies.
- d. **Data Gaps:** Are there **data gaps**? If so, how can you obtain better data? What additional data would help analyze the program, policy, or plan?

a. Sonoma County's FY 2026–2029 BHSA Integrated Plan is designed to improve behavioral health outcomes across the county. However, its impacts will be particularly significant in geographic areas where behavioral health needs, homelessness, and disparities in service access are most pronounced. These include larger population centers such as Santa Rosa, Petaluma, Rohnert Park, and Sonoma Valley, as well as rural communities throughout West County and other unincorporated areas. Rural communities often face additional barriers to care, including transportation challenges, fewer behavioral health providers, and limited culturally and linguistically responsive services. By expanding mobile crisis response teams, outreach programs, prevention services, and partnerships with community-based organizations, the plan seeks to improve access to behavioral health care in both urban and rural areas of Sonoma County.

Sonoma County has a population of approximately 485,000 residents with diverse racial and ethnic demographics. White residents represent about 57% of the population, while Hispanic or Latina/e residents make up the largest racial and ethnic minority group at approximately 31%. Asian residents account for about 4% of the population, Black or African American residents about 2%, American Indian/Alaska Native residents about 1%, and approximately 5% of residents identify as multiracial. Although White residents represent the largest share of the county's population overall, Hispanic and Latina/e residents are more likely to live in higher-need areas and communities with fewer resources and greater barriers to behavioral health services, as highlighted in the *Portrait of Sonoma*.

Data from the BHSA Integrated Plan and Sonoma County demographic analyses highlight several populations that experience disproportionate impacts across behavioral health, housing, and justice-related outcomes. For example, American Indian and Alaska Native residents experience the highest rates of homelessness in the county, with rates significantly higher than the overall county average. Black residents—particularly Black men—experience disproportionately high arrest rates and greater involvement with the criminal justice system compared to other racial and ethnic groups. Hispanic and Latino residents have lower access to specialty mental health services relative to other populations, suggesting barriers related to language access, cultural responsiveness, and service navigation.

Additionally, middle-aged and older men experience significantly higher suicide rates in Sonoma County, particularly veterans and individuals who identify as LGBTQ+. This disparity is especially concerning given that Sonoma County's suicide mortality rate exceeds the statewide average.

Low-income residents, immigrants, and rural populations also face structural barriers that affect their ability to access behavioral health services. These barriers may include transportation limitations, language barriers, stigma associated with behavioral health care, fear or mistrust of government systems, and limited availability of culturally responsive

providers. As a result, these communities may experience higher rates of untreated behavioral health conditions, housing instability, and crisis system involvement.

The BHSA Integrated Plan aims to address these geographic and demographic disparities by directing resources and services toward communities with the greatest need. DHS-BHD is expanding culturally and linguistically responsive behavioral health programs, strengthening partnerships with community-based and culturally specific providers, and investing in prevention, early intervention, crisis response, housing supports, and peer services. The plan also prioritizes improved data collection and analysis, including disaggregated data by race, ethnicity, and geography, to better identify and address inequities. Through these strategies, the plan seeks to reduce disparities in behavioral health outcomes and ensure that residents across Sonoma County—particularly those most negatively impacted—have equitable access to the services and supports needed to achieve long-term health and stability.

b. Community-level data from Sonoma County’s FY 26–29 BHSA Integrated Plan, combined with population-level indicators, reveal significant racial inequities across behavioral health access, homelessness, justice involvement, and health outcomes. Quantitative data indicate that certain racial and ethnic groups experience disproportionate impacts compared to the county average. For example, American Indian and Alaska Native residents experience the highest rates of homelessness, with a Point-in-Time (PIT) count of approximately 455 per 10,000 people—nearly nine times the overall county rate. Black residents also face disproportionately high rates of homelessness and justice system involvement; arrest data show that Black residents, particularly Black men, are arrested at rates several times higher than other racial groups in Sonoma County. Additionally, Hispanic and Latino residents have lower penetration rates for specialty mental health services, reflecting barriers to accessing behavioral health care. These quantitative indicators underscore clear disparities in who is most affected by housing instability, justice involvement, and limited behavioral health access.

Population-level data further highlight disparities intersecting with race and ethnicity. In 2023, over half of adults who needed help for mental health or substance use concerns did not receive services, with unmet need especially high among individuals identifying as two or more races. Suicide mortality data show Sonoma County’s overall rate exceeds the statewide average, with particularly high rates among middle-aged and older men, veterans, and LGBTQ+ individuals. These outcomes, while varying by demographic group, point to broader gaps in prevention, crisis response, and ongoing treatment engagement.

Qualitative data gathered through community engagement—such as BHSA Listening Sessions, Stakeholder meetings, Town Halls, provider and client surveys, and input from community-based organizations—help illuminate the root causes of these disparities. Community members frequently identify barriers such as language access challenges, lack of culturally responsive services, transportation limitations in rural areas, stigma surrounding behavioral health, and limited trust in public systems due to historical and ongoing discrimination. Immigrant and BIPOC communities also report difficulties navigating complex systems of care and accessing services that reflect their cultural and linguistic needs.

Together, the quantitative and qualitative data reveal underlying factors driving racial inequities in Sonoma County. These include structural inequities related to income, housing stability, and access to health care; historical disparities in how systems have served communities of color; geographic barriers affecting rural residents; and limited availability of culturally and linguistically responsive providers. These root causes influence who can access behavioral health services, who experiences housing instability or justice system involvement, and who receives timely prevention and treatment supports. The BHSA Integrated Plan uses these insights to guide strategies that prioritize culturally responsive services, strengthen community partnerships, expand prevention and early intervention programs, and address disparities through an Anti-Racist Results-Based Accountability (AR-RBA) framework wherever possible.

c. DHS-BHD used statewide and county performance-level data to evaluate the needs of programs, services, and goals outlined in the FY 2026–2029 BHSA Integrated Plan. The use of specific performance indicators was required by the California Department of Health Care Services (DHCS) as part of the BHSA planning process. The DHCS provided data, allowed DHS-BHD to assess system performance and identify disparities related to behavioral health access, homelessness, justice system involvement, institutionalization, untreated behavioral health conditions, removal of children from homes, and suicide rates.

Access-to-care data used in the plan was primarily collected through Medi-Cal claims, encounter data, and eligibility systems reported to DHCS by Managed Care Plans (MCPs). The data included indicators such as penetration rates for Specialty Mental Health Services (SMHS) and Non-Specialty Mental Health Services (NSMHS), initiation of substance use disorder treatment, follow-up after emergency department visits for mental illness or substance use, adults' access to preventive and ambulatory health services, and child and adolescent well-care visits. These indicators help the county monitor whether residents are accessing services and whether care is delivered in a timely and effective manner.

Data related to homelessness was obtained through the annual Point-in-Time (PIT) Count, which measures sheltered and unsheltered individuals experiencing homelessness on a single night in January and is reported to the U.S. Department of Housing and Urban Development.

Justice involvement data was collected by local law enforcement agencies and reported to the California Department of Justice (DOJ), who then compiles and validates arrest and disposition data through the California Open Justice Portal. Additional justice system indicators include the Adult Three-Year Recidivism Conviction Rate calculated by the California Department of Corrections and Rehabilitation (CDCR), which tracks individuals released from state institutions and monitors convictions within three years after release. Data related to felony Incompetent to Stand Trial (IST) referrals reflect individuals committed to Department of State Hospitals.

DHS-BHD also reviewed indicators related to children and families, including the number of children in foster care, open child welfare cases, and child maltreatment substantiations reported through the Child Welfare System.

Suicide and overdose mortality data were drawn from the California Comprehensive Death File (CCDF), which compiles death certificate information reported by county vital records offices and coded by the National Center for Health Statistics using the International Classification of Diseases mortality classification system.

Additional indicators related to institutionalization include inpatient administrative days for adults and youth, crisis service utilization such as Crisis Intervention, Crisis Stabilization, and Crisis Residential Treatment services, involuntary detention rates (14-, 30-, and 180-day holds per 10,000 residents), and temporary and permanent conservatorship rates. This data came from DHCS reporting systems, Medi-Cal claims and encounter data, and county behavioral health quarterly reports. However, it is important to note that the institutionalization data reported for Sonoma County was later identified as inaccurate due to a reporting error. DHS-BHD is currently working with DHCS to correct the data and improve the accuracy of future analyses related to institutionalization indicators.

In addition to these quantitative performance measures, DHS-BHD also considered other county analyses and community engagement findings to better understand service gaps and community priorities. These sources included the Sonoma County Housing and Homelessness Gap Analysis, the Sonoma County Behavioral Health Division Gap Analysis Report, and Sonoma County's FY 2023–2024 BHSA Community Program Planning Listening Sessions Report. DHS-BHD also incorporated qualitative feedback gathered from community stakeholders during two bilingual Community Town Hall meetings held in 2025. Furthermore, DHCS data and performance indicators were analyzed and discussed during MHSA/BHSA Steering Committee meetings, stakeholder meetings, Sonoma County housing workgroups, and Life Worth Living Suicide Prevention Alliance meetings, which helped inform priorities and strategies included in the Integrated Plan.

To strengthen accountability and advance equity, DHS-BHD is incorporating an Anti-Racist Results-Based Accountability (AR-RBA) framework into program evaluation. This framework examines three key questions: how much was done (such as the number of individuals served or outreach events conducted), how well services were delivered (including timely access to care, culturally responsive services, and client satisfaction), and whether anyone is better off (such as improved mental health outcomes, reduced crisis episodes, increased housing stability, or reduced justice system involvement). Ideally, if available, data would be disaggregated by race, ethnicity, age, and geography to identify disparities and evaluate whether programs are improving outcomes for historically underserved populations. DHS-BHD will also work with BHSA contractors to provide equity foundations and AR-RBA training to support shared understanding of equity-centered evaluation practices, strengthen data-informed decision-making, and promote continuous quality improvement across programs.

d. Although Sonoma County has access to extensive performance-level data, several gaps limit a full understanding of behavioral health inequities and overall system performance. In some areas, such as institutionalization measures, substance use treatment disparities, and crisis service utilization data disaggregated by race and ethnicity are limited, missing, or not consistently available. Additionally, data for smaller populations, including American Indian/Alaska Native, Black, and Native Hawaiian or Pacific Islander residents, are sometimes

suppressed due to small sample sizes, making it difficult to fully assess disparities within these communities.

Some datasets also rely on older reporting structures or inconsistent data collection practices across providers and systems, which can affect data quality and comparability over time. Differences in how agencies collect and report data across behavioral health, housing, justice, and child welfare systems can also make it difficult to fully understand how individuals interact with multiple systems of care.

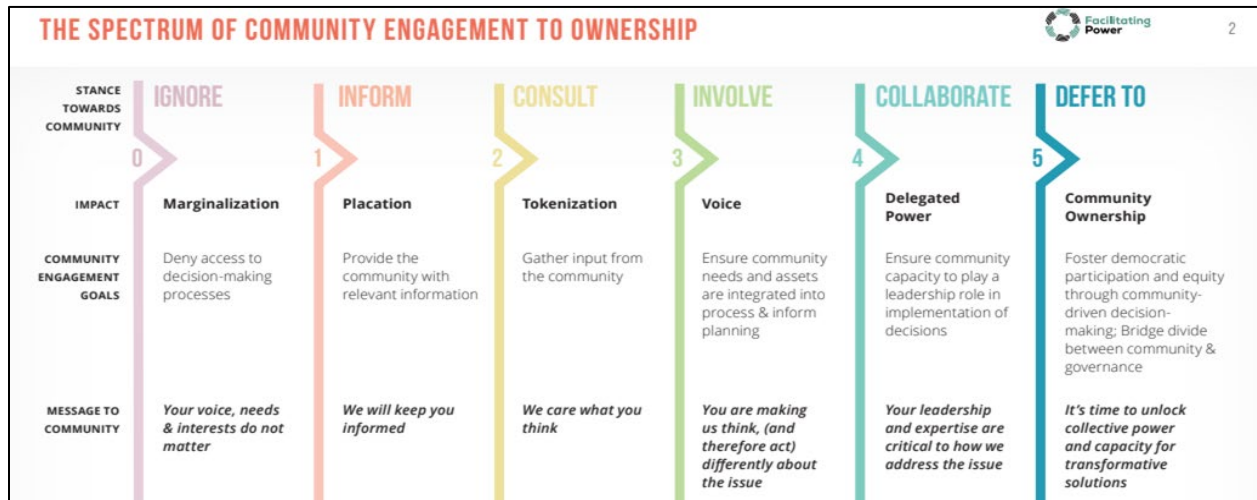
Another important gap involves qualitative and community-level insights. While DHS-BHD gathers input through stakeholder meetings, listening sessions, town halls, and surveys, there is a continued need for more consistent qualitative data from communities most impacted by disparities. Better data on lived experiences, barriers to care, and cultural needs would strengthen the county's ability to design responsive services.

To address these gaps, Sonoma County plans to expand the use of disaggregated data, improve coordination across behavioral health, housing, justice, and child welfare systems, and enhance reporting from contracted providers. The county will also continue gathering community input through listening sessions, surveys, and partnerships with culturally specific organizations. Improvements to integrated data systems and performance dashboards will help DHS-BHD track outcomes more consistently and support a stronger evaluation of the BHSI Integrated Plan's impact on advancing racial equity.

### **Step 3. Community Engagement: How have communities been engaged?**

We often focus on the benefits of making decisions, but we don't always ask **who** benefits from those decisions. It is important to ask who benefits, and to identify if there is a pattern over time about who has benefited- and who has held most of the burden- from government decisions. Doing so can help you make informed choices in both the short and long term about policies, practices, procedures, and budgets when the goal is racially equitable outcomes.

The Office of Equity created two resources, the [OOE Community Engagement Guide](#) and [OOE Informational Brief on Intergovernmental Relations with Native Nations in Sonoma County](#) as guides and models for intentional community engagement.



Full Resource: [Spectrum of Community Engagement](#)

Based on the information gathered in Step 2, explore:

- Who are the **most affected community members** who are involved with or have lived experience related to this program, policy, or plan? How have you **involved these community members** in the development of this program, policy, or plan?
- What community engagement/strategic partnerships are **already underway** (departmental or organization-wide)? What was **learned from the past** community engagement/partnership processes?
- What has your engagement process told you about the **burdens or benefits** for different groups? (concerns, facts, potential impacts)
- What has your engagement process told you about the **root causes** that produce or perpetuate racial inequity related to this program, policy, or plan?
- What does the **community need to know** about this program, policy, or plan?
- What are ways to minimize any negative impacts (harm to communities of color, increased racial disparities, etc.) that may result? What opportunities exist for increasing racial equity?

a. The community members most affected by the FY 2026–2029 Behavioral Health Services Act (BHSA) Integrated Plan include individuals and families with lived experience of behavioral health conditions, substance use disorders, homelessness, and involvement with crisis or justice systems. This includes individuals receiving Specialty Mental Health Services (SMHS), participants in programs such as Full Service Partnerships (FSP), people experiencing homelessness, and families involved with the child welfare system. Data and community engagement also indicate that several populations experience disproportionate impacts, including Black residents, Hispanic or Latina/e residents, American Indian/Alaska Native residents, immigrants, rural residents, low-income communities, veterans, LGBTQ+ individuals, and middle-aged and older men, who experience higher suicide risk.

DHS-BHD engaged these community members in the development of the BHSA Integrated Plan through multiple outreach and engagement strategies. Through BHSA's Community Program Planning process, DHS-BHD lead: community listening sessions, stakeholder meetings, focus groups, surveys, and two community Town Hall meetings were held in 2025. The targeted outreach created a space for individuals with lived experience, family members,

community-based organizations, and behavioral health providers to share input on community needs, service gaps, and program priorities. Additional feedback was gathered through the MHSA/BHSA Steering Committee and the Life Worth Living Suicide Prevention Alliance, both of which include representation from community members, service providers, and individuals with lived experience.

b. The Behavioral Health Services Act (BHSA) requires a robust Community Program Planning process that includes ongoing community engagement and strategic partnerships to support behavioral health planning and service delivery. These partnerships include community-based organizations, culturally specific providers, housing and homelessness service providers, health care partners, law enforcement, education systems, and peer-led organizations. Community engagement occurs through the MHSA/BHSA Steering Committee, stakeholder meetings, and collaborative groups such as the Life Worth Living Suicide Prevention Alliance.

BHSA listening sessions were intentionally organized using racial and cultural affinity groups to create a safer environment for open and honest discussion about behavioral health needs. These affinity spaces center lived experience, allowing participants to share perspectives more freely and generating deeper insights that can inform actionable recommendations. Focus groups and surveys also provided opportunities for community members to share candid feedback about behavioral health needs, service gaps, and community concerns.

Information gathered through these engagement efforts informed the development of several reports, including the BHSA Listening Session Report, the Behavioral Health Gap Analysis, and the Housing Gap Analysis. These reports highlight key findings and recommendations from the community engagement process. Across engagement activities, community members consistently identified a need for increased access to culturally and linguistically responsive behavioral health services, expanded prevention and early intervention programs, and additional housing supports for individuals experiencing behavioral health challenges. Participants also emphasized the importance of peer services, family support, and stronger coordination between behavioral health, housing, and justice systems.

BHSA Town Hall meetings and stakeholder meetings also provided opportunities for collective feedback and discussion, while allowing DHS-BHD to share information about the transition from MHSA to BHSA and respond to community questions. Together, these engagement efforts reinforced the importance of community-informed planning and ongoing collaboration with organizations that serve historically marginalized populations.

c. Community engagement has highlighted both benefits and challenges within the behavioral health system. Identified benefits include the availability of crisis response services such as the Mobile Support Team (MST), InResponse, 988, and CAPE; increased access to culturally and linguistically responsive behavioral health services, including programs such as the Latinx Clinic; and expanded housing supports, including developments such as Eliza's Village and Micky Zane's Place.

However, the engagement process also revealed significant barriers affecting certain populations. Communities of color, immigrants, and non-English-speaking residents reported difficulties accessing culturally responsive and linguistically appropriate services, particularly for individuals who do not qualify for Medi-Cal. Rural residents identified challenges related

to transportation barriers and limited availability of behavioral health providers. Community members also described barriers related to stigma, limited awareness of available services, and the complexity of navigating the behavioral health system. In addition, some individuals with lived experience reported concerns about delays in accessing care, insufficient coordination across service systems, and limited availability of prevention and early intervention supports.

d. Community engagement and data analysis suggest that racial inequities in behavioral health outcomes are influenced by several structural and systemic factors. These include historical and ongoing disparities in access to health care, housing instability, income inequality, and limited access to culturally responsive services. Community members also highlighted systemic barriers such as language access challenges, lack of providers who reflect the cultural backgrounds of the communities served, and mistrust of public systems due to past experiences of discrimination.

Additionally, social determinants of health, including housing instability, poverty, and limited access to preventive services play a major role in shaping behavioral health outcomes. Rural geography, transportation barriers, and service fragmentation further contribute to inequitable access to care. These root causes help explain why certain populations, including American Indian/Alaska Native communities, Black communities, Hispanic/Latino communities, and low-income populations, experience higher rates of homelessness, justice involvement, or unmet behavioral health needs.

e. Community members need to know that the BHSa Integrated Plan aims to expand access to behavioral health services, improve prevention and early intervention supports, and strengthen community-based care for Sonoma County residents. The plan focuses on addressing disparities in behavioral health access and outcomes while investing in programs that promote housing stability, crisis response, and recovery supports.

The community should also be aware that DHS-BHD is committed to transparency and ongoing engagement throughout the implementation of the plan. This includes sharing information about available services, funding priorities, and program outcomes. DHS-BHD will continue to communicate with community members and stakeholders through public meetings, community partnerships, and outreach efforts to ensure that residents understand how the BHSa Integrated Plan supports behavioral health needs across the county.

f. To minimize potential negative impacts and reduce racial disparities, DHS-BHD is prioritizing equity-focused strategies throughout the BHSa Integrated Plan. These include expanding culturally and linguistically responsive services, increasing partnerships with culturally specific community-based organizations, and improving access to behavioral health services in rural and underserved communities. DHS-BHD also plans to strengthen workforce diversity and provide ongoing equity and cultural responsiveness training for staff and contracted providers.

The division is also implementing an Anti-Racist Results-Based Accountability (AR-RBA) framework to monitor whether programs are effectively improving outcomes and reducing

disparities. This approach includes collecting and analyzing disaggregated data, incorporating AR-RBA performance measures into contractor agreements, and ensuring that programs are evaluated based on their impact on historically underserved populations.

Opportunities to increase racial equity also include expanding prevention and early intervention services, strengthening peer and family support programs, improving language access, and increasing investments in housing-related behavioral health services. Continued community engagement with individuals who have lived experience will also help ensure that the behavioral health system evolves in ways that are responsive, equitable, and aligned with the needs of Sonoma County residents.

### **Step 1. Analysis and Strategies: What are your strategies for advancing racial equity?**

As reflected in the [Portrait of Sonoma](#) (pages 10-12, 35), racial inequities exist across every indicator for health, wealth, and well-being when disaggregated by race. This is why, when we are working towards the goal of racially equitable outcomes for all groups, we need to ask, "How might (a given decision) impact communities of color and other systematically marginalized communities?" In addition, we also need to ask what unintended consequences a decision might have, so that we can try to prevent or further potential disparate outcomes.

- a. Given what you have learned from research and stakeholder involvement, how will your recommended actions **increase or decrease racial equity**? Who will benefit from or be burdened by your proposed strategies?
- b. What are **potential unintended consequences**? What are the ways in which your program, policy, or plan could be modified to **enhance positive impacts** or reduce negative impacts for impacted communities?
- c. Are there complementary strategies that you can implement? What are ways in which existing partnerships could be strengthened to maximize impact in the community? How will you partner with stakeholders for **long-term positive change**?
- d. Are the impacts aligned with your community outcomes defined in Step #1? If not, what will you change in order to create alignment?

a. The strategies outlined in the BHSA Integrated Plan are intended to advance racial equity by expanding access to culturally and linguistically responsive behavioral health services and directing resources toward populations experiencing the greatest disparities. These strategies include expanding prevention and early intervention programs, strengthening crisis response services, increasing housing-related behavioral health supports, and expanding partnerships with culturally specific community-based organizations.

One example of advancing racial equity through the BHSA plan is the implementation of new Request for Proposal (RFP) programs that specifically address disparities affecting communities of color. One program is the Latinx Youth Wellness and Advocacy Program, which will provide culturally responsive and linguistically appropriate services for Latino/x/e youth in Sonoma County. This program will include mentorship, leadership development, peer education, and outreach to Latino/x/e youth and families. Through the Latino/x/e youth *promotores* model, participants will receive skill-building training and opportunities to engage in advocacy and community awareness initiatives. The program will also conduct outreach to increase awareness of behavioral health services and address cultural and systemic barriers

that prevent Latino/x/e youth from accessing care. By supporting leadership development, culturally grounded wellness programming, and community engagement, this program aims to reduce disparities in behavioral health outcomes and justice system involvement among Latino/x/e youth.

Another example is the Community-Defined Best Practices (CDBP) for BIPOC Populations Program, which will support culturally rooted wellness approaches for communities of color. This early intervention program will implement community-defined models of care, such as Indigenous healing practices or culturally specific wellness models. Activities will include culturally grounded support groups, talking circles, peer-to-peer health promotion, and community workshops focused on behavioral health awareness and suicide prevention. The program will also host cultural gatherings and events that celebrate cultural strengths while promoting mental health and resilience. By supporting culturally rooted practices and peer-led wellness initiatives, the program aims to reduce untreated behavioral health conditions, strengthen cultural identity and resilience, and increase access to behavioral health resources for BIPOC communities.

These strategies are expected to benefit communities that have historically faced barriers to behavioral health services, including communities of color, immigrants, rural residents, low-income communities, veterans, LGBTQ+ individuals, and individuals experiencing homelessness or behavioral health crises. Expanding culturally responsive services, improving language access, and strengthening community partnerships will help reduce structural barriers to care and build trust between underserved communities and the behavioral health system.

b. While the BHSa Integrated Plan is designed to advance equity, it is important to consider potential unintended consequences. For example, expanding new programs without adequate outreach or language access could result in services primarily reaching individuals who are already connected to the behavioral health system. Additionally, smaller culturally specific organizations may face challenges navigating county contracting processes, which could limit their ability to participate in new funding opportunities.

To mitigate these risks, DHS-BHD will prioritize outreach to historically underserved communities through our community program planning, community events and partnerships, and through DHS's Community Health Workers (CHWs). DHS-BHD will also explore opportunities to improve the County's procurement process, including providing technical assistance to community-based organizations interested in applying for future Requests for Proposals (RFPs), as the timeline for the current BHSa RFP has already passed. In addition, DHS-BHD will continue strengthening language access services and culturally responsive outreach strategies. Monitoring program outcomes through AR-RBA and disaggregated data will help identify disparities early and allow programs to be adjusted if certain communities are not benefiting as intended.

c. Advancing racial equity requires sustained collaboration across multiple sectors and community partners. DHS-BHD will continue to strengthen partnerships with culturally specific organizations, community-based service providers, other County departments, health care

systems, housing and homelessness service providers, schools, and justice system partners. Through the BHSA Community Program Planning process, DHS-BHD will continue implementing equity-focused strategies to strengthen existing programs and advocate for new services based on identified community needs.

Existing partnerships will be further strengthened through increased coordination, shared data analysis, and ongoing stakeholder engagement. DHS-BHD will continue to engage community members through the BHSA Steering Committee, BHSA stakeholder meetings, listening sessions, and other community program planning opportunities. DHS-BHD will also continue partnering with organizations that serve communities of color and advocate for an equity-centered program approach. This approach includes ongoing staff training; culturally and linguistically responsive, trauma-informed, and person-centered practices; meaningful inclusion of individuals and families with lived experience; and AR-RBA data collection to support ongoing program evaluation and improvement. Through these efforts, DHS-BHD will help ensure that behavioral health programs remain responsive to evolving community needs.

d. The strategies outlined in the BHSA Integrated Plan are aligned with the community outcomes identified earlier in the planning process. These outcomes include increasing equitable access to behavioral health services, reducing homelessness and housing instability among individuals with behavioral health needs, improving prevention and early intervention supports for youth and families, reducing justice system involvement related to behavioral health needs, and reducing suicide deaths.

If ongoing monitoring or community feedback indicates that strategies are not achieving the intended outcomes, DHS-BHD will look into making changes during BHSA's Annual Program Plan Update. Through the use of AR-RBA performance measures, disaggregated data analysis, and review of DHCS statewide goals, DHS-BHD will continue to evaluate whether programs are improving outcomes for communities most affected by disparities.

This ongoing evaluation process helps ensure that the programs and services outlined in the BHSA Integrated Plan remain responsive to community needs and adaptable over time. It also supports DHS-BHD's commitment to advancing equitable behavioral health outcomes across Sonoma County, with particular attention to communities of color and other historically underserved populations who have experienced disproportionate barriers to accessing behavioral health care.

## **Step 2. Implementation: What is your plan for implementation?**

Now that you know what the unintended consequences, benefits, and impacts of the proposal and have developed strategies to mitigate unintended consequences or expand impact, it is important to focus on thoughtful implementation.

### **Describe your plan for implementation:**

DHS-BHD will implement the FY 26 -29 BHSA Integrated Plan after it has been reviewed and stakeholders, including the County's Behavioral Health Board, have had an opportunity to provide feedback. The plan must also be approved by Sonoma County's Board of Supervisors and California's Department of Health Care Services. Its development reflects a long,

coordinated process designed to ensure it is equity-focused, data-informed, and grounded in community engagement, with strong partnerships with community-based organizations. The plan builds on strategies identified during planning and aims to improve behavioral health outcomes while reducing racial and geographic disparities across Sonoma County.

A key component of implementation will be the BHSA Request for Proposal (RFP) and Behavioral Health’s Request for Applications (RFA) process, which will fund new and expanded programs addressing service gaps and disparities. DHS-BHD will prioritize partnerships with culturally specific and community-based organizations to deliver culturally and linguistically responsive programs, such as the Latinx Youth Wellness and Advocacy Program and the Community-Defined Best Practices (CDBP) program for BIPOC populations, which expand outreach, prevention, and early intervention services for historically underserved communities. The RFP evaluation panel includes diverse reviewers, including BIPOC evaluators and individuals with lived experience, to support equitable decision-making and reduce bias in funding.

DHS-BHD will continue strengthening the behavioral health continuum through existing programs and partnerships, including Full Service Partnership (FSP) programs, crisis response services such as the Mobile Support Team (MST) and Crisis Assessment, Prevention, and Education (CAPE), housing programs such as Behavioral Health Bridge Housing, and suicide prevention initiatives coordinated through the Life Worth Living Suicide Prevention Alliance. Coordination across these programs ensures access to services across the full continuum, from prevention and early intervention to crisis response, treatment, and recovery.

Community engagement will remain central to implementation. DHS-BHD will continue involving stakeholders through the BHSA Steering Committee, stakeholder meetings, community events, and partnerships with community organizations. To increase accessibility and transparency, the County will translate the BHSA Integrated Plan into Spanish and post it online, enabling Spanish-speaking residents to review the plan and provide feedback.

To ensure accountability and equitable outcomes, DHS-BHD will implement the AR-RBA framework across funded programs. DHS-BHD will provide training and guidance for contractors who will track performance indicators measuring service delivery and community impact, while disaggregated data by race, ethnicity, age, and geography will be used to identify disparities and monitor progress. Ongoing equity and AR-RBA training for staff and contractors will strengthen capacity to advance racial equity, and outcomes will be incorporated into agreements to ensure accountability for improving access and results for historically underserved populations.

Finally, DHS-BHD will use continuous monitoring, evaluation, and community feedback to adjust implementation strategies as needed. By reviewing performance, addressing unintended consequences, and strengthening partnerships, DHS-BHD will ensure the BHSA Integrated Plan advances equity, expands access to care, and improves behavioral health outcomes for all Sonoma County residents, especially to communities of color and other historically underserved populations.

<b>Is this implementation plan:</b>	<b>Yes</b>	<b>No</b>	<b>I’m Not Sure</b>
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Realistic?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Adequately funded?	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Adequately resourced with personnel?	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Adequately resources with mechanisms to ensure successful implementation and enforcement?	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Adequately resourced to ensure on-going data collection, public reporting, and community engagement?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If the answer to any of these questions is no or unsure, what resources or actions are needed?

DHS-BHD’s Full Service Partnership programs will be required by DHCS to operate with fidelity, but some programs currently fall short of this standard. To provide more effective, robust, and trauma-informed services that utilize a true “whatever it takes” approach, DHS-BHD will need to increase staffing and reduce provider-to-client ratios. This will require hiring additional clinicians and support personnel, with particular emphasis on bilingual and bicultural staff. Current limitations in the County’s hiring practices may restrict DHS-BHD’s ability to secure sufficient resources and staffing, which could affect the successful implementation of the BHSA Integrated Plan.

**Step 3. Accountability and Communication: How will you ensure accountability, communicate, and evaluate results?**

Accountability entails putting processes, policies, and leadership in place to ensure that program plans, evaluation recommendations, and actions leading to the identification and elimination of root causes of inequities are implemented. Just as data is critical in analyzing potential impacts of the program or policy, data will be important in seeing whether the program or policy has worked. Developing mechanisms for collecting data and evaluating progress will help measure whether racial equity is being advanced. Evaluating results means that you will be able to make any adjustments to maximize impact.

- a. How will impacts be documented, evaluated, and shared? How will the public know whether you are achieving the anticipated outcomes? How will you report on community impacts?
- b. How will you continue to partner and deepen relationships with the communities most impacted to make sure your work to advance racial equity is working and sustainable for the long-haul? How and when will you check back in with community to share your findings and hear their feedback?
- c. What [communication strategies](#) will help advance racial equity? (Think of data narratives)

a. DHS-BHD will ensure accountability by systematically tracking program and policy outcomes using both quantitative and qualitative data through BHSA quarterly reports, Annual BHSA Program Impact Statements, and analysis of AR-RBA performance measures. DHS-BHD will also report on DHCS standard metrics, including service utilization, penetration rates for Specialty and Non-Specialty Mental Health Services, crisis intervention outcomes, suicide and overdose mortality rates, housing stability indicators, and justice system involvement, all of which contribute to statewide analysis. Programs funded through BHSA will report AR-RBA measures addressing three key questions: How much was done? How well

were services delivered? Is anyone better off? These measures ensure that programs are effectively improving the lives of community members. Annual BHSAs are presented publicly and posted on the DHS-BHD website, allowing the community to review BHSAs program impacts and outcomes.

b. Sustainable progress toward racial equity requires ongoing collaboration with communities most affected by behavioral health disparities. As noted previously, DHS-BHD will continue engagement through BHSAs community program planning processes, including the BHSAs Steering Committee, stakeholder meetings, Sonoma County's Life Worth Living Suicide Prevention Alliance, and other events that strengthen community partnerships and relationships. BHSAs is also working collaboratively with our local health jurisdiction on the coordination and implementation of the Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP) to identify key health issues, disparities, and community needs. Through the CHA-CHIP process and other BHSAs analyses, DHS-BHD will continue gathering community input particularly from BIPOC populations and individuals with lived experience. Community needs, gaps, and impact reports are presented at BHSAs meetings and posted on the DHS-BHD webpage for our community to review. These iterative feedback loops help ensure that programs remain responsive to community needs, culturally relevant, and effective, while fostering trust and long-term partnerships.

c. Effective communication is essential to advancing equity. DHS-BHD will continue to host BHSAs stakeholder meetings and community gatherings to present data narratives that contextualize BHSAs findings and highlight both community-level outcomes and individual experiences. DHS-BHD strives to use simple language with Spanish translation/interpretation available if requested, clear and informative visuals, organized presentation materials, and imbed storytelling techniques to make complex data accessible to all stakeholders. These efforts will emphasize how BHSAs programs listed in the BHSAs Integrated Plan reduce disparities, address systemic barriers, and improve outcomes for historically underserved populations.

DHS-BHD strives to deliver culturally and linguistically responsive communications, including Spanish translations where possible and engagement with community media serving BIPOC communities, to ensure accessibility and inclusivity. Through these strategies, DHS-BHD aims to maintain accountability, transparency, and equitable partnerships, while using evaluation and communication as tools to continuously improve BHSAs programs and advance racial equity across Sonoma County.

# OFFICE OF EQUITY (OOE) SUMMARY



The Office of Equity completes this Summary page in collaboration with the department lead. It highlights effective practices that are helping to identify and narrow disparities and outlines key recommendations to further advance equitable community outcomes. This summary is intended to support tracking, implementation, and monitoring of racial equity priorities and community impact more effectively across the county.

## Highlights & Key Actions

Sonoma County's FY 2026–2029 BHSA Integrated Plan reflects a strong and ongoing departmental commitment to equity, demonstrating how the Department of Health Services (DHS) continues to lead the way in identifying and addressing disparities across the county. The plan is intentionally designed to improve behavioral health, well-being, and stability for all residents- particularly for communities that have historically experienced inequitable access to care, including Black, Indigenous, and People of Color (BIPOC), immigrants, rural residents, and low-income populations. It outlines a coordinated, equity-centered approach that integrates mental health services, substance use treatment, and housing supports, prioritizing strategies that reach individuals and families with the greatest needs.

DHS-BHD has embedded racial equity throughout the plan's strategies by expanding access to culturally and linguistically responsive behavioral health services and ensuring resources are directed toward populations experiencing the most severe disparities. A key component of this work is implementing the Anti-Racist Results-Based Accountability (AR-RBA) framework across funded programs, strengthening data-driven decision-making, accountability, and transparency. This approach reinforces the department's commitment to reducing inequities in access, experience, and outcomes.

The Behavioral Health team consistently goes above and beyond to center equity in its internal culture and external partnerships, including deep collaboration with the Health Equity Team, participation in the Equity Circle cohorts, and an ongoing commitment to staff training and capacity building. Notably, DHS-BHD proactively requested and completed an Office of Equity Racial Equity Foundations (REF) training tailored specifically for their division, reaching approximately 80 staff and contractors. This investment supports a shared understanding of how communities in Sonoma County experience inequities and what efforts their department is taking to address them.

Taken together, these efforts demonstrate DHS-BHD's strong leadership in advancing equitable behavioral health outcomes and ensuring that the programs, partnerships, and strategies outlined in the BHSA Integrated Plan are responsive to the needs and experiences of the communities most impacted by disparities.

## Key Recommendations

1. **Headline Recommendation: Continue equitable data practices to track and analyze a comprehensive set of indicators and performance measures to monitor disparity reduction and service improvements across Sonoma County.**

As early adopters of AR-RBA, DHS-BHD will maintain its commitment to equitable data practices by collecting, disaggregating, and analyzing data by race, ethnicity, gender, geography, and other key demographics. Using the Anti-Racist Results-Based Accountability (AR-RBA) framework, DHS-BHD will continue to assess three core questions: *How much did we do? How well did we do it? Is anyone better off?* This approach will help ensure accountability, illuminate disparities, and guide targeted interventions.

DHS-BHD will also continue monitoring whether individuals from historically underserved communities, including Black, Indigenous, and People of Color (BIPOC), immigrants, rural residents, and low-income populations, are accessing behavioral health services at higher or lower rates. Disaggregated data will support more accurate identification of disparities and inform targeted interventions designed to reduce inequities in access, experience, and outcomes across the behavioral health system.

2. **Headline Recommendation: Expand partnerships with culturally specific and community-based providers to strengthen meaningful engagement with community members with lived experience and other key stakeholders, throughout all phases of the BHSI Integrated Plan.**

DHS-BHD has outlined strong plans for ongoing community engagement that center collaboration with individuals with lived experience of behavioral health conditions, substance use, homelessness, and crisis or justice system involvement, as well as community-based organizations and other partners.

Using a design-to-the-margins framework, the Office of Equity (OOE) recommends expanding partnerships and strengthening relationships with culturally specific providers and organizations, especially Black- and Indigenous-led organizations, to deepen collaboration and co-design of strategies that are relevant, culturally responsive, and grounded in community priorities. Their models support community-rooted healing practices, reduce cultural and linguistic barriers, and help strengthen trust.

Continued public meetings, community partnerships, and outreach efforts will help ensure residents understand how the Integrated Plan addresses behavioral health needs, available services, funding priorities, and program outcomes. DHS-BHD should continue providing culturally and linguistically responsive communication, including arranging Spanish translation when possible and partnering with media outlets that serve BIPOC communities. OOE further recommends utilizing translation and interpretation providers who practice culturally responsive, gender-neutral, and asset-based language to promote accessibility, inclusivity, and transparency.

Sonoma County FY2021 Specialty Mental Health Services (SMHS) penetration data revealed significant disparities in access across racial and ethnic groups. Black residents had the highest penetration rate—over 5%—more than double the county average of 2.4%. White residents were slightly above average at roughly 3%, while individuals categorized as “Other Race/Ethnicity” accessed services at about 2.8%. In contrast, Alaska Native or American Indian residents accessed services at lower rates (1.7%), and both Asian/Pacific Islander and Hispanic residents had the lowest penetration rates (around 1%). These disparities underscore the need for intentional outreach and strengthened partnerships with these communities to identify root causes of under- and over-utilization and to support equitable access to quality behavioral health care.

**3. Headline Recommendation: Continue cultivating internal equity practices at DHS-BHD to foster a culture of learning and capacity building.**

DHS-BHD should maintain and expand its internal equity initiatives to foster a sustained culture of learning, accountability, and anti-racist practice. This includes ongoing participation in foundational equity trainings, Anti-Racist Results-Based Accountability (AR-RBA) trainings, and continued partnership and collaboration with the Equity Circle workgroup and Health Equity Team. Investing in staff competencies, such as culturally and linguistically responsive, trauma-informed, and person-centered practices, will strengthen the department’s ability to advance equitable outcomes and implement the BHSA Integrated Plan with fidelity. These internal commitments help ensure that DHS-BHD’s workforce is equipped to address disparities, build trust with the community, and respond effectively to the evolving needs of historically marginalized populations.

Department Head has reviewed the analysis and the OOE Summary:  Yes  No

CEO Analyst has reviewed the analysis and the OOE Summary:  Yes  No

Core Team 2 Lead has reviewed the analysis and the OOE Summary:  Yes  No

**Progress Updates:** To be completed by the OOE 6-12 months after Board item.

**Progress Updates**

Click or tap here to enter text.