California Reducing Disparities Project

Strategic Plan to Reduce Mental Health Disparities

Developed by the California Pan-Ethnic Health Network
In Partnership with the California Reducing Disparities Project Partners

PROPOSITION 63 · MENTAL HEALTH SERVICES ACT · CALIFORNIA

CPEHN
California Pan-Ethnic Health Network

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Chapter 1: Introduction and Background

The Strategic Plan to Reduce Mental Health Disparities was developed between 2012 and 2015 by the California Pan-Ethnic Health Network (CPEHN) in collaboration with the leads of five Strategic Planning Workgroups (SPWs) and the California MHSA Multicultural Coalition (CMMC), collectively known as the California Reducing Disparities Project Partners. The CRDP is funded through the Mental Health Services Act (MHSA, or Proposition 63). The SPWs represent five populations: African Americans, Asians and Pacific Islanders (API), Latinos, Native Americans, and lesbian, gay, bisexual, transgender, queer, and questioning (LGBTQ) communities. Part of the California Reducing Disparities Project (CRDP), the plan was developed to represent the voice of unserved, underserved, and inappropriately served communities, and targets stakeholders involved in California's public mental health system – from the Mental Health Services Oversight and Accountability Commission (MHSOAC) and State agencies to local county departments of mental health and community organizations working on the frontlines. The focus of the strategic plan is to present the recommendations of the five target populations to improve the delivery of prevention and early intervention services for California's unserved, underserved, and inappropriately served communities.

California's Cultural Diversity

California's diversity is one of the state's greatest assets. In neighborhoods across the state, you can hear innumerable languages and see the benefits that come from welcoming so many different, vibrant cultures. Estimates developed by the California Department of Finance using data from the 2010 U.S. Census show that communities of color are the majority in California, with Latinos being the largest group at 39%, Asians at 13.1%, African Americans at 5.7%, and Native Americans and Native Hawaiian/Pacific Islanders both at 1% (see *Figure 1*). Just 30 years ago, the 1980 Census found that communities of color represented slightly over one-third (33.4%) of the state's population.[1] After three decades of steady growth, these communities now represent nearly 60% of all Californians.[2] This trend is likely to continue, as people of color make up nearly three quarters (72.6%) of people under the age of 18 in the state.

Figure 1: California Population by Race/Ethnicity, 2015
California Department of Finance
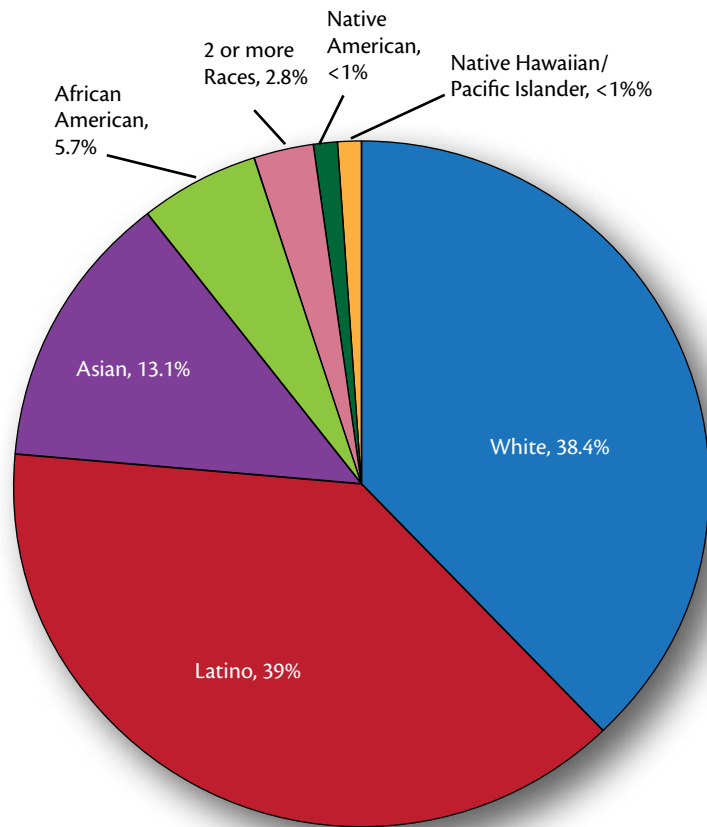
Note: The data in Figure 1 *does not include lesbian, gay, bisexual, transgender, queer, and questioning (LGBTQ) communities who are not included in current statewide or federal data collection systems. In addition, communities of color are often not accurately reported due to racial misclassification and under-reporting. As a result of the way that the Census records race and ethnicity, certain populations (most notably Native Americans) are consistently undercounted. While the Census collects data on a number of different races, Latinos are recorded as an ethnicity. If Latinos were to be included as a racial group, counts for other races would decline. For example, Native Americans identifying ethnically as Latino would be reclassified as Latino rather than Native American. This results in a decreased count of Native Americans from 1% of the population to less than half a percent.*

As California's diversity grows, the State has a responsibility to address inequities in both physical health and mental wellbeing. The five CRDP populations – African American, Latino, Native American, Asian and Pacific Islander, and Lesbian, Gay, Bisexual and Transgender – have historically been challenged in obtaining optimal mental health, despite a mental health system that's expected to provide adequate and appropriate services to all persons, regardless of our race, ethnicity, nativity, gender, age, sexual orientation, or gender identity. In addition, other communities remain underserved, such as the homeless, Limited English Proficient, persons with disabilities, immigrants and refugees, and those living in rural areas. This report is a call to action to move us from a one-size-fits-all approach to one that recognizes and embraces our unique characteristics.

Accessing Mental Health Services in California

According to a study by the UCLA Center for Health Policy Research, over 2 million adults in California, or roughly 8% of the adult population, have mental health needs, meaning they are in need of mental health services due to serious psychological distress and a moderate level of difficulty functioning at home or at work. The study showed that of the 2.2 million adults who report mental health needs, the vast majority received either inadequate treatment or no treatment at all. Responses to the 2007 California Health Interview Survey (CHIS) showed that several factors impact disparities in accessing mental health services, including age, gender, educational attainment, insurance status, race and ethnicity, sexual orientation, nativity, disability status, and English proficiency.[3] See *Appendix 1* for more information.

In addition, other research shows that youth face even more challenges in accessing mental health services. Prior to the Affordable Care Act (ACA), over 70% of youth with mental health needs did not have access to services, even if they have health insurance. This increases to 80% among youth with non-English-speaking parents. Interestingly, of those youth who are receiving mental health services, 70% receive them at school.[4]

Mental Health Disparities in Communities of Color and LGBTQ Communities

Disparities in diagnosis of illness and access to mental health services are found in all races, ethnicities, genders, sexual orientations, gender identities/expressions, and across the lifespan, including transition-age youth, transitional aging adults, and elders. The Population Reports developed by the five SPWs found that the history of racism, bigotry, heterosexism, transphobia, ageism, and other discrimination in the United States is a constant source of stress which can lead to feelings of invalidation, negation, dehumanization, disregard, and disenfranchisement. For some populations, most notably African Americans and Native Americans, laws and policies enacted over the past 400 years have resulted in mental health stressors passing from generation to generation.[5] Discrimination based on language and cultural assimilation adds significant stress in many populations, in particular among Latino and Asian communities. Due to stigma, discrimination, prejudice, and rejection at all levels of society, LGBTQ individuals face added stress every day, and for many, across a lifetime. Efforts are needed to increase cultural understanding on the societal level to help create environments where everyone can live with dignity, respect, and equal rights. For more information on disparities in mental health for the target populations, see *Appendix 2.*

The Landscape of Public Mental Health Services in California

In order to understand the landscape of mental health services in California, it's important to be familiar with the entities and organizations that support the State's public mental health system, which has gone through numerous changes since 2004.

One of the key initiatives to improve Californians' mental and behavioral health began in November 2004, when California voters passed Proposition 63, the Mental Health Services Act (MHSA). The MHSA set a 1% tax on adjusted gross income above $1 million, earmarking those funds to transform the State's public mental health system into one that is more client-and family-driven, culturally and linguistically competent, and recovery-oriented.[6] MHSA funding is divided into five major components:

1. Community Services and Supports
2. Workforce Education and Training (WET)
3. Capital Facilities and Information Technology Needs
4. Innovation
5. Prevention and Early Intervention (PEI)

The CRDP is focused on PEI programs, which emphasize reducing negative outcomes that may result from a lack of timely treatment – including suicide, incarceration, school dropout, unemployment, homelessness, and the removal of children from their home.

The Mental Health Services Oversight and Accountability Commission (MHSOAC) is an independent body that oversees implementation of the MHSA and advises the governor and legislature on mental health policy. Several State agencies oversee the delivery of mental health services in the state, including the Department of Health Care Services (DHCS), the California Department of Public Health (CDPH), the California Department of Education (CDE), the Office of Statewide Health Planning and Development (OSHPD), and the California Mental Health Planning Council (CMHPC).

California's county departments of mental health work closely with State agencies to provide mental health services, and indicate a commitment to reducing disparities, both through the work of county Cultural Competence/Ethnic Service Managers and the development of Cultural Competence Plan Requirements (see *Current State and Local Efforts to Reduce Disparities* on page 8). The majority of the MHSA funding is distributed through county mental health programs. The County Behavioral Health Directors Association of California (CBHDA) represents the mental health directors of California's counties, and the California Mental Health Services Authority (CalMHSA), a joint-powers authority, administers mental health programs at the state, local, and regional level under the direction of its Board of Directors. See *Appendix 3* for a detailed glossary of California public mental health entities.

The Delivery of Public Mental Health Services in California

While counties are responsible for providing the majority of mental health services, the State's behavioral health system has become complicated, with multiple agencies serving overlapping populations. Before 2011, the former California Department of Mental Health (DMH) and Department of Alcohol and Drug Programs administered funding for services at the county level. In addition, DMH administered care in five State-run mental hospitals and for the California Department of Corrections and Rehabilitation, which also provided in-patient care for inmates who suffer from mental illness. The Community Services Division of the DMH oversaw county community-based mental health services and was responsible for distributing MHSA funds.

AB 100 (Committee on Budget), which passed in the 2010-11 legislative session, realigned implementation and administration of the MHSA from the State to the local level. Without State oversight, implementation of MHSA programs can vary widely depending on the county. While many counties have made considerable efforts to reach out to unserved, underserved, and inappropriately served and vulnerable communities for stakeholder input, many others have not kept these populations engaged.[7] In order for this realignment to be successful, each county must make community engagement and inclusivity a priority through a robust stakeholder engagement process.

> *"We need to focus on strategies that empower community groups at the local level...to grow and change according to their needs and priorities."*
> *   - Latino Community Member*

More recently, we have continued to see a shift in the role of the State in mental health services. On July 1, 2012, the former DMH transitioned many of its functions related to community mental health to DHCS, and a new Department of State Hospitals was created to oversee the administration of California's state hospitals, part of Governor Jerry Brown's plan to shift oversight of community mental health services to the local level.

As part of this transition, many of the services formerly under DMH are now under the purview of other State departments and counties. Many have moved to the DHCS, including support and review of the Cultural Competence Plan Updates, Mental Health Rehabilitation Centers and Psychiatric Health Facilities licensing, the Office of Suicide Prevention, Veterans Mental Health, and several other MHSA programs. The Office of Multicultural Services, which included the CRDP, has moved to the new Office of Health Equity in the California Department of Public Health (CDPH).

In addition, the MHSA Workforce Education and Training program is now at the Office of Statewide Health Planning and Development (see *Workforce Education and Training* on page 10).

Current State and Local Efforts to Reduce Disparities

Efforts to reduce disparities in mental health are already underway, and the importance of this issue cannot be understated. In the summer of 2011, the State held community meetings across the state to gather input from hundreds of mental health stakeholders – clients, family members, health care providers, county representatives, local and state level client groups, and county organizations – about changes to state-level mental health functions resulting from AB 100. Reducing disparities emerged as a priority.[8]

Several programs and initiatives, at both the state and local levels, have been implemented to improve the public mental health system in California. These programs and initiatives include:

California Institute for Behavioral Health Solutions (CiBHS) Programs: A nonprofit agency, CiBHS provides leadership and support to State and county public behavioral health systems and their partners to create positive outcomes for all ethnic, linguistic, and cultural communities, and other unserved, underserved, and inappropriately served populations. CiBHS works with county, state, and national organizations; academic/ research organizations; and foundations to document, address, reduce, or eliminate disparities. It focuses on translating and bridging the gap between research and implementation in local systems of care and supporting the development and study of effective practices.

CBHDA Cultural Competency, Equity & Social Justice Committee (CCESJC): One of 14 committees of the county behavioral health directors, the CCESJC was formed from the merger of the former Ethnic Services and Social Justice Advisory committees. The committee moves forward policies and recommendations within CBHDA to advance multicultural services and reduce disparities using a social justice lens. It also plans Regional Cultural Competence and Mental Health Summits to advance culturally and linguistically appropriate practices in serving unserved, underserved, and inappropriately served cultural, racial, and ethnic communities across the lifespan.

County Cultural Competence Plan Requirements (CCPRs): An initiative to reduce disparities, each county must develop and submit to the Department of Health Care Services a cultural competence plan for the county public mental health system, including Medi-Cal services, MHSA programs, and realignment. These plans aim to develop culturally and linguistically competent programs and services to meet the needs of California's diverse racial, ethnic, and cultural communities in the public mental health system of care. While it is assumed that LGBTQ is included in "cultural communities" in the CCPRs, it is not explicitly stated, and should be included. The CCPR set forth by the State are based on the U.S. Department of Health and Human Services' *National Standards for Culturally and Linguistically Appropriate Services in Health Care* (CLAS). The requirements also incorporate eight domains that provide the framework for criteria to assist counties in identifying and addressing disparities across the entire public mental health system, including:

1. Commitment to cultural competence
2. Updated assessment of service needs
3. Strategies and efforts for reducing racial, ethnic, cultural, and linguistic mental health disparities
4. Client/family member/community committee
5. Culturally competent training activities
6. County's commitment to growing a multicultural workforce
7. Language capacity
8. Adaptation of services

Counties have not submitted updated cultural competency plans to the State since 2010; DHCS is currently updating the CCPRs with input from counties and other community stakeholders.

Cultural Competence/Ethnic Service Managers (CC/ESM): Established in 1989 by the predecessor to CBHDA (the California Conference of Local Mental Health Directors), the CC/ESMs are county staff responsible for ensuring that their county meets cultural and linguistic competence standards in the delivery of community-based mental health services, including Medi-Cal specialty mental health services, and Mental Health Services Act services. They are the liaison between the county and key cultural groups in their communities. CC/ESMs also take the lead for developing, implementing, and monitoring cultural and linguistic competence activities in the county; identifying the mental health needs of ethnically and culturally diverse populations; tracking penetration and retention rates of diverse populations; maintaining relationships with clients and family members; and working with county partners to ensure the workforce is ethnically, culturally, and linguistically diverse. As this is an important function, ESMs should remain an integral part of the mental and health care delivery system.

MHSOAC Cultural and Linguistic Competence Committee (CLCC): One of five committees of the MHSOAC, the CLCC works to ensure that all MHSOAC decisions and recommendations consider the perspective and participation of individuals, parents, caregivers, and families across the lifespan, representing diverse racial, ethnic, LGBTQ, and other cultural communities. The CLCC reviews MHSOAC processes and provides recommendations on how the Commission can foster meaningful participation from these communities, how the MHSA reduces disparities and improves outcomes in these communities, and organizes activities to increase learning related to cultural and linguistic competence. The MHSOAC also hosts several community forums each year to reach diverse stakeholders and explore avenues to reduce disparities.

Workforce Education and Training (WET): Another initiative, and one of the five components of the MHSA, the WET program is designed to address the serious shortage of mental health service providers in California. Before the MHSA, California faced a shortage of public mental health workers, and the public mental health system has historically suffered from a lack of diversity, poor distribution of existing mental health workers, and the under-representation of individuals with client and family member experience in services and supports. Successful parts of the program have included the Mental Health Loan Assumption Program, which aims to retain qualified mental health professionals working within the public mental health system; stipend programs for graduate students who plan to work in the public mental health system; and regional partnerships and county-level efforts to promote and develop the local workforce.

These efforts represent a good starting point in the fight to reduce mental health disparities in California. However, given the significance of existing disparities and the overarching goal to address the needs of underserved populations, the State should pursue additional approaches to build on the progress made by these programs and initiatives.

It should be noted that many of these entities do not explicitly mention LGBTQ communities as populations that they address.

The California Reducing Disparities Project

In response to former U.S. Surgeon General David Satcher's call for national action to reduce mental health disparities, the former DMH, in partnership with the MHSOAC, and in coordination with the CBHDA and the CMHPC, created a statewide policy initiative to identify solutions for historically unserved, underserved, and inappropriately served communities. In 2009, DMH launched a statewide PEI effort, the California Reducing Disparities Project, which focused on five populations, including African Americans; Asians and Pacific Islanders (API); Latinos; Lesbian, Gay, Bisexual, Transgender, Queer, and Questioning (LGBTQ) communities; and Native Americans. In addition, a statewide coalition, the California MHSA Multicultural Coalition (CMMC), was also funded to provide a voice on statewide advocacy efforts for these populations and others, including Arabic-speaking, Russian-speaking, Armenian, and the Deaf and Hard of Hearing community, among others.

The CRDP seeks to move away from "business as usual" and provide a truly community-focused approach to reducing disparities. The CRDP is divided into two phases. Phase I focused on developing strategies to transform the public mental health system and identifying community-based promising practices in each of the five targeted populations. Phase II focused on funding and evaluating the promising practices identified in Phase I, as well as advancing the strategies outlined in this plan. There has not been a project of this scope before – one that recognizes and elevates community practices and identifies strategies for systems change. Throughout this process, California will present this work nationally so that other states can learn from our efforts.

Chapter 2: Community Assets to Reduce Disparities

Communities of color have a number of assets that form the foundation for a community-based system of services that meets the mental health needs of all Californians. Community resiliency is developed when families, friends, churches, schools, and community groups work together to strengthen both individuals and communities. Individuals with strong ties to their community are more likely to increase their resilience, develop a positive cultural identity, and form networks. For example, African American children and adolescents may confront negative stereotypes in the wider culture, but if parents, peers, and other important adults counter these messages, youth are less likely to have negative outcomes and more likely to be resilient in adverse conditions.[9]

In many unserved, underserved, and inappropriately served communities, family involvement is also key to improving mental health outcomes. Many people of color who have actively sought mental health treatment or had a family member looking for help have described the significant role that family plays in recovery. For example, participants in the Latino SPW focus groups thought it would be helpful if individuals from families who've experienced successes in mental health treatment could share their experiences, knowledge, and skills with other families going through similar challenges.[10] Conversely, family rejection and rejection by communities of faith play a large role in the mental health challenges faced by LGBTQ youth and young adults. LGBTQ youth who report high levels of family rejection are more likely to attempt suicide, experience depression, and use illegal drugs.[11] Community resources, such as school-based mental health

programs and faith-based programs, can help fill the gap in the mental health needs of the unserved, underserved, and inappropriately served. However, community resources alone are not enough, and efforts must be made to educate parents on how rejection due to sexual orientation and/or gender identity impacts the mental health of their children and other family members.

A community draws strength from its culture, heritage, and traditions. Among youth, we are starting to see a cultural revival – an increased sense of belonging and a pride in the family's roots. Some innovative programs are fusing cultural activities with mental health services and programs. For the elderly, this can be dignifying. For instance, the Hmong Community Garden in Fresno introduces the community to mental health services that they might not otherwise seek in a culturally and linguistically competent manner. Gardeners and their families are encouraged to attend workshops each month that include information about mental illnesses and resources available within the community. This program has proven to lower thoughts of suicide in participants.[12] In Native American communities, spiritual healers and traditional medicine men and women hold a very important place in the community. While methods vary from tribe to tribe, all communities respect the role of the healer, a trusted source of care in the community, and any approaches to promote mental health should take into account their importance.[13] Latino communities emphasized the use of "*platicas*" or meaningful conversations, in support groups, which provided hope and inspiration when they included people with similar experiences and/or testimonials of Latino clients with successful recovery stories.[14] It's vital to integrate LGBTQ individuals into cultural practices where they will feel accepted and affirmed, as well as integrating cultural practices into LGBTQ-specific services. For instance, ensuring compliance with California's FAIR Education Act can help connect LGBTQ youth to historical and positive portrayals of their identities through an inclusive school curriculum, community events, and media. African Americans have rich cultural traditions and practices that foster resiliency, engender hope and avert depression. Among them are spiritual, faith, and belief guidance; family connectedness; positive racial identity; and participating in intergenerational community activities with storytelling. The Rites of Passage Program at the DuBois Institute in Riverside County embodies these African American cultural traditions.[15]

Building on Strengths to Reduce Barriers

A number of innovative approaches capitalize on these community assets to increase access to mental health services. By addressing barriers – stigma, discrimination, language, insurance status, social and environmental conditions, quality of care, and lack of appropriate data collection – California can create a comprehensive system of services that strives to improve mental health outcomes across race, ethnicity, nativity, gender, sexual orientation, gender identity/expression, disability, and age. While many community organizations have implemented innovative and successful prevention and early intervention programs, more broad-based support is required to sustain and expand these models, and adapt them to serve other underserved populations, such as the homeless and rural populations. Throughout this section, the plan highlights several barriers, with a few examples taken from the five Population Reports of communities using their assets to address these issues.

Reducing Stigma

Due to its many manifestations, stigma is a major barrier to seeking mental health services. Reducing the stigma around having mental health needs or receiving mental health services must be a top priority. In order to effectively treat individuals with mental health needs, the system must provide safe and welcoming environments that encourage clients to ask for help. Culturally and linguistically appropriate outreach and education can help confront attitudes and beliefs about mental illness and cultural prohibitions against talking about mental health. Effecting cultural change can be an extremely difficult, slow-moving process, but by transforming perceptions of mental health and reducing the stigma associated with it, these promising practices can ease common fears, such as the belief that a person seeking mental health services will be perceived as weak. For examples of community assets and considerations to address stigma, see *Appendix 4.*

Addressing Discrimination and Social Exclusion

All five of the population groups, as well as other underserved communities, face discrimination. This has not only compounded the stigma of having mental health issues, but also exacerbated it. Embracing culture and strengthening identity can help diminish the impact of historical discrimination on communities of color. LGBTQ individuals not only have to deal with discrimination due to their sexual orientation or gender identity/expression, but may also have to confront bigotry and prejudice based on their race or ethnicity, or face exclusion from their racial/ethnic community. Social exclusion – the process by which individuals and groups of people are wholly or partly barred from participation in social activities – was also a major issue in the Population Reports. In this process, some individuals, due to their background, life experiences, or circumstances, are denied access to society's resources, resulting in poor living conditions, physical and mental health problems, and other interrelated issues. For Latino youth, feeling excluded from the larger society in general and disconnected from the Latino community was associated with increased substance abuse and other risky behaviors that can lead to mental health problems.[16] African American experiences of endemic intergenerational societal micro-aggressions (especially related to skin color and other physical features) engender discrimination, exclusion, and hostile responses, which perpetuates a "post traumatic slavery disorder." This creates stress-related problems which increase the risk of both mental and physical illnesses.[17] In order to treat the effects of discrimination and social exclusion, the public mental health system must be equipped and providers trained to deal with the mental health concerns of these populations. Too often the system itself is rooted in racist, sexist, and homophobic practices. For example, historical trauma has deeply impacted African American and Native American cultures, which has greatly affected mental health. Strengthening cultural identity is a key way to counter this exclusion and discrimination while promoting wellness. Communities should be supported in efforts to revive or sustain cultural traditions/practices, languages, and ceremonies to address the loss of culture and improve wellness. See *Appendix 5* for more community assets and considerations to address discrimination and social exclusion.

> *"Learning about our tribal history was one of the most healing things I've done, my cultural learning has brought me to a good place."*
> *-Native American Community Member*

Removing Language Barriers

While California leads the nation in providing linguistic access to health care, many in our communities still lack access to linguistically appropriate services, which creates a barrier for many underserved individuals with mental health needs. Without appropriate outreach and education, language barriers can deter many individuals from seeking treatment either because they do not know where to go or they feel they would not be able to adequately communicate with their providers. Translated outreach materials that take into account cultural attitudes, literacy levels, and other key factors can be useful in educating clients and the community about available services. Ethnic and LGBTQ media outlets, including newspapers, radio, and television, can effectively reach large audiences in their preferred language.

Reports from all populations indicated that once they access services, individuals experiencing mental health issues often have a hard time talking about them, so it's important to create an environment where people feel comfortable. In addition to receiving services in their primary language, supportive staff must understand and respect cultural differences. For example, bilingual staff who are not trained interpreters often don't have adequate proficiency in both languages to interpret.[18] To receive appropriate services, clients must be able to fully communicate with their provider. Interpretation services can also be helpful, but both providers and interpreters must be trained on how to manage an interpreted encounter, including cultural nuances. In order to deliver quality care to clients, interpreters and providers must be trained on not only the language of the populations they're serving, but also on mental health issues and cultural considerations. An interpreter should be aware of the country or culture's history, recent events affecting the population, and any associated historical trauma. Understanding gender and generational roles will also help build trust with a client or families. In particular, interpreters must be able to interpret seamlessly; clients often associate the quality of care they receive with the skill of the interpreters. For example, if the interpreter is ineffective at communicating the client's needs to the provider and vice versa, the client could leave without having their condition appropriately addressed.

To address language barriers, providers can leverage the client's culture and community assets so that he or she feels acknowledged and validated. For example, in the Latino community, a *fotonovela*, a culturally informed health literacy media tool that presents information in a familiar, readable, and entertaining format, can help increase client understanding. See *Appendix 6* for more community assets and considerations to address language barriers.

Expanding Health Care Coverage

Cost of treatment is a significant barrier in mental health.[19] While opinions differ on whether insurance status is directly related to accessing mental health care, the fact remains that many people of color and low-income individuals are likely to be uninsured.

The Affordable Care Act (ACA) has tremendously increased access to, and improved coverage of, Medicaid mental health services in California by expanding the array of "non-specialty" mental health services that are included in the essential health benefits package. Communities of color represented 75% of the state's 7 million who were formerly uninsured. It is unclear how many LGBTQ individuals in California lack health coverage, because reliable information is not currently being collected. One limited study estimates that lesbian and gay (17%), and bisexual (24%) individuals also lacked coverage at high rates, with transgender individuals at even higher rates.[20] Through the expansion of public coverage programs, over five million Californians gained access to coverage, including over four million who are covered by the expansion of Medi-Cal and over one million who are able to purchase coverage through Covered California, the state's insurance marketplace, using a federal subsidy. The ACA also expanded mental health benefits to those enrolled in Medi-Cal and the commercial market. Mental health and substance use disorder services are one of the ten essential health benefits that must be covered by plans participating in Medi-Cal Managed Care and Covered California. The ACA also requires that these plans offer rehabilitative services and prescription drugs. (For more on mental health and the ACA, see *Appendix 12*.) California should continue to rigorously defend the ACA and look for opportunities to expand coverage to the remaining uninsured.

A number of community efforts aim to improve access to mental health services. For example, in San Francisco, Communities United Against Violence (CUAV) provides accessible violence reduction and mental health services to low- and no-income individuals. Through their Wellness Wednesdays program, CUAV offers support to low-income LGBTQ people of color around issues of domestic violence, hate violence, and police violence. See *Appendix 7* for more community assets and considerations to address a lack of insurance.

Improving Social and Environmental Conditions

Good health is also grounded in a strong social and economic foundation that allows people to play a meaningful role in the social, economic, and cultural life of their communities. In addition, our natural and built environments have a tremendous impact on health. Determinants of health include income, poverty, employment, education, housing, transportation, air quality, and community safety, and these hugely influence the physical and mental wellbeing of community members. As a result, health disparities tend to reflect the underlying social and economic inequalities in society.

a katz / Shutterstock.com

Unserved, underserved, inappropriately served, and marginalized populations, including LGBTQ and many communities of color, often are not able to participate in the social and economic fabric of society, which can result in negative health outcomes. For example, the life expectancy of individuals who drop out of high school (willingly or unwillingly) is 10 years shorter than those with a college degree.[21] These communities are also more likely to live in areas that are unsafe, which can have a negative impact on their mental health. According to the California Health Interview Survey, over half of the youth of color in California do not feel their nearest park or playground is safe at night, compared to just 40% of Whites.[22] Many people of color and LGBTQ people feel

unsafe in their communities, which is correlated with increased levels of psychological distress. For example, African Americans, Asians and Pacific Islanders, Latinos, and Native Americans who feel unsafe in their neighborhoods are more likely to report psychological distress than those who feel safe.[23] (For more on social and environmental indicators and mental health, see *Appendix 13*.)

Transportation to appointments and hours of operation of providers can be significant barriers. For example, in Asian, Pacific Islander, and Latino communities, limited office hours and a lack of transportation have deterred many community members from accessing services. To address these barriers, providers need to adopt more flexible and expanded office hours and provide transportation assistance, particularly in rural communities that lack a public transit infrastructure. See *Appendix 8* for more community assets and considerations to address social and environmental conditions.

Increasing Quality of Care and Satisfaction

Even after entering treatment, many people of color and LGBTQ individuals may remain unsatisfied with the quality of care. This dissatisfaction may stem from negative experiences, culturally and linguistically inappropriate care, unawareness and insensitivity, and lack of language services. The Institute of Medicine has defined care quality as "the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge."[24] Client satisfaction can tremendously impact outcomes in physical and mental health. Embracing culture and engaging the community in outreach efforts and treatment strategies can build the trust necessary to improve health outcomes. Additionally, language barriers, particularly for limited-English proficient populations, impact the perception of care quality (see *Removing Language Barriers* on page 15). Offering services only in a clinical setting might not always produce the best results. For group-oriented cultures like many Native American communities, group-based or community-oriented interventions are often effective, more accepted, and many times more appropriate. As widely documented in psychosocial literature, some of the protective factors embedded in Native American culture include belonging, feeling significant, and having a supportive social network of family and community members who serve as counselors, mentors, and friends.[25] See *Appendix 9* for more community assets and considerations to address quality of care and satisfaction.

Enhancing Data Collection

One of the greatest challenges faced by many communities is the lack of data on their specific populations. Even though individuals within communities of color and LGBTQ communities in California share some similarities, there are also significant differences in terms of culture, language, religion, history, and available resources. Treating all members of these communities as though they have a common life experience overlooks the unique and different needs of each population. For Native American communities in particular, racial misclassification and historical undercounts confound efforts to accurately represent this population. The U.S. Census consistently undercounts Native Americans, and this issue is compounded by current political complexities around who can claim Native American heritage. Native Americans are also misclassified into other racial categories by local, regional and statewide databases. For Asian and Pacific Islander communities, the need for disaggregation of data is key in identifying disparities. In response to this need, California passed into law the AHEAD Act (AB 1726, 2016,

Chapter 607), which requires state agencies to disaggregate demographic data for certain Asian and Pacific Islander populations by 2020.

The lack of data collection and research is particularly challenging for LGBTQ communities. LGBTQ communities are incredibly complex, with each population having its own needs as well as its own issues of diversity. A number of factors affect how an individual experiences their sexual orientation or gender identity/expression, including age, gender, sex assigned at birth, socioeconomic status, education, differences in abilities, religious upbringing, and ethnic and racial background. Data collection and analysis should not be predicated solely on the assumption that LGBTQ individuals will self-identify on intake forms or in interviews. CHIS, which is considered a comprehensive source of health research and information in the state, has made strides toward including more populations, but the State needs better data about these subpopulations in order to adequately understand and address mental health needs and disparities within this community. For example, CHIS only collects sexual orientation data on ages 18-70 and does not collect gender identity at all. Some providers refuse to collect sexual orientation and gender identity data. According to the LGBTQ Population Report released in 2012, only 29% of providers ask about sexual orientation and only 26% surveyed ask about gender identity. As we design new systems, we must pay attention to the need for anonymity among many LGBTQ individuals.[26] See *Appendix 10* for more community assets and considerations to address a lack of appropriate data collection.

Additional Approaches to Reduce Disparities in Mental Health
Our communities have been building capacity to reduce disparities in many ways. Local organizations rooted in LGBTQ, racial, and ethnic communities know their community members well, and have developed innovative ways to address the many issues that friends, family members, and clients face daily. (Some work directly with county departments of mental health; others work independently within the community.) See *Appendix 11* for some additional promising practices to reduce disparities. Many more of these practices can be found in the five Population Reports, which are available at the following link: https://www.cdph.ca.gov/Programs/OHE/Pages/CRDP.aspx

These promising practices are taking place at the community level, and need continued support to address mental health needs in unserved, underserved, and inappropriately served communities. But these practices must also be recognized and validated so that they are eligible for sustained funding.

The findings from the Strategic Planning Workgroups demonstrate how local, grassroots organizations in communities of color and LGBTQ communities are increasing access to care, broadening the definition of mental and behavioral wellbeing, and building community capacity.

Chapter 3: Community Plan to Reduce Disparities in Mental Health

Prevention and early intervention (PEI) programs emphasize strategies to reduce negative outcomes that may result from untreated mental illness, such as suicide, incarcerations, school failure or dropout, unemployment, prolonged suffering, homelessness, and removal of children from their homes. California's historic commitment to prevention and early intervention through the Mental Health Services Act (MHSA) moves the mental health system towards a help-first instead of a fail-first strategy. PEI identifies individuals at risk of or indicating early signs of mental illness or emotional distress and links them to treatment and other resources. PEI creates partnerships with schools, justice systems, primary care, and a wide range of social services and community groups and locates services in convenient places where people go for other routine activities.

The *Strategic Plan to Reduce Mental Health Disparities,* developed by CPEHN in collaboration with the California Reducing Disparities Project (CRDP) Partners, focuses on prevention and early intervention. It includes 27 community-identified strategies for transforming the California public mental health system into one that better meets the needs of unserved, underserved, and inappropriately served communities in the state. The strategic plan focuses on representing the authentic voices of the community, with the majority of the long-term strategies aimed at State and local policymakers. These strategies will require an investment of time and resources to accomplish; the CRDP Partners see this strategic plan as a first step in this process, and recommend that all parties – community members and policymakers – work together to collaboratively develop a plan for moving forward.

Purpose of the Strategic Plan

The groundbreaking CRDP statewide strategic plan aims to provide community-driven direction to transform California's public mental health system and reduce disparities in racial, ethnic, and LGBTQ communities. This strategic plan incorporates a two-pronged approach to reducing disparities through prevention and early intervention initiatives:

- Identifying culturally and linguistically appropriate strategies to improve access, services, and outcomes for unserved, underserved, and inappropriately served populations.
- Providing guidance to the State as it develops the solicitations for Phase II of the CRDP, including recommendations to ensure that the pilot programs chosen for funding will be rooted in the community and are evaluated and validated so that they are defined as evidence-based practices.

Since the passage of the MHSA in 2004, there have been efforts to improve the health of LGBTQ communities and communities of color at the state and local levels. Many partners – including the former California Department of Mental Health (DMH), the Mental Health Services Oversight and Accountability Commission (MHSOAC), the county departments of mental health, and community organizations – have worked

hand-in-hand to improve the wellbeing of unserved, underserved, and inappropriately served communities. Yet disparities remain. The CRDP aims to look deeper and explore three overarching questions:

- What strategies for increasing mental health treatment participation are working in unserved, underserved, and inappropriately served communities?
- What community activities are helping to reduce mental health disparities and keeping our communities healthy?
- What can policymakers do to support local community efforts to reduce individual and community barriers to mental health services?

While this strategic plan is a roadmap to transform the public mental health system into one that better meets the behavioral health needs of all Californians, Phase I is just the first mile of the journey. California is deciding which roads to take and who should be behind the wheel. We envision a more diverse workforce, more culturally and linguistically competent services, more collaborative partners, more resilient communities, and increased equity.

The eyes of the nation are on California and this effort. Numerous CRDP Partners have been asked to share their work at a national level. As this strategic plan is implemented across California, the State needs to share the findings and recommended strategies to influence federal systems. The system is changing, and will continue to change as the health care delivery system transforms. This strategic plan is not the end of this process, but the beginning of a new and necessary dialogue. For more on the strategic planning process, see *Appendix 14.*

Recommended Actions to Reduce Disparities in Mental Health

This strategic plan highlights recommended actions to reduce disparities in mental health, organized into overarching themes, goals, and strategies. The four overarching themes should be considered in every goal and strategy for every population, and should be addressed at the state, county, and local levels. The five goals will move us toward a system where all communities – not just the five that are the focus of this project – are afforded quality, accessible, and culturally and linguistically appropriate prevention and early intervention services within the context of an engaged and empowered community. The goals are accompanied by 27 strategies that provide specific recommendations for moving forward.

The themes, goals, and strategies highlight opportunities to reduce mental health disparities at the policy level, and should be implemented and incorporated into Phase II of the CRDP and the public mental health system, including all MHSA-funded programs and components. It is important to note that this strategic plan represents a snapshot in time. This is an evolving body of work, and the efforts of the five strategic planning workgroups are only the beginning of what will be a challenging effort to reduce disparities.

The strategic plan and the five Population Reports emphasize the importance of cultural revival among the population groups. Enhancing mental health prevention services with a strong cultural context is an essential component of comprehensive care. For instance, in the Latino community, local health workers, or *promotoras/es*, are a trusted source of care and can be an effective bridge into mental health treatment. For Native

Americans, spiritual healers and traditional medicine men and women hold important places within society. In Asian and Pacific Islander communities, the inclusion of family members in treatment can help reduce stigma about mental health conditions. For African Americans, recognizing the impact of historical trauma within a cultural context contributes to effective treatment. And finally, work must be done across populations to affirm LGBTQ individuals, and within the mainstream LGBTQ population, to incorporate cultural and linguistic competence in services, since LGBTQ individuals come from all races, ethnicities, cultures, and backgrounds.

The following themes, goals, and strategies come from the five Population Reports and represent the voice of diverse unserved, underserved, and inappropriately served communities who participated in an extensive stakeholder process the past three years. While the CRDP Partners led the process for identifying and developing the themes, goals, and strategies, in many ways, these community members wrote this report. A number of the strategies appear in all five reports, and a few appear in only one or two, but all were prioritized for inclusion by the CRDP Partners because of their applicability to the five populations and other underserved populations. The CRDP Partners as a whole recommend these actions, and hold State agencies, departments, and policymaking bodies, as well as county departments of mental health, responsible for their implementation. These strategies build on recommendations in the Population Reports that hold State and local entities accountable for improving the health and wellbeing of these populations.[27,28,29] Their implementation will take the full commitment of every stakeholder – advocates, policymakers, clients, and family members – to achieve. We recognize that the types of structural and policy changes recommended in this strategic plan will take several years to achieve – and along with time and commitment to see it through, resources and support are necessary to achieve true equity. The CRDP Partners hope that these themes, goals, and strategies lead to a system that embraces culture and community and affirms all sexual orientations, gender identities, and gender expressions. This is fundamental to reducing mental health disparities.

"Our parishioners come to us for help. We have a responsibility to help them. Our biggest need is for community mental health resources to help our people get the right assistance they need."
- African American Community Member

Overarching Themes

In order to address disparities in California, policymakers must address the following four overarching issues: cultural and linguistic competence, capacity building, data collection, and the social and environmental factors that impact health. These issues were identified and highlighted in all five Population Reports. State agencies, including the Health and Human Services Agency, Department of Health Care Services (DHCS), California Department of Public Health (CDPH), and the MHSOAC; the State legislature; and county departments of mental health and their contractors, should prioritize these issues to reduce disparities in unserved, underserved, and inappropriately served communities at every level and in all MHSA-related programs.

Whether we are providing services, recruiting and training the workforce, or implementing prevention activities, cultural and linguistic competence must be at the forefront of our planning: are outreach activities culturally and linguistically appropriate? Are flyers and intake forms in the right language and inclusive of sexual orientation and gender identity? Capacity building must also be a key consideration: do community

organizations have the tools they need to successfully implement these programs? Do State agencies understand the needs of the community organizations with whom they're working? In order to be able to have a sense of disparities and develop the solutions to overcome them, data collection that informs decisions is critical. Disparities could be exacerbated when incomplete data leads agencies to eliminate or reduce critical services to some populations that actually have high need. Finally, if the underlying issues that lead to disparities – everything from jobs, education, and income to the neighborhoods we call home – are not addressed, the challenge of reducing disparities will only grow.

Address and Incorporate Cultural, Linguistic, and LGBTQ Competence at All Levels

A comprehensive approach to cultural, linguistic, and LGBTQ competence is vital for improving mental health in these five populations and other underserved groups. At its core, a culturally competent health care system is one that provides care to client

with diverse values, beliefs, and behaviors, and tailors services to meet clients' social, cultural, and linguistic needs. Cultural competence is an ongoing process that evolves over time as we gain experience and knowledge of the cultures and communities around us. At the systems level, this approach should build upon the work of county Cultural Competence/Ethnic Services Managers (CC/ESMs) and the Cultural Competence Plan Requirements (CCPRs). The CCPRs help to ensure that eligible beneficiaries receive timely access

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to specialty mental health services through culturally competent best practices. Here are eight concrete ways county departments of mental health, their contractors, and their staff can implement culturally and linguistically appropriate community outreach and engagement efforts:

- Counties and providers should employ culturally and linguistically appropriate community outreach and engagement in order to improve accessibility, availability, affordability, and advocacy of mental health issues in each community.

- Within a cultural context, care providers must focus on early identification and accurate assessment of mental health needs in order to change the course of mental illness in unserved, underserved, and inappropriately served communities.

- To provide culturally and linguistically appropriate services, agencies and care providers should collaborate with community organizations and Native American tribes that have the expertise, staffing, and programs needed to effectively engage their respective populations. Resources should be allocated to develop these relationships.

- Trainings should include cultural knowledge gained through real-life interactions with communities and mental health clients. This will improve county mental health and support staff's understanding of issues related to racism, sexism, heterosexism, and ageism.

- Cultural competency standards used in California – including the Culturally and Linguistically Appropriate Services (CLAS) standards developed by the

U.S. Department of Health and Human Services – should be updated for the state and build upon county cultural competence plan requirements to include cultural and linguistic competency for all underserved populations, including LGBTQ communities. Without standards of care and training, many LGBTQ clients will experience the same harassment, discrimination, or invalidation that they experience elsewhere in society. This may not only harm LGBTQ clients, but decrease rates of program enrollment, engagement, and retention, as well as diminish positive outcomes.

- Cross-cultural competency training (across racial, ethnic, and LGBTQ communities) should be prioritized in order to address issues that arise from the intersection of identities. For instance, an LGBTQ individual is never only LGBTQ, but also identifies as a particular race or ethnicity. Each of those intersecting identities needs to be cared for.

- A wide range of fields and professions beyond health care should receive cultural competence training, including city and county social service staff, educators and school administrators, and police officers and other emergency responders. Ideally, cultural competence would be integrated as a part of all post-secondary education to develop a more culturally-competent workforce in the health care system and beyond.

- Considerations should be provided to those working with other groups with diverse needs, including rural communities with limited access to providers, training, and services; veterans, particularly those with post-traumatic stress disorder who default to receiving services from the very system that contributed to their conditions; and homeless populations who have limited access services on a regular basis.

Along with cultural competence, we need to embrace the concept of cultural humility, which acknowledges the fact that we can never be truly competent on the cultural values, beliefs, and behaviors that are necessary to serve our communities. We must instead engage in a process of lifetime learning to ensure appropriate service delivery.

Implement Capacity Building at All Levels

The State should use a portion of available resources for capacity building for community organizations on outreach and engagement, leadership, community participation in decision-making, and resource development and sustainability. Capacity building should also help community organizations apply for funds, conduct the work, and evaluate the outcomes of disparities reduction initiatives. Capacity building should focus on developing partnerships between mental health professionals and local community leaders to collaboratively implement effective approaches and continue to work together to improve mental health outcomes for underserved populations.

Special considerations must be extended to those working with other underserved populations within the five target populations, including transition age youth and older adults, homeless, people with disabilities, veterans, and those living in rural areas with limited access to services.

In addition, the State should also make available resources for capacity building for State departments and agencies, county departments of mental health, and any other relevant partners at the systems level. This will enable these agencies to work more closely with and understand the unique needs of local, community, and grassroots organizations with limited capacity. It is through this type of bridge building, capacity building and

relationship building that we can develop ongoing partnerships to support sustainable, ongoing, community-defined promising practices beyond Phase II.

Improve Data Collection Standards at All Levels

The State should make improvements to policy and systems to ensure appropriate data collection, disaggregation, analysis, and reporting for all underserved populations at the state, county, and local levels to help identify disparities and develop strategies to address them. In particular, for diverse communities of color and LGBTQ communities,

disaggregated data is necessary to identify disparities within subgroups of each population. Asians and Pacific Islanders are often grouped together as one community, but these populations, and their subpopulations, differ greatly in demographics, health status, and outcomes. Forms and other data collection tools at the state and county levels should allow Asian and Pacific Islanders to select subpopulations. A recent change in state law, AB 1726 (Statutes of 2016, Chapter 607) requires the Department of Public Health, Center for Health Statistic and Information to provide this information and make these changes by January 1, 2022.

Measures for race, ethnicity, culture, language preference, and age should be developed for data collection and reported at the state and county levels. Data on LGBTQ communities is often not collected at all. Standardization of sexual orientation and gender identity measures across the lifespan should also be developed and reported at the state and county levels. Finally, it is important to disaggregate data by gender so that we are able to identify any disparities along gender lines and develop ways to address them.

We need uniformity in data collection across systems and agencies to ensure that we collect the same data and minimize the necessity to collect it at multiple times across the span of service delivery. Collecting, disaggregating, analyzing, and reporting data for these populations will give us a much clearer picture of the inequities they face and the potential for addressing them.

Address the Social and Environmental Determinants of Health

In order to effectively reduce disparities, we must address the social and environmental factors that impact the daily lives of Californians. Socioeconomic status is a fundamental factor in Californians' health. Education, employment, and income all combine to directly influence access to both social and economic resources: a better education leads to a better job, and a better job leads to a higher income. Higher incomes relieve the stress of having to decide between seeking services and putting food on the table for your family.[30] These are some of the key factors that impact health and mental health, and they are a primary cause of California's health inequities.

In addition to socioeconomic factors, the environment also shapes our communities' health. Everything from the quality of the air people breathe to how safe one feels in one's community impacts the wellbeing of California residents. When a person can access parks or safe places to be physically active, this not only relieves stress but also creates community cohesion and a feeling of belonging. Exposure to toxic chemicals in the air we breathe, the land our housing is built on, the water we drink, and the products we use causes us harm on an ongoing basis. Transportation – or the lack of access to public transportation – is also a huge barrier to accessing services for both rural and urban Californians.[31]

The safer our communities are, the more likely we are to walk or bike in our neighborhood, socialize with our neighbors, and take public transit.[32] Conversely, the fear of violence—real or perceived—leads to increased isolation, psychological distress, and prolonged elevated stress levels.[33] Increased violence in our neighborhoods also leads to high incarceration rates, which destabilize our communities by removing parents, children, brothers, and sisters. By breaking up families and support systems, we see higher rates of financial instability, poorer housing conditions, and higher levels of stress, one of the factors that can increase risk of heart disease.[34] Research indicates that developing relationships, feeling a sense of belonging, and being able to rely on those around us for support all promote wellbeing by reducing stress, improving mental health, increasing positive health-related behaviors.[35]

A comprehensive approach to reducing mental health disparities must take into account many of the social and environmental stressors experienced by California's communities and find ways to address them so that everyone has the opportunity to lead a healthy life.

Goals and Strategies

Please note: This report as well as the following are the recommendations of the CRDP Partners, but represent the voice of the community members engaged during the extensive stakeholder process undertaken by the five Strategic Planning Workgroups. Any reference to the CRDP Partners includes the communities they represent.

Goal 1. Increase Access to Mental Health Services for Unserved, Underserved, and Inappropriately Served Populations.

The first step in reducing disparities in mental health for these communities is making services more available to those in need. The State and county departments of mental health and their funding mechanisms can increase the availability of services and make it easier for community members to access them by expanding options and locations of services; providing assistance to make it easier to get to services; bringing services to the community; and making sure that those seeking services know where to find them.

Strategies to Increase Access to Mental Health Services:

1. **Increase Opportunities for Co-Location of Services and Integration:** Locating mental health services in community facilities, faith-based organizations, cultural centers, and other entities where people are comfortable will increase access and combat stigma. The CRDP Partners recommend that funders of existing mental health services – including the DHCS and county departments of mental health – coordinate and partner with networks of providers and community entities to improve mental health outcomes. Partners should include:

    - Child Protective Services
    - Churches and other faith-based organizations
    - Community colleges, four-year colleges, and universities
    - Community centers and senior centers
    - Community organizations, specifically those that primarily serve racial, ethnic, and LGBTQ communities

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- Elementary and secondary schools
- Equine therapy ranches
- Foster care agencies
- Hospitals and emergency rooms
- Juvenile justice agencies
- LGBTQ community centers and other gathering places for the LGBTQ community, such as coffee houses and bookstores
- Local businesses
- Local law enforcement agencies and the adult criminal justice system
- Native American tribes
- Non-traditional organizations (e.g., sports clubs, cultural arts sponsors, youth development programs) and new indigenous venues that are deeply rooted in the community
- Organizations working with the homeless and homeless youth
- WIC and other county social services offices
- Workplaces
- YMCA, YWCA, and Boys and Girls Clubs

It is essential that network members have experience in mental health and are culturally and linguistically competent to work with the community being served. In particular, these places (including churches and faith-based organizations) must be affirming of LGBTQ individuals to foster a welcoming place for all who seek mental health treatment. In addition, the physical location of these services must be easily accessible to the community and the hours of operation should be based on convenience for the clients. Finally, we should ensure that community entities may enter into contracts with the county department of behavioral health and the State, and we should build their capacity to do so.

We must also emphasize the benefits of integrating culturally, linguistically, and LGBTQ competent mental health and primary care services in the same setting. Community clinics and health centers (CCHCs) remain challenged by a variety of regulatory barriers to full integration. For example, CCHCs are limited in the types of billable providers that can provide services; they're also restricted from billing for mental health and medical care on the same day. The CRDP Partners recommend the State look for opportunities to continue to better integrate mental health and primary care, and to better address some of these remaining challenges. This could reduce stigma specifically, which would result in individuals and families seeking mental health care in a more timely manner. In addition, a single administrative system for billing and other operations would simplify service delivery and reduce costs.

2. **Develop Resource Guides to Facilitate Access to Services:** The CRDP Partners recommend the State legislature allocate resources to the CDPH Office of Health Equity (OHE) to fund community-based organizations to develop new or update existing statewide resource guides, both in print and online. These resource guides should list community clinics and health centers, social service agencies, community programs, and other service providers that are culturally and linguistically competent and LGBTQ-sensitive and affirming for each of the five targeted populations, as well as other underserved populations who reach a language threshold in their respective jurisdiction. The guides should also be regularly updated to reflect the ever-changing service delivery

system. The CRDP Partners also recommend that the MHSOAC provide oversight and support to this effort to ensure alignment with MHSA principles. Given the number of programs in the state, it could not possibly be an exhaustive list, but should include listings in each region of the state, including rural areas.

3. **Elevate Schools as Centers for Wellness in the Community:** The State's public schools – elementary, high school, community college, and public universities – can be a valuable asset when developing ways to improve mental health in children and adolescents by adequately screening, detecting, and diagnosing potential mental health issues. Schools are generally a safe setting where children and young adults go almost every day. They can be used to educate youth and their families about mental health, and intervene to decrease the risk of incarceration, drug use, and mental illness. Schools can also be used as portals to help adolescents and young adults access prevention and early intervention programs in their communities. The CRDP Partners recommend that the MHSOAC facilitate a conversation between the California Department of Education, CDPH, DHCS, and other stakeholders to ensure that current funding for school-based mental health services, such as the Early Periodic Screening, Diagnosis, and Treatment Program and other statewide projects, are reaching the communities with greatest need.

While schools play a critical role in providing access to mental health services, schools must ensure that they provide environmental that contribute to wellness, rather than reinforce traumas. For example, it is important that students see themselves and their ancestry represented accurately in the curriculum.

Other efforts to improve mental health treatment through schools should include:

- A plan to create and integrate mental health into school curricula dealing with health to help increase awareness of mental health issues and treatment.
- Programs to ensure early detection of mental disorders and a strategy to change the course of these disorders, reduce the incidence of adolescent suicides, and avoid misdiagnoses that may result in mistreatment and school dropouts.
- Schools equipped to provide services, resources, and referrals to students with post-traumatic stress and other trauma-related disorders and in need of trauma-informed models of care.
- Statewide workforce training and technical assistance for all public school staff and administrators to improve culturally and linguistically competent treatment of all students, including LGBTQ students. Training should focus on the specific health and safety needs within each population group, including all LGBTQ populations. Organizations performing these trainings should meet continuing education standards and have community endorsement.

- Effective school climate programs – including anti-bullying and anti-harassment programs, trauma-sensitive school programs, and restorative discipline practices – should be mandated for public schools at all levels and should include language addressing race, ethnicity, sexual orientation, perceived sexual orientation, gender, gender identity, and gender expression. Proven interventions that specifically address bullying and harassment should also be mandated for all public schools and all grade levels.
- Safe spaces for LGBTQ youth to help address harmful school behavior. Gay-Straight Alliances and other such LGBTQ-affirming clubs should be supported by school administration and staff, and barriers to forming these clubs on middle and high school, community college, and university campuses should be eliminated.

Additional research is also needed to clarify how to expand efforts beyond public schools to include charter schools and private schools as well.

4. **Ensure Ancillary Services are Eligible for Reimbursement:** To improve access to necessary mental health services, the CRDP Partners recommend OHE in partnership with key federal and state stakeholders convene a meeting to discuss clarifying or modifying requirements to allow service providers to be reimbursed through Medi-Cal for ancillary services that support community engagement, such as transportation, particularly in rural communities; interpretation and translation of documents; peer-to-peer support; cultural competence and other training; and after-hour services. These services might have high initial costs but can lead to significant cost savings through increased patient access and improved outcomes. Ensuring a clear understanding of how to access these services and categorizing these services as medically necessary will help increase access in unserved, underserved, and inappropriately served communities by making services more affordable.

5. **Create a Culturally Competent Justice System:** With increasing cases of profiling and brutality by law enforcement across the country, we see a need to ensure that law enforcement – police and peace officers, judges and court personnel, and prison and jail staff – are trained to be culturally competent, to recognize the inherent racial bias that communities of color face, and to recognize individuals with mental illness and how to appropriately serve them. The CRDP Partners recommend that the California Department of Justice mandate cultural competence training for all personnel, especially frontline staff working directly with the community.

6. **Prioritize Prison Re-Entry and Post-Diversion Efforts:** Many people of color and LGBTQ individuals have their first contact with mental health services in the prison system. When they are released, they face great challenges in securing housing, employment, and health care. To improve mental health treatment for those returning from prison through release or State hospitals, the CRDP Partners recommend county departments of mental health and local sheriff departments, in collaboration with the State Department of Corrections, recognize the role mental illness plays in many offenses and how the mental health system can help rehabilitate former offenders. We must prioritize access to no-cost or low-cost treatment for those returning from prison. The State criminal justice system, local police departments, district attorneys, faith communities, and community organizations should work together to develop alternative sentencing and housing options for individuals with mental illness in the system. Each county should also develop a re-entry plan that is

vetted by the community and other stakeholders, including the California Department of Corrections and Rehabilitation, to prevent recidivism and promote community reintegration.

The CRDP Partners also recommend that attention and resources be directed to ensure that the specific mental health needs of children of incarcerated parents are met.

7. **Fund Culturally Competent and Linguistically Appropriate Outreach:** A comprehensive outreach plan is necessary to engage all communities in efforts to improve mental health services in California. The CRDP Partners recommend the State legislature allocate additional resources to DHCS, and the MHSOAC provide oversight, for the development of culturally, linguistically, and LGBTQ appropriate PEI outreach materials for the five populations through the California Mental Health Services Authority's (CalMHSA) statewide stigma and discrimination reduction project. CalMHSA should in turn fund communities and provide technical assistance and additional support to local experts to develop these tailored materials. Outreach should be mass distributed using diverse media outlets, social marketing, and awareness campaigns with influential personalities, such as those involved with professional sports, the entertainment industry, the food industry, barber and beauty shops, and LGBTQ coffee shops and community centers.

Funding is needed to engage ethnic and LGBTQ media, which remain a trusted source of information for many racial, ethnic, and LGBTQ populations. Youth workgroups should also be convened to design thoughtful messages relevant to their age group to confront stigma and develop ways to disseminate these messages using Facebook, Twitter, YouTube, blogs, and other social media outlets. Community-based providers should receive funding to conduct outreach in addition to serving their clients.

Goal 2. Improve the Quality of Mental Health Services for Unserved, Underserved, and Inappropriately Served Populations.

Services must not only be accessible, but also be of the highest quality and meet the needs of these communities. State agencies and local departments of mental health must ensure that services they are funding are culturally and linguistically competent and have staff that reflects the community being served.

Strategies to Improve the Quality of Mental Health Services:

8. **Build and Sustain a Culturally, Linguistically, and LGBTQ Competent Workforce:** To improve the cultural and linguistic competence of mental health services, the CRDP Partners recommend that the Office of Statewide Health Planning and Development (OSHPD) focus on creating and supporting a well-trained and culturally, linguistically, LGBTQ-responsive workforce. The State must also ensure clear pathways for clients, family members, and those with lived experience to pursue careers in the field. In order to improve the mental health workforce on a systems level, the CRDP Partners ask the State legislature to allocate funding for OSHPD to implement, and the MHSOAC to provide oversight for:

- Promoting mental health careers through outreach to youth and parents in all racial, ethnic, and LGBTQ communities, including mentorship opportunities for future workforce development. This includes providing incentives for diverse mental health practitioners to provide services in underserved areas of the state, including rural communities.

- Encouraging cultural, linguistic, and LGBTQ competency as part of mental health career training at all academic levels, from certification to advanced degrees. This should include strengthening connections with population-specific studies programs – such as African American studies, Chicano/a and Latino studies, and LGBTQ studies – on postsecondary campuses to increase training opportunities for those seeking careers in the mental health field. OSHPD should prioritize loan repayment programs and tuition reimbursement for individuals from these populations pursuing a career in the mental health field, as well as for current providers looking for retraining opportunities.

- Courses for individuals to become specialists in working with or across specific population groups. The State should identify the appropriate entity to train community organizations within each population group.

- Resources for managers and support staff at community based organizations to attend ongoing training, and technical assistance in mental health and all related fields for providers serving the five target populations. The State should provide technical assistance to traditional healers within each community.

- Expanded opportunities for community health workers (e.g., *promotoras/ es*) who are proficient in the languages and cultures of their communities to receive education, training, and employment to meet community needs. County departments of mental health should make opportunities available for providers to further their education in behavioral health so that they may provide a greater range of services and assume leadership roles in the community.

- Ensuring the safety of staff that are part of a diverse workforce, particularly for LGBTQ-identified providers and support staff.

While much can be done to improve the cultural and linguistic competence of the workforce at the systems level, any significant efforts also require buy-in at the provider level. The CRDP Partners recommend all mental health service providers receive cultural, linguistic, sexual orientation, and gender identity/expression competency training, offered through the contracting agency (i.e., county departments of mental health) in partnership with community organizations that have experience conducting these types of trainings. In turn, culturally and linguistically competent providers should employ, train, and support staff that possess the skills necessary to work with their clients. Simply hiring bilingual or LGBTQ staff is not adequate, however, as cultural and linguistic competence goes far beyond language or LGBTQ identity. It is also essential to support bicultural, bilingual, and LGBTQ staff to avoid burnout. Providers should also participate in certification programs to ensure that they are proficient in specific competency categories related to their clients.

In addition to cultural and linguistic competency, any individual provider should possess a clear understanding of prevention and early intervention and relevant clinical issues. The CRDP Partners recommend county departments of mental health provide the local agencies they work with continuous training on prevention and early intervention, clinical treatment options, and related topics so that they can provide culturally, linguistically,

and LGBTQ appropriate outreach, engagement, education, services, retention, and interventions.

Finally, there should be some consideration to overall equity in salary and wages for the mental health workforce. We recommend that DHCS and other relevant State agencies review their contracting agreements to ensure that they are in line with state and local minimum wage standards.

9. **Ensure Culturally, Linguistically, and LGBTQ Competent Services:** In order to have culturally, linguistically, and LGBTQ appropriate services, the CRDP Partners recommend local service providers work with the target population to develop culturally and linguistically competent programs based on community-defined evidence. Providers should also conduct an analysis of assessment and screening tools used for mental health services to ensure cultural and linguistic appropriateness, and then implement culturally-adapted tools. A culturally, linguistically, and LGBTQ competent provider must also be able to work with the community and other agencies, provide proper linkages to available resources, and manage the stressors and challenges inherent in working with underserved populations.

10. **Ensure Linguistic Access to Mental Health Services:**

The CRDP Partners recommend the State legislature provide additional resources for DHCS to fund – and county departments of mental health and local service providers to implement – comprehensive approaches to improve linguistic access for all clients of all MHSA-funded programs. The CRDP Partners also recommend that the MHSOAC provide oversight to ensure these approaches are implemented in the spirit of the MHSA. These approaches should include:

- Enforcing federal CLAS standards, except when existing California standards provide for broader provision of culturally and linguistically appropriate services. Standards should also account for the cultural and linguistic needs of LGBTQ populations. CLAS standards pertaining to communication and language assistance include the following:

  > Offer language assistance to individuals who have Limited English Proficiency, low literacy, and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.

  > Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.

  > Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.

  > Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.

- Written materials that are available in the preferred language of the clients. Materials should also consider the cultural context and literacy level of the targeted community, and county departments of mental health should support contracted community agencies to provide these types of services.

- Interpreters must have adequate training in mental health and know how to properly translate mental health terms and concepts in a culturally and linguistically acceptable and understandable manner to the clients – often, the literal translation of "mental health" can have negative connotations (e.g., "crazy"). Providers must not utilize bilingual staff who are not trained or have not been evaluated for language proficiencies as interpreters, nor should children, friends, or families ever be utilized to provide these services.
- Interpreters must also know and be comfortable using terms regarding sexual orientation and gender identity.
- Interpreters must be trained in maintaining a code of ethics, which requires them to respect the culture of their clients and consider the confidentiality, accuracy, and impartiality of the service they provide. Interpreters are often seen as community leaders, serving as a link between the community and health providers.
- Training to foster effective working relationships between mental health staff and interpreters.
- Assistance for Deaf and Hard of Hearing clients whose first language is American Sign Language (ASL). Providers should have plans in place to assist these clients with interpreters.

Goal 3. Build on Community Strengths to Increase the Capacity of and Empower Unserved, Underserved, and Inappropriately Served Communities.

Access to quality services will mean nothing if the community is not engaged in local mental health programs. The State and local service providers need to offer community members the tools, information, and opportunities to be involved and engaged in the development, implementation, and evaluation of services on a statewide and local level; and to be engaged in policymaking at a local and statewide level.

Strategies to Build on Community Strengths and Increase Community Capacity:

11. **Engage Spiritual Leaders, Healers, and the Faith-Based Community:** The CRDP Partners recommend the State legislature fund the Office of Health Equity to support a statewide consortium of faith-based organizations and other spiritual leaders to develop and implement pathways to wellness, reduce mental health stigma, and advocate for the importance of spirituality in reducing mental health disparities. Many people in communities of color are intimately connected to their faith communities or spiritual families, and many see them as a source of comfort and support. They are the first place people turn when they need help. But for the LGBTQ community, the faith community is also a source of rejection and stress.[36, 37, 38] It is recommended that these faith-based organizations be LGBTQ-affirming in order to be a part of the consortium, meaning they are supportive and on the path to welcoming and celebrating LGBTQ members of the congregation. Recommendations from this consortium must be implemented on both a statewide and local level to increase the involvement of the faith community in efforts to reduce disparities.

12. **Working with Parents, Foster Parents, and Families to Reduce Disparities:**
Parents and foster parents should help to ensure that adolescent mental health needs are met. The CRDP Partners recommend county departments of mental health educate parents and foster parents about the availability of free or low-cost academic and mental health services through classes or seminars. Potential foster parents, in particular, need training to prepare them for fostering children who might be suffering from trauma-related mental health issues. Finally, parents of LGBTQ youth and young adults should be trained on the dangers of rejecting behaviors. Family rejection is a significant factor in the mental health of LGBTQ youth and young adults.

Local service providers should develop and implement programs that stabilize the family unit, particularly in populations that have experienced intergenerational traumatic experiences, such as the African American and Native American communities. Comprehensive services that build on the natural family support system will help stabilize families. These families need opportunities to recover and establish stable environments, and the CRDP Partners recommend the State fund population-specific culture centers (such as family enrichment centers) and evaluate the effectiveness of a culturally-based approach to mental health.

The CRDP Partners also recommend state and local funders support efforts to expand social and family networks to increase social engagement and emotional support for older adults.

13. **Support Community Involvement and Engagement:** The CRDP Partners recommend local Boards of Supervisors generate and sustain community involvement and engagement through local Mental Health Boards to ensure buy-in, change attitudes about mental health, and improve programs and services. The CRDP Partners ask the State legislature to make resources available to the MHSOAC to support and enhance recruitment of underserved communities for local mental health boards, particularly from the five targeted populations and/or other unserved, underserved, and inappropriately served racial/ethnic/cultural populations of various age groups. Training Mental Health Board Members is also essential, and adequate funding must be available to ensure each individual is trained and supported to fulfill their responsibilities to other stakeholders. According to California Welfare and Institutions Code, 50% of local Mental Health Board membership shall be consumers or the parents, spouses, siblings, or adult children of consumers, who are receiving or have received mental health services. At least 20% of the total membership shall be consumers, and at least 20% shall be families of consumers.[39] It is vital that community needs are addressed and MHSA-funded services are evaluated using culturally and linguistically appropriate approaches. Including community members in the decision-making process empowers them to be involved in identifying alternative solutions. Local Mental Health Boards should be supported and bolstered based on the community engagement models developed for the CRDP, and should be focused on improving conditions for unserved, underserved, and inappropriately served racial, ethnic, and LGBTQ communities.

14. **Go Beyond Community Engagement:** Providers must earn and establish credibility in the community not just by engaging and serving community members, but also by advocating for their needs in ways that will improve overall wellness. At the provider

level, service organizations should have Boards of Directors and/or Advisory Boards that reflect the racial, ethnic, and LGBTQ composition of the community the provider serves. Providers should design the program using a community-based participatory approach, including:

- Recognizing community as a unit of identity
- Building on strengths and resources within the community
- Facilitating a collaborative, equitable partnership in all phases of the work
- Fostering co-learning and capacity building among all partners
- Disseminating results of learning and capacity building to all partners and involving them in the wider dissemination of results
- Involving a long-term process and commitment to sustainability
- Openly address issues of race, ethnicity, racism, sexism, heterosexism, biphobia, transphobia, and social class, and embody "cultural humility"
- Working to ensure research rigor and validity and seeking to "broaden the bandwidth of validity" with respect to research relevance[40]

Providers should also work with the community to create networks to link clients to appropriate services. When implementing these networks, providers should work with community members to ensure that they are implementing programs that will have a positive impact on the health and wellbeing of their communities. Providers should also work with community researchers to make sure they're collecting adequate data and analyzing program effectiveness.

15. **Develop and Support Community Leadership:** The CRDP Partners recommend that OHE identify community and faith leaders within each of the targeted populations to serve as expert advisors on reducing disparities. The leaders should be willing to make a commitment to actively advocate for and disseminate the strategies from this strategic plan and the recommendations identified in the five Population Reports – helping to provide oversight and ensure that the strategies necessary to improve mental health services in each community are implemented in the most effective manner.

Goal 4. Develop, Fund, and Demonstrate the Effectiveness of Population-Specific and Tailored Programs.

The State must make a commitment to support, research, implement, and evaluate community-defined approaches such as those identified in the five Population Reports in order to reduce disparities. This support should go beyond the funding available through Phase II of the CRDP, and apply to all MHSA-funded Prevention and Early Intervention programs.

Strategies to Develop, Fund, and Demonstrate the Effectiveness of Community Programs:

16. **Establish a Network of Community Health Workers and Indigenous Healers:** The CRDP Partners recommend the State prioritize efforts to strengthen and replicate community-based practices that have been proven effective within each population. County departments of mental health should fund and support the identification and

recognition of community health workers (e.g., *promotoras/es*), community healers, and indigenous/non-traditional practitioners to ensure an effective, culturally-appropriate mental health and primary care integrated care structure. These community healers, who have not been part of the traditional public mental health system, are familiar with the needs of their communities. The State should fund their efforts, possibly as pilot projects in each region, to evaluate the efficacy of alternative approaches to mental health integration.

17. **Fund Culturally-Specific Research:** The CRDP Partners recognize that Phase I of the CRDP has barely scratched the surface in identifying promising practices to reduce disparities in the five targeted populations. The CRDP Partners therefore recommend the State legislature allocate resources to OHE for additional community-based research to identify effective community-defined approaches to sustain and expand mental health services, similar to the work undertaken during Phase I of the CRDP. As in Phase I, culturally-congruent researchers with experience in the targeted populations should implement these efforts to ensure the approaches used will generate the most reliable results. This research can help highlight promising community-based programs as examples of best practices that can be replicated across the state. Additionally, it is important to identify currently unknown disparities, particularly within LGBTQ communities. It is impossible to define appropriate practices while lacking information on the problems that need to be solved. Continued research is imperative in LGBTQ communities, particularly for bisexual and transgender individuals, and those at the intersection of identities. Finally, this additional research should include profiles that examine the specific needs of sub-groups within the five targeted populations, including gender differences between men and women, as well as veterans, the homeless, people with disabilities, and rural communities.

18. **Develop Culturally-Specific Mental Health Practice Models:** While the $60 million made available during Phase II is a good first step, this funding is a drop in the bucket in the fight against health disparities. The CRDP Partners recommend the State legislature provide further resources to OHE to fund the implementation of additional community-level, population-specific practices, like those to be funded and evaluated during Phase II. Particular effort should be made to reach areas of the state not addressed during Phase II, including rural communities. Funding should be made available to develop practice models in each of the targeted populations, as well as underserved populations not included in Phase I such as women, veterans, the homeless, people with disabilities, and rural communities, to build alternatives to mainstream mental health models and create a more holistic approach toward mental health tailored to each population.

19. **Allocate MHSA Prevention and Early Intervention Funding According to Community Need:** The CRDP Partners recommend DHCS, County Behavioral Health Directors Association of California (CBHDA), and the MHSOAC work together to develop methods to determine community need. They should determine future MHSA funding, including PEI initiatives, using these methods. DHCS should take these methods into account when determining county MHSA allocations. County departments of mental health should use these funds to replicate and expand locally those successful models highlighted in the five Population Reports. In addition, other successful community-defined practices which may not have been listed, but

which meet the same criteria, should also be considered for funding and replication. PEI funding should be allocated in a manner that supports the strategies from this plan, with particular consideration for local demographics and need, so that all communities are appropriately served.

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20. **Conduct Culturally-Congruent Evaluation of Community-Defined Practices:** The CRDP Partners recommend the State and county departments of mental health ensure that they are adequately supporting community-based evaluation of current mental health services, including Phase II of the CRDP and all MHSA-funded programs. Evaluation should include both qualitative (e.g., case studies, in-depth interviews, and focus groups) and quantitative measures, and involve a representative sample of the target population receiving services. For Phase II of the CRDP, the CRDP Partners recommend CDPH contract with evaluators from the target communities, with the MHSOAC engaging with similar evaluators to measure all MHSA-funded programs.

21. **Develop a Simplified and Streamlined Process for Recognizing Evidence-Based Practices:** The CRDP Partners recommend OHE convene a task force of key stakeholders, including federal CMS representatives, DHCS, CDPH, the MHSOAC, CBHDA, culturally-congruent evaluators, and community members to identify or develop a mechanism whereby community defined practices that have been shown, through the CRDP Phase II process, to be effective can be eligible for Medicaid reimbursement in California. The funding available through CRDP Phase II to pilot and evaluate promising community-defined practice will help recognize the results of many programs that are reducing mental health disparities in underserved communities. Community stateholders have found the process to recognize a program as evidence-based and eligible for Medicaid reimbursement or funding from the federal Substance Abuse and Mental Health Services Administration to be difficult to navigate. Therefore, this task force should research the various bodies that recognize evidence-based practices (including efforts that have been undertaken in other states including Oregon), and develop recommendation for how California can lead the way to broader recognition of community-defined practice.

Goal 5. Develop and Institutionalize Local and Statewide Infrastructure to Support the Reduction of Mental Health Disparities.

In order to build on the momentum of Phase I of the CRDP, the State and county departments of mental health must support systemic changes to develop an infrastructure that ensures all MHSA-funded programs incorporate and implement the recommendations, strategies, and promising practices in the five Population Reports. This support should develop and sustain community engagement and empowerment structures on a state, regional, and local level; engage community members with

knowledge of underserved populations and disparities reduction efforts in the planning, implementation, and evaluation of Phase II; and build the capacity of local community members and organizations indigenous to underserved populations to collaborate with county departments of mental health and advocate for systems change on the local and statewide level.

Strategies to Develop and Institutionalize Local and Statewide Infrastructure to Reduce Disparities:

22. **Engage Community in the Implementation of the California Reducing Disparities Project:** The community must be involved in implementing this groundbreaking project at the local level. Many local Mental Health Boards and their committees need more robust representation from unserved, underserved, and inappropriately served communities with knowledge and expertise in disparities reduction – communities that need to be represented in work groups to support the strategies in this plan. Some in communities of color and LGBTQ communities might have avoided engagement in stakeholder processes due to a lack of cultural or linguistic competence in the mental health system. The CRDP Partners recommend the State legislature make available resources to the MHSOAC to support and enhance recruitment of these representatives of underserved communities on local mental health boards, particularly for community capacity building and comprehensive, multilingual outreach and education. Local Boards of Supervisors should then make an effort to recruit, train, and maintain the involvement of community members on their local Mental Health Boards through sustained leadership development and quality improvement reviews (see *Strategy 13: Support Community Involvement and Engagement*).

23. **Replicate Models for Community Engagement on the Local Level:** Community engagement models implemented by the Strategic Planning Workgroups (SPWs) and California MHSA Multicultural Coalition (CMMC) through the CRDP should be developed and supported at the local level. The SPWs have engaged specific unserved, underserved, and inappropriately served populations in a meaningful way, soliciting their input and incorporating their feedback in the development of policy recommendations and the identification of community-based best practices. The CMMC has created a model for multicultural advocacy and collaboration to ensure that underrepresented communities are engaged in statewide policy. Using these models would ensure that the services being planned and implemented would best meet the needs of the local community. The CRDP Partners recommend county mental health departments and county mental health boards should use these effective community engagement models to involve unserved, underserved, and inappropriately served communities in local policy, program planning, and the evaluation of MHSA-funded programs. If local resources are limited, county departments of mental health should form regional partnerships to collaborate and leverage resources (see *Strategy 13: Support Community Involvement and Engagement*).

24. **Collaborate with Existing County Reducing Disparities Efforts:** In order to ensure that unserved, underserved, and inappropriately served communities gain equitable access to MHSA-funded programs and services, the CRDP Partners recommend counties work collaboratively with community organizations and partners that they may not traditionally work with to adopt and implement the community-defined strategies from this plan and the five Population Reports.

Counties should seek community engagement to design their county cultural competency plans and implement the strategies identified in this strategic plan, including working closely with community-based programs which exemplify MHSA prevention and early intervention efforts. In counties where CC/ESMs and others have developed strong working relationships with community organizations, stakeholders – both the county and organizations – should work collaboratively to maintain and strengthen linkages.

25. **Develop New Community/County Partnerships:** The CRDP Partners recommend county mental health departments work more closely and develop partnerships with community-based organizations funded to implement the strategies identified for Phase II of the CRDP. These collaborations should include providing technical assistance and evaluation support to each other, and sharing promising practices and successes. The work of the CRDP must continue beyond Phase II; fully-engaged counties are an important part of moving this work forward and will help lay the groundwork for deeper collaboration and sustainability in the future.

26. **Evaluate and Monitor the Implementation of the California Reducing Disparities Project:** The CRDP Partners recommend the State legislature provide resources through OHE to fund community organizations to monitor the implementation of Phase I and Phase II of the CRDP. This infrastructure would serve to ensure that policymakers are engaged in the implementation of the strategies on the statewide and local level, and are held accountable to the communities invested in this plan's development.

27. **Continue the Work of the California Reducing Disparities Project:** The CRDP Partners recommend that the State legislature make additional resources available in the future to OHE so that other unserved, underserved, and inappropriately served communities can identify promising practices and recommendations for reducing disparities. (This is similar to the process that these five populations undertook during Phase I of the CRDP.) These other communities may include diverse Arab communities; ethnic communities such as the Slavic, Russian, Armenian, and other Middle Eastern communities; Mixtecos and other indigenous populations; religious communities such as the Muslim, Sikh, Buddhist, and Hindu communities; and other unserved, underserved, and inappropriately served communities including the Deaf and Hard of Hearing, veterans, people transitioning from the public safety or penal system, victims of trauma, women, the homeless, rural communities, transition-age youth, and older adults.

Implementation of the Strategies

Implementation of the 27 strategies outlined above requires long-term planning and commitment. The CRDP Partners recommend these strategies be implemented over the next 5-10 years, with the commitment and involvement of all stakeholders in the public mental health system. While the $60 million in CRDP funds for Phase II is a good start, the State must commit to additional resources to continue long-term efforts to accomplish these goals. Also, all stakeholders – from the statewide to the local level – should be involved in implementing the strategies to reduce disparities in mental

health. Over the course of Phase II, all parties – statewide and local policymakers and community members – need to determine a consensus course of action, including the development of a detailed work plan to outline responsibilities and benchmarks, in collaboration with CDPH. In the short-term, we can ensure that these strategies are addressed by embedding them into the planning and implementation of CRDP Phase II.

In addition, there are several risks and challenges to implementing these strategies including:

- Lack of funding: The remaining funding available for CRDP included $60 million primarily to implement promising practices as part of a pilot program, as well as additional supports including evaluation and technical assistance. This left very little funding available to support the implementation of the 27 strategies in this plan.
- Lack of commitment from all stakeholders: While the CRDP Partners have agreed to move forward with implementing these strategies, all parties (e.g., MHSOAC, DHCS, CDPH, county departments of mental health) must collaborate further to develop a plan to move forward together and implement the 27 strategies listed in this plan.

In order to accomplish these strategies, we must not see reducing disparities as a niche issue to be taken up only by organizations committed to unserved, underserved, and inappropriately served populations. It is paramount for everyone involved in the system – from Statewide policymakers to community organizations to clients and family members – to make reducing disparities a priority. In the short-term, every stakeholder should use these strategies as a framework for the implementation of CRDP Phase II.

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Chapter 4: Recommendations for CRDP Phase II

Note: The California Reducing Project Strategic Plan was developed beginning in 2012 and the implementation of Phase II started in late 2015, at which time this report had not yet been completed. To preserve the integrity of the initial Strategic Planning process, this report includes all of the recommendations even though some have been adopted in Phase II. More information regarding the current status of Phase II of the CRDP is available at https://www. cdph.ca.gov/Programs/OHE/Pages/CRDP.aspx.

While implementing the goals and strategies of the strategic plan is a long-term approach to reducing disparities, the next phase of the CRDP (Phase II) presents a more immediate opportunity to fund and evaluate promising practices. The practices will have an immediate impact on disparities and will make the case for the long-term sustainability of community-defined practice. CRDP Phase II includes several components necessary to reduce disparities. First, it funds selected prevention and early intervention approaches across the five populations with a strong community-based participatory evaluation component. This recognizes these practices as equal to evidence-based practice. In addition to funding and evaluating these programs, Phase II should also include technical assistance and capacity building for the funded pilots, and ongoing work to implement the policy-level strategies in this plan. We hope that this process will open the door to future funding of these practices through existing county, state, and federal systems and mechanisms.

> *"Not feeling well physically, I see doctors. Not feeling well mentally, I go to the temple and talk to monks."*
> *-API Community Member*

The State set aside an allocation of $60 million for these pilot programs, and allocated $15 million each year. After successfully completing this unprecedented investment in community-defined evidence, California will be in a position to better serve all communities; replicate the new strategies, approaches, and knowledge across the state; and act as a role model for the nation.

In addition, implementing Phase II requires close collaboration with county departments of mental health. As the largest sources of local funding for public mental health service in the state, counties will play a vital role in ensuring the ongoing sustainability of the promising practices identified by the Population Reports. Counties must be a part of all components of Phase II.

The strategic plan lays out recommendations from the CRDP Partners for implementing Phase II, including the types of entities that should be funded; how funding should be allocated and for what purpose; the funding mechanism; and potential supports needed for implementing the pilots, such as evaluation, technical assistance, and ongoing work to adhere to the 27 strategies. The plan also includes recommendations for after Phase II, and addresses potential risks and challenges associated with sustaining and replicating the funded pilots.

Funding Promising Practices

The success of the CRDP depends in large part on how the State allocates funds for Phase II. With that in mind, the CRDP Partners recommend the State allocate the vast majority

(70-80%) of the Phase II funds for the development and implementation of prevention and early intervention promising practices. PEI is the key to transforming California's public mental health system into a "help-first" system, or one that brings mental health and wellness to the community before mental health needs become severe. Each of the five Population Reports identified a catalog of promising practices in their communities that foster wellness. We must implement these types of programs across the state, with culturally, linguistically, and LGBTQ competent organizations who know their communities and have their trust. We should also note that a promising practice does not mean taking an existing practice and translating it for a different population. We must make real, concerted efforts to ensure that the practice is relevant to the targeted population in terms of race, ethnicity, language, culture, sexual orientation, gender, gender identity, and age.

The State should make Phase II funds available to local organizations and agencies that are rooted in the communities they serve, represent those communities in their board and staff composition, and provide services in a culturally competent and linguistically appropriate manner. While we recognize that Latinos are the largest population group in California (as seen in *Figure 1*), several issues would make proportional allocation of funds difficult and could potentially lead to less-than-successful pilot programs for some populations. This includes the limited resources available for CRDP Phase II, the lack of a reliable count of LGBTQ populations, and historic undercounts of Native Americans pose particular problems. The CRDP Partners have agreed to recommend that the State allocate funds equally (i.e., one-fifth of the available funds to each of the five populations) to all five CRDP Phase I identified targeted populations: African American, Asian and Pacific Islander, Latino, LGBTQ, and Native American communities.

The California Department of Public Health (CDPH) should develop the solicitations for the CRDP Phase II pilot program to closely mirror the strategies identified in the strategic plan and recommendations and promising practices from the five Population Reports. The CDPH solicitation writer should adhere to the goal of reducing disparities in racial, ethnic, and LGBTQ communities by employing community-defined practices. CDPH should award funding in keeping with the strategies identified in this plan, preferring organizations and programs that value:

- Collaboration with community services and resources, such as faith-based communities and schools
- Collaboration with county departments of mental health, county mental health boards, and other local policymakers
- Community-defined practices
- Culturally competent and linguistically appropriate services and adherence to federal CLAS standards in service delivery at a minimum
- Culture as the cornerstone for mental health and wellbeing
- Involvement of clients and family members to develop, implement, and evaluate programs
- Methodologically rigorous data collection standards at all levels
- Stakeholder-focused and culturally-congruent evaluation
- Workforce that reflects the diverse communities being served

The proposal review process should grant priority in funding to applicants that are endorsed by the community, have knowledge of and experience working with the target population(s), and are in the designated geographic area. Applicants should list

relevant programs and services conducted; describe the project and target population; outline the need their existing program(s) meet; share the number reached through the program; list staff with three to five years working with the target population; and show a commitment to partnering with other community organizations. The applicant should be able to provide a thorough narrative of the proposed project; specify its relevance to the community it proposes to serve; broadly highlight the connection to the recommendations in the relevant Population Report; outline the activities to be conducted; provide an impact report that outlines specific strategies to meet the needs of special communities within the target population, such as veterans, women, the homeless, people with disabilities, and rural communities; and include a timeline, work plan, and evaluation plan that involves community participation.

The CRDP Partners recommend Phase II fund no more than 10 practices in each of the populations, with a minimum of $200,000 for each program per year. This may include multicultural, multigenerational approaches such as efforts to address the needs of boys and young men of color or people of color with diverse sexual orientations and gender identities. The programs should focus on both urban and rural communities from diverse locations across the state. The intent would be to fund each program during the Phase II period, while the grantee would commit to leveraging this funding with additional support from local funders, foundations, and other sources. Grantees could use these matching funds to advocate for systems change at the state and local levels and to sustain the work beyond Phase II. Each grantee would use the funds to administer and implement the promising practices, including organizational infrastructure development, oversight and administration, staffing and training, materials, travel, occupancy expenses, reporting, monitoring, and evaluation.

Many small community organizations, including those that might be engaged in the promising practices identified in the Population Reports, lack the infrastructure to replicate their projects on a larger scale without sufficient resources invested during the startup period. For this reason, the CRDP Partners recommend flexibility in contracting and awarding funds for Phase II. We also recommend allowing small community organizations seeking this funding to either contract with CDPH directly or partner with a larger organization to serve as a fiscal agent.

The remaining funds (20-30% of Phase II funds) should be allocated for statewide and population-level community-based evaluation of the project, technical assistance for grantees and county departments of mental health, and ongoing work to ensure implementation of the goals and strategies in this strategic plan. (For more information, see *Evaluating Promising Practices, Providing Technical Assistance, and Implementing the Goals and Strategies* below.)

Evaluating Promising Practices

A key part of Phase II is the evaluation of the pilot programs in order to recognize community-defined best practices as equivalent to evidence-based practices, thereby facilitating the sustainability of the programs through funding eligibility beyond Phase II. Phase II intends to prove that the promising programs identified during Phase I – activities developed by and for unserved, underserved, and inappropriately served communities across the state – are in fact reducing disparities and improving health outcomes. If these programs become eligible for reimbursement by Medicaid, and county departments of mental health fund and implement these programs in partnership with community-based organizations after the pilot program, this will be one important indicator of success.

The evaluation process must balance the needs of a system that will allow for sustainability of these programs with the community members whose needs are being met by the interventions. We need to take a strengths-based, community-based, community-driven approach to ensure that we address the unique challenges each population faces – including stigma, discrimination, and marginalization –in the most effective way. We should consider the culture and language of each population when conducting an evaluation of services. When appropriate, providers should engage consultants with experience conducting evaluation in specific racial, ethnic, and LGBTQ communities. In order for this to happen, the CRDP Partners recommend the State fund a thorough, community-based evaluation to accompany the implementation of the pilot through a portion of Phase I funds. This evaluation could happen in three components:

- Each funded organization must incorporate an evaluation component in its program plan. The solicitations should include guidance on how to evaluate the pilot program, including quantitative data such as how many people are served, retention rates, geographic location, and demographic information (e.g., race, ethnicity, primary language, gender, sexual orientation, gender identity, and age); and qualitative information including client satisfaction, successes, and case studies. Grantees should be informed that this evaluation data will be shared with an external evaluator, and that they must be available for additional consultation with the evaluator. Grantees must understand the importance of the evaluation to the project's future.

- The State should fund a culturally, linguistically, and LGBTQ appropriate independent evaluator or an evaluation team to collect data and measure the impact of the pilots in each of the identified populations (i.e., one evaluator each for the African American, Asian and Pacific Islander, Latino, LGBTQ, and Native American communities). These evaluators or teams should have a deep knowledge and understanding of the community they are working with, as well as 5-10 years' experience conducting community-based evaluation in unserved, underserved, and inappropriately served communities. They must also have experience with both quantitative and qualitative evaluation, and have experience in mental and behavioral health.

- Evaluators must also provide robust technical assistance to the grantee organizations on how to develop and maintain evaluation of their interventions. Many of the organizations have never evaluated their programs before, and in fact may view evaluation as an intrusive or culturally inappropriate paradigm. We need to work with community organizations to move away from this perception and develop a framework where evaluation is recognized as a welcome, necessary component to make community practices sustainable in the long run.

- Finally, the State must also fund a statewide independent evaluator or evaluation team to compile and analyze the information from the five population-based evaluations to determine the effectiveness of the interventions and recognize them as evidence-based best practices. The evaluation will also have to measure other components, including the technical assistance and ongoing work. In addition, evaluation of promising practices should recognize any effectiveness on additional underserved populations receiving services through the pilot programs to help build capacity in those populations.

The evaluation of promising practices should look at whether the program is having the desired positive outcomes for the population; whether it is having an impact on reducing disparities; whether the practice is successfully sustainable in the long run; and whether the practice can be replicated with the same population in different geographic regions.

The evaluation process should be as manageable as possible for community organizations with limited capacity. In addition, traditional surveys might not work in some populations, and evaluation efforts should combine quantitative and qualitative approaches to collect data and outcomes. Case studies, in-depth interviews, and focus groups that focus on participant satisfaction would provide data that are not observed or measured by self-reporting scales. In addition, the evaluators must collect pre-Phase II implementation baseline data before pilot programs begin operation. For this to happen, CDPH should release the evaluation component of the Phase II solicitations before the pilot program component.

We should also consider the effectiveness of the State's systems and structures to support community organizations funded during Phase II, with the State and its evaluators sharing and disseminating lessons learned during the multi-year pilot program.

Providing Technical Assistance (TA)

In order to effectively implement the pilot of promising practices, many community organizations might need technical assistance or capacity building throughout Phase II. Through technical assistance, funders can help grantees build their capacity to better serve their clients and improve the services being offered. A vital component of most funded initiatives, the funder should provide TA at no cost and with no bearing on the grantee's ability to continue performing its tasks. Often, the grantee can see asking for help as admitting a weakness, which might hold them back from asking for help. For this reason, the funder should provide help in a culturally, linguistically, and LGBTQ competent manner, tailored to the individual organization's needs. The funder can frame TA as an opportunity to build the grantee's capacity to serve their community and build the evidence base for the success of the promising practice.

In addition, technical assistance should go both ways. While the organizations implementing the promising practices will need assistance to increase their capacity and manage State funding, the State and county departments of mental health will also need help in working with community-based organizations – particularly those who have not received State or county grants in the past. The State and counties should receive help to increase their cultural and linguistic competence and collaborative skills to ensure strong relationships. Technical assistance should also be provided to the State and counties in order to broker and strengthen relationships with community-based organizations and stakeholders. County departments of mental health should also receive assistance to continue the work through Phase II.

Each of the identified populations should have at least one TA provider. The providers should have extensive experience working in the target population and have community endorsement; experience in community participatory research and engagement; a solid understanding of the capacity and needs of the types of organizations conducting the promising practices; and the capacity to provide both short- and long-term assistance tailored to the individual organization's needs and capacity. They should be able to assist with both programmatic and organizational issues, including program development and implementation; outreach; evaluation; knowledge of the county, State, and federal public mental health system; strategic planning; board development; fiscal management; and grant writing and resource development for ongoing sustainability. If the applicant does not have the staff capacity to provide assistance in all areas, it must show the ability and willingness to contract with consultants who have subject matter expertise and experience working with the population. Grant awards to TA providers should reflect the expense of hiring or subcontracting with additional consultants in those areas.

During the application period, the State should also make available technical assistance to smaller community organizations interested in submitting a proposal. CDPH should contract with consultants who can provide assistance in grant writing, program development, and evaluation.

Implementing the Goals and Strategies

Finally, funding for ongoing implementation of the 27 strategies is needed. The hallmark of Phase I, community engagement should be an important component throughout Phase II, from implementing and evaluating the promising practices to ensuring that the voices of unserved, underserved, and inappropriately served communities are heard by policymakers. To do so, the State should sustain and replicate on a regional or county level the community engagement infrastructures developed through the CRDP. By bringing together local advisory boards unaffiliated with any existing government agency or funder, local communities will be involved in implementing and evaluating promising practices. Many of these local community members do not have a voice on current mental health initiatives, and including them in the planning process would ensure that unserved, underserved, and inappropriately served communities have buy-in and commitment to the process. These boards should be multicultural and made up of representatives of organizations funded to implement the promising practices, and may include additional community representatives. They could play a number of roles including:

- Providing feedback to local agencies as they conduct promising practices
- Ensuring a community voice in the evaluation of promising practices
- Advocating on the local and statewide level for the implementation of strategies in the strategic plan

These boards should also be supported with Phase II funds. A local, regional, or statewide organization with the experience and capacity to engage in ongoing implementation of the 27 strategies should serve as the convening organization. This organization may be one of the funded TA providers, but must also possess capacity to engage on a local level.

The State should also make available funding for organizations with experience working across all five of the target populations to educate policymakers on the implementation of the 27 strategies in the strategic plan. These organizations should develop a timeline, benchmarks, and an overall strategy for effecting policy change at the state and local levels.

What Comes Next

After the completion of Phase II, county departments of mental health and their grantees could continue this work by replicating the promising practices funded during the pilot program and the State should put in place a mechanism to ensure that counties implement them as part of their Medi-Cal and MHSA-funded activities. Counties should be strongly encouraged to contract with the community organizations funded to implement the pilot programs on a wider scale to reach even more unserved, underserved, and inappropriately served communities and bring them under the umbrella of mental health services. Counties should also continue to work closely with community organizations so that they know which community-defined practices cannot be replicated without the guidance of cultural healers. Elevating the promising practices to a level where they are recognized as evidence-based and eligible for Medicaid reimbursement would allow providers to reach more unserved, underserved, and inappropriately served communities. There must also be a level of accountability to encourage counties to undertake these activities. CDPH, DHCS, the MHSOAC, and CBHDA should collaborate to develop the best methods of ensuring that counties sustain the practices that have been prove through the CRDP Phase II. It is our hope that after the conclusion of Phase II, each county in California will undertake to implement a number of the promising practices across all five target populations. Appropriate data collection and reporting methodologies will allow for accountability and reimbursement of promising practices. The ultimate goal is to use data to improve access, timeliness, and quality of promising practices, and reduce disparities for unserved and underserved populations in California.

The CRDP Partners also recommend that the State expand the activities conducted during Phase I to focus on additional unserved, underserved, and inappropriately served communities, especially immigrant groups, so that they may go through a community-led process to identify promising practices and recommendations for reducing disparities. These communities may include the Arab American community; other ethnic communities such as the Slavic, Russian, Armenian, and other Middle Eastern communities; Mixtecos and other indigenous populations; religious communities such as the Muslim, Sikh, Buddhist, and Hindu communities; and other unserved, underserved, and inappropriately served communities including the Deaf and Hard of Hearing, veterans, people transitioning from the public safety or penal system, transition-age youth, and older adults. Their recommendations and identified practices could be incorporated into the existing CRDP catalog to be funded and implemented at the conclusion of this proposed Phase III.

Finally, unserved, underserved, and inappropriately served communities should have a place at the policymaking table by the time Phase II is complete. These communities should be serving on local and statewide boards and commissions and should have a voice in the funding and evaluation of activities to reduce disparities.

## Chapter 5: Implications and Conclusion

As illustrated in this strategic plan, the current public mental health system in California is in need of transformation. With people of color representing nearly 60% of the state's population, and countless LGBTQ individuals across every race, ethnicity, age, and geographic location, the time has come to pursue targeted approaches to reduce mental health disparities for all unserved, underserved, and inappropriately served communities. With a focus on five populations –African American, API, Latino, LGBTQ, and Native American – the CRDP SPWs engaged community leaders, mental health providers, clients, and family members to identify promising practices and recommendations to transform our current public mental health system into one that better meets their needs. Their work identifies community-defined evidence that must be recognized and elevated to reduce disparities in communities large and small across the state.

The four overarching themes, five goals, and 27 strategies outlined in this strategic plan highlight the importance of culture and identity in mental health. As the State moves forward, it must incorporate cultural, linguistic, and LGBTQ competence; capacity building; data collection; and social and environmental factors that impact our daily lives into all Phase II and MHSA-funded activities. In order to reduce mental health disparities in California, the State must prioritize the five goals laid out in this plan:

- **Increase access to mental health services by providing services** in new and varied locations; ensuring communities know where to find services; focusing efforts on schools; funding services such as interpretation, staff training, and transportation; working with our criminal justice and prison systems; and developing outreach and education efforts that are culturally and linguistically appropriate.

- **Improve the quality of mental health services** by creating and supporting a culturally, linguistically, and LGBTQ competent workforce; ensuring that services are also culturally, linguistically, and LGBTQ competent; and improving linguistic access to services.

- **Ensure that communities are empowered** and provided with the tools to engage and be leaders in the public mental health system, including faith communities; parents, foster parents, and families; and all unserved, underserved, and inappropriately served racial, ethnic, and LGBTQ communities.

- **Demonstrate the effectiveness of population-specific programs,** including working with community health workers and indigenous healers; funding culturally-specific research; developing and evaluating culturally-specific practice models; allocating MHSA funding according to community need; and developing a streamlined process for recognizing evidence-based practice.

- **Develop an infrastructure to reduce disparities** by supporting state and local community engagement models to implement the CRDP strategic plan; developing community-county partnerships; evaluating and monitoring the implementation of the CRDP; and expanding the CRDP to include other underserved populations.

The 27 strategies should be implemented over the next 10 years, and need the commitment and involvement of all stakeholders in the public mental health system: the California Health and Human Services Agency, Department of Health Care Services, the California Department of Public Health, the Mental Health Services Oversight and Accountability Commission; the State legislature; and county departments of mental health. While the strategies are long-term solutions, CRDP Phase II presents an immediate opportunity to implement promising practices in unserved, underserved, and inappropriately served communities. Funding selected approaches across the five populations with strong community-based evaluation will elevate them to the level of evidence-based practice.

The California Reducing Disparities Project is a great first step to focus much-needed resources on the mental health needs of communities of color and LGBTQ communities. This strategic plan is just the beginning of what we hope will be a long-term, concerted effort to improve mental health outcomes for all Californians. By following the strategies in this plan, California can bring attention to community-defined practices and build a system that truly meets the needs of all Californians.
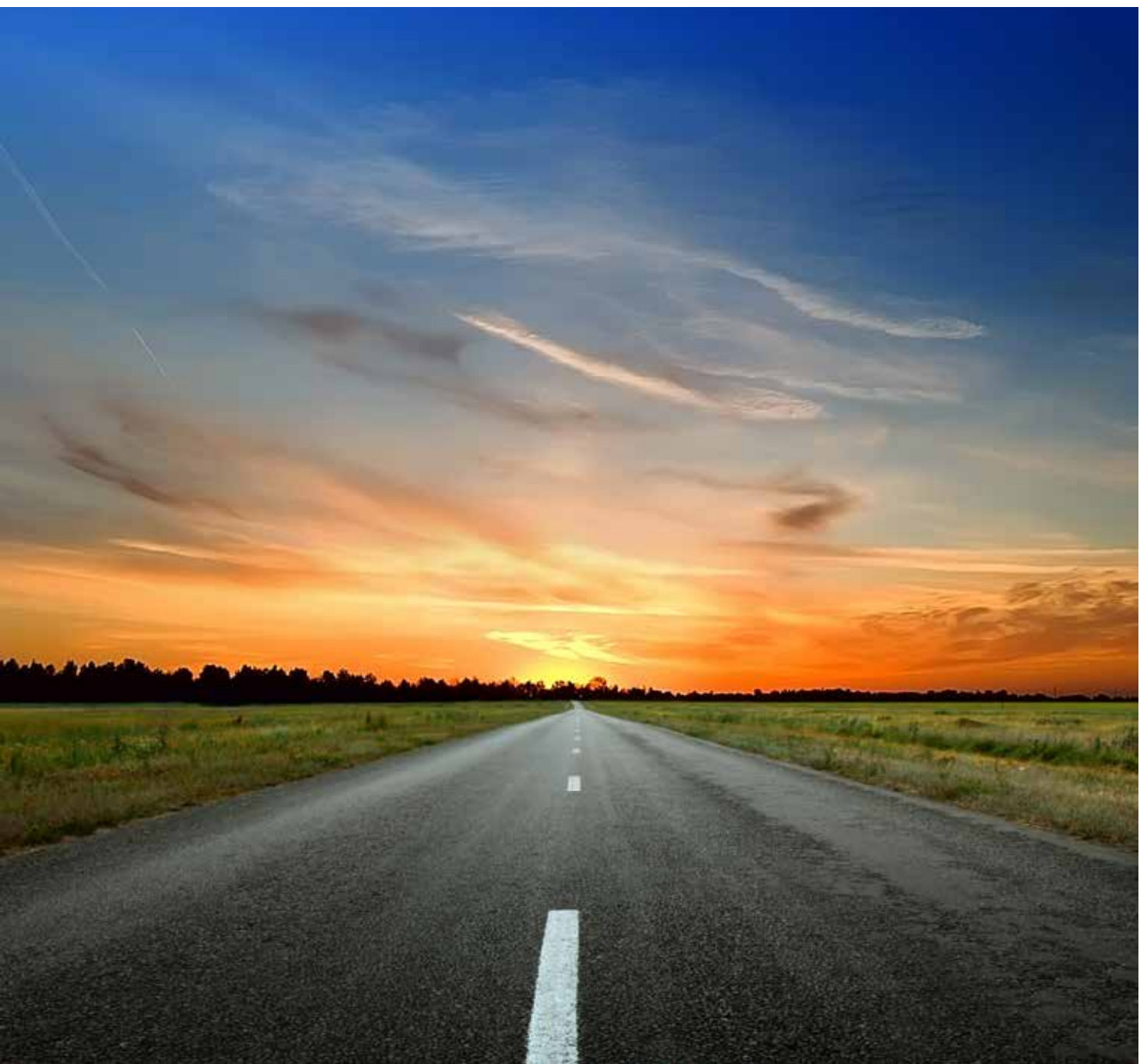
Appendix 1: Disparities in Accessing Mental Health Services

This table breaks down statistics for the 2.2 million adults who report mental health needs.

In 2011, the UCLA Center for Health Policy Research measured mental health needs by sexual orientation in their report *Adult Mental Health Needs in California*, and found that LGBTQ populations were more than twice as likely to report mental health needs. However, the study did not record the actual unmet needs for this population. Therefore, it was not possible through this study to identify disparities in unmet mental health needs among LGBTQ populations.

Age	Eleven of every twelve young adults ages 18-24 and three-quarters of adults 65 and older with mental health needs say they have received inadequate treatment or no treatment at all
Gender	Males show higher unmet needs than females, with more than three-quarters of males receiving either inadequate treatment or no treatment at all
Educational attainment	Seven out of eight adults with less than a ninth-grade education have unmet needs
Insurance status	Uninsured adults and those who are privately insured have higher rates of unmet need than those who have public insurance (e.g. Medi-Cal or Medicare)
Race and ethnicity	African Americans, Asians, Latinos, and Native Americans are more likely to have unmet needs compared to other subgroups, with Native Hawaiians, Pacific Islanders, and multiracial groups showing the highest rate of inadequate treatment
Nativity	Latinos and Asians born abroad have the highest rates of unmet needs, and U.S.-born Latinos and Asians have the highest rates of inadequate treatment
Disability Status	The rate of having a condition that limited basic physical activities was more than double among adults with mental health needs compared to those without mental health needs
English proficiency	Those with limited English proficiency have the highest rate of unmet needs
LGBTQ	After adjusting for age, gender, income, and education, the percentage of adults with mental health needs among sexual minorities (17.9%) was more than double the rate of mental health needs among heterosexuals (7.9%).

Note: Sexual minorities include adults ages 18 to 70 who self-identified as gay, lesbian, or bisexual or who reported having sex with someone of the same sex (including those with both same- and opposite-sex sexual partners) in the past 12 months.

Appendix 2: Mental Health Disparities in Communities of Color and LGBTQ Communities

Disparities in diagnosis of illness and access to mental health services are found in all races, ethnicities, sexual orientations, gender identities/expressions, and across the lifespan, including transition-age youth, transitional aging adults, and elders. The five Population Reports found that racism, bigotry, heterosexism, transphobia, ageism, and other discrimination in the United States is a constant source of stress which can lead to feelings of invalidation, negation, dehumanization, disregard, and disenfranchisement. All stakeholders must make an effort to increase cultural understanding on the societal level to help create environments where everyone can live with dignity, respect, and equal rights.

African Americans: In the African American community, members of this population are more likely than Whites to be diagnosed with serious psychological distress. For example, in California in 2005, 6.3% of African Americans were significantly more likely to report symptoms associated with serious psychological distress than Whites (3.3%).[41] Diagnosis and treatment are issues for African Americans, who are much more likely to receive a diagnosis of a condition with a poorer treatment outcome such as schizophrenia, while treatable conditions such as anxiety and mood disorders often go untreated. For example, Whites are more than twice as likely to receive antidepressant prescription treatment as are African Americans.[42] Due to a lack of access to appropriate quality care, African Americans are much more likely to have their first mental health treatment in an emergency room, or as the result of incarceration, with inadequate follow-up or referral for continuing care. They are underrepresented in outpatient care.[43]

Asians and Pacific Islanders: For adults with serious mental illness, Asians and Pacific Islanders were estimated to have a prevalence rate closer to that of all Californians. These numbers can be misleading, however, because of a disparity between native-born and foreign-born Asians. For example, while Asian mothers in general have similar rates of depressive symptoms compared to the general population, foreign-born Asian mothers had higher rates than U.S.-born mothers. These disparities are even more evident between the various Asian ethnic groups, with Filipinas reporting higher needs than Chinese and Indians, for instance, which highlights the need to disaggregate data to showcase differences between ethnic groups. Disparities are much more evident in Pacific Islanders, with Native Hawaiian and Pacific Islander adults suffering from the highest rate of depressive disorders (20%) among all racial groups, and the second highest rate of anxiety disorders (15.7%).[44]

Latinos: The prevalence of mental health conditions in the Latino community is often associated to nativity, with rapid assimilation into American culture having a negative impact. Latinos, who are 39% of California's population, continue to face significant barriers to treatment. Compared to Whites, Latinos have limited access to mental health services, often do not receive needed care, and when they do receive treatment, it is generally of a poorer quality. There are a number of reasons for these treatment disparities, including limited insurance coverage, poor provider-client communication, and limited representation of Latinos in the health care workforce.[45] The problem of underutilization is even higher in Mexican immigrants: 85% of Mexican immigrants who needed services remained untreated. Mexican migrant agricultural workers have even more pronounced underutilization, with only 9% of those needing mental health counseling obtaining services.[46]

LGBTQ Communities: LGBTQ communities encompass all races and ethnicities, so the disparities faced by all populations also apply to these communities. While LGBTQ individuals seek mental health services at much higher rates than their heterosexual or gender-conforming counterparts, they face many barriers to actually receiving the care they need. They also report high rates of emotional difficulties, such as stress, anxiety or depression. It is important to note that higher rates of mental health needs for this population are a reflection of the prevalence of the societal heterosexism, homophobia and family rejection these communities face.[47] When LGBTQ individuals seek treatment, they often do so with trepidation, fearing a provider's negative perception of their sexual orientation or gender identity/expression. These fears are often warranted: studies show that LGBTQ clients are more likely to be inappropriately served when seeking treatment for mental health needs.[48]

Native Americans: It is important to consider tribal sovereignty when addressing mental health disparities in Native Americans. Federally-recognized tribes have "nation within a nation status," allowing them the authority to govern themselves and create their own policies and laws to protect the health of their citizens. External entities – including the State and county departments of mental health – must have knowledge about the different health policies that impact tribal and urban Native Americans, and how those policies interact with federal, state, and local policy. While Native Americans have higher rates of mental health needs, they face many barriers in gaining entry into services. In California, American Indians and Alaska Natives (AI/AN) are twice as likely as Whites to have experienced serious psychological distress during the past year (11.6% vs. 5.6%). However, California AI/AN have had more difficulty than Whites (10.6 % vs. 6.8%) when accessing mental health care.[49] In addition to facing high rates of psychological distress and difficulty accessing care, they are also hampered by their own cultural experiences. Hundreds of years of historical injustice have left Native Americans distrustful of treatment options grounded in mainstream American culture, because they are based on the beliefs and values of White Americans, their historical oppressors.[50]

Appendix 3: California Public Mental Health System Entities

California Department of Education (CDE): CDE oversees California's public school system, including the oversight and enforcement of relevant laws and regulations, and ensuring continued improvement in access and quality. As part of this mission, the Department manages myriad student support services programs, including those that are related to mental health and well-being. Finally, CDE is responsible for the administration of numerous grant programs to schools, some of which support mental health programs for students.

California Department of Public Health (CDPH): CDPH oversees the Office of Health Equity (OHE), which was established in 2012 to reduce mental and physical health disparities in California. OHE works with community leaders to make sure that local input is included in policies, strategic plans, and other recommendations. The CRDP, which has worked to develop this strategic plan, is under the purview of the OHE. The Office of Multicultural Services (OMS) from the former California Department of Mental Health (DMH) is now part of the OHE.

California Mental Health Planning Council (CMHPC): The CMHPC advocates on behalf of children and adults with serious mental illness. With 32 members appointed by the Director of DHCS and eight other members chosen as state representatives, the CMHPC also provides oversight and accountability for the public mental health system and makes recommendations for mental health policy. The CMHPC serves as a conduit between the mental health system and the public, with four quarterly meetings each year in different locations across the state to maximize participation. The CMHPC conducts reviews of available mental health services and develops annual reports based on defined performance indicators.

California Mental Health Services Authority (CalMHSA): CalMHSA is a joint-powers authority that provides 53 member counties with an administrative/fiscal structure focused on mental health programming through collaborative partnerships. They pool efforts in the development and implementation of common strategies and programs; fiscal integrity, protections, and management of collective risk; and accountability at state, regional, and local levels.

Council on Criminal Justice and Behavioral Health (CJBH): CJBH is a 12-member advisory council, created by the Legislature in 2001 (as the Council on Mentally Ill Offenders) to investigate, identify, and promote cost-effective strategies that prevent adults and juveniles with mental health needs from becoming justice-involved, improve services for people with mental health needs who have a criminal justice history, and provide incentives to encourage state and local criminal justice and mental health programs to adopt best practices. CJBH is housed at the California Department of Corrections and Rehabilitation and provides advice to the Legislature and Governor.

County departments of mental health: The departments of mental health in each of California's 58 counties work closely with the State to provide mental health services, and indicate a strong commitment to reducing disparities, both through the work of county Cultural Competence/Ethnic Service Managers and the development of Cultural Competence Plan Requirements. The counties work with the Department of Health Care Services and the Mental Health Services Oversight and Accountability Commission

(MHSOAC). The majority of funding for mental health flows through the counties, which deliver services directly and through contractors.

Much of the Mental Health Services Act (MHSA) funding is distributed to county mental health programs to be spent in accordance with the required Three-Year Program and Expenditure Plans and Annual Updates for MHSA programs approved by the respective county Boards of Supervisors. The MHSA provides funding to expand community mental health services for various components, including Prevention and Early Intervention funds to reduce the stigma and discrimination associated with mental illness and to offer preventive services to avert mental health crises.[51] The Three-Year Program and Expenditure Plans and Annual Updates include information on the following programs:

- Prevention and Early Intervention (PEI)
- Services to children, including services for transition-age youth (ages 16 to 25) and foster youth (the number of children served and the cost per person must be included)
- Services to adults and seniors (the number of adults and seniors served and the cost per person must be included)
- Innovation
- Technological needs and capital facilities
- Identification of shortages in personnel and additional assistance needs from education and training programs

In developing each Annual Update, counties are required to work with community stakeholder groups, which can come from a wide range of individuals and entities involved in the mental health system, including clients, family members, service providers, law enforcement, education, social services, veterans and representatives from veterans' organizations, alcohol and drug service providers, and health care organizations, among others.

Counties must work with these stakeholders on various aspects of MHSA services, including policy, program planning, implementation, monitoring, quality improvement, evaluation, and budget allocations. When a draft Annual Update is available, counties must present it for public comment for 30 days, after which the county mental health board holds a public hearing. All substantive public recommendations are included in the Annual Update before it's approved by the county Board of Supervisors. Once adopted by the county Board of Supervisors, the Annual Update is submitted to the MHSOAC within 30 days of adoption so that they can provide the MHSOAC with the information it needs to track, evaluate, and communicate the statewide impact of the MHSA.[52]

Department of Health Care Services (DHCS): The DHCS Mental Health Services Division (MHSD) administers and oversees mental health services provided by the counties. These include Medi-Cal specialty mental health services, Mental Health Services Act services, and other community mental health services. DHCS MHSD works closely with county departments of mental health in their provision of mental health services and reviews, approves, and oversees the implementation of the Cultural Competency Plans to ensure compliance with Cultural Competence Plan Requirements (CCPRs) per 9 CCR §1810.410. Reduction of disparities is also required to be included in DHCS' Quality Strategy Report that, based on new Medicaid rules, is due annually to CMS. To that end, data collection efforts are planned to improve access, timeliness, and quality of care to previously unserved and underserved populations. The DHCS Managed

Care Divisions oversee the Medi-Cal managed care plan that cover non-specialty mental health services for Medi-Cal beneficiaries that have mild to moderate levels of impairment. In 2012, all Medi-Cal related mental health functions were transferred from the former DMH to DHCS.

Mental Health Services Oversight and Accountability Commission (MHSOAC): The Mental Health Services Oversight and Accountability Commission, an independent state agency, was created in 2004 by voter-approved Proposition 63, the Mental Health Services Act. The Commission provides oversight, accountability and leadership to guide the transformation of the California mental health system. The Commission fulfills this charge by advising the Governor and Legislature, conducting research and evaluation, administering stakeholder advocacy and mental health triage personnel grants, and reviewing and approving county innovation projects and undertaking special research projects related to mental health service delivery.

Office of Statewide Health Planning & Development (OSHPD): OSHPD enhances access to safe, quality health care environments that meet California's diverse and dynamic needs. In 2012, the MHSA WET program was transferred from the former DMH to OSHPD. Designed to remedy the shortage of qualified individuals who can provide services to those who are at risk of or have a severe mental illness, the WET program focuses on improving access to qualified mental health professions. The WET program looks to address California's mental health workforce needs through the implementation of: stipend and loan forgiveness programs that help recruit and retain individuals; grants to educational institutions to increase the capacity of mental health training and education programs; grants to entities that engage in mental health career awareness and retention activities; and grants to entities that engage in activities to increase the employment of consumers and family members. It also funds regional partnerships to address regional mental health workforce needs. All statewide mental health workforce development strategies are outlined in the WET Five-Year Plan 2014-2019.

Appendix 4: Community Assets and Considerations to Address Stigma

Population	Examples
African American	Because belief and trust are so critical to the acceptance of mental health services in the African American community, faith-based organizations often receive the first inquiries when individuals or families are experiencing mental health concerns.[53] Several interdenominational alliances in the African American community help pastors and lay ministers understand how to respond to these queries and refer community members to trusted sources for appropriate professional care.
Asian and Pacific Islander	Immigrant-focused organizations that use culturally and linguistically appropriate outreach approaches and programs can effectively reduce stigma and determine mental health needs. Psycho-education workshops in the language of choice are often effective in addressing stigma.
Latino	Latino focus group participants emphasized the importance of using *promotoras/es* to reduce stigma. *Promotoras/es* can connect clients with resources, and mentor and train others to serve as *promotoras/es*. The *promotoras/es* model builds on community strengths and is guided by a goal to empower and organize the community so that people know what to do during a crisis.
LGBTQ	Assessment should include gender-neutral and open-ended questions. Asking questions in a manner that presumes gender-conforming identity, heterosexuality or different-sex attraction can be interpreted as heterosexist, potentially alienating LGBTQ clients and/or causing them to be fearful of revealing their LGBTQ status. In addition, mental health providers should not assume they know a client's sexual orientation based on the client's sexual behavior or vice versa. It is also important to recognize that a client's gender identity may differ from their outward appearance.
Native American	Promising efforts to reduce stigma include community gatherings with speakers discussing wellness and the strengths of family and community. Native American culture naturally embeds protective factors for mental health without using the terms "mental health."[54]

Note: Additional approaches and specific examples can be found in the five Population Reports, available at the following link:

https://www.cdph.ca.gov/Programs/OHE/Pages/CRDP.aspx

Appendix 5: Community Assets and Considerations to Address Discrimination and Social Exclusion

Population	Examples
African American	Programs that develop a sense of self-confidence, self-esteem, and racial identity help foster resilience and strength, and improve the wellbeing of African American children in a society that often devalues them with negative stereotypes and assumptions. This could include community-based, culturally appropriate services such as psycho-social educational support groups for youth; guidance in establishing healthy African American identity; youth leadership; and life skills training.
Asian and Pacific Islander	Community-based programs or centers that provide culturally and linguistically appropriate outreach, engagement, and services to the API community can be critical partners in addressing discrimination and social exclusion. Programs that provide services in addition to mental health can be effective in encouraging service utilization.
Latino	Co-location is an approach that integrates mental health into primary care as a pathway to improve access to and utilization of mental health services. For Latinos, co-locating resources in areas central to the community plays an important role in building an infrastructure that is inclusive, culturally and linguistically relevant, sensitive to Latino LGBTQ needs, and comfortable for clients. Co-location also increases the likelihood that individuals and families will seek care and adhere to their treatment. Latinos who sought mental health treatment or had a family member seek help described the significant role that family plays in the success of individuals' recoveries.
LGBTQ	Community-based partnerships that include local entities and services, such as churches, schools, mental health centers, and community-based agencies, can help address discrimination and social exclusion. Using concepts based on the Family Acceptance Project to highlight the impact of rejection on LGBTQ youth, they can expand the model beyond the family to broader social settings and address policy and practice changes within schools, faith-based, and mainstream social service and medical-based settings.
Native American	Historical trauma and the historical trauma response has deeply impacted Native American culture and affected mental health. Strengthening cultural identity is a key way to promote wellness. Communities should revive or sustain cultural traditions/practices, languages, and ceremonies to address the loss of culture and improve wellness.

Note: Additional approaches and specific examples can be found in the five Population Reports, available at the following link:
https://www.cdph.ca.gov/Programs/OHE/Pages/CRDP.aspx

Appendix 6: Community Assets and Considerations to Address Language Barriers

Population	Examples
African American	Acknowledging that Black people in America are different relative to socialization and nationality is critical to providing appropriate services. For example, programs that provide cultural services including language interpretation in African and Caribbean languages and dialects may help clients feel comfortable, validated, and appropriately served.
Asian and Pacific Islander	Interpretation services have proven effective in some cases, but only when both the clinician and the interpreter are appropriately trained to work with the population they serve. Providers should add additional time for appointments when interpretation services are used; this can help clients feel that they have time to discuss their needs. Interpretation services must also be billable and reimbursable.
Latino	The key to addressing language barriers is to leverage the culture and community assets of the client so that he or she feels acknowledged and validated.[55] For example, a *fotonovela*, a culturally informed health literacy media tool that presents information in familiar, readable, and entertaining format, will help increase client understanding. In addition, having interpreters or bilingual providers may increase providers' ability to not only speak the client's language, but also understand the client's historical and cultural background. The ability to understand mental disorders within the context of the Latino culture and the ability to perform culturally sensitive and acceptable treatment is of great importance to the community.
LGBTQ	LGBTQ individuals exist in all populations and therefore LGBTQ competent services need to include the ability to communicate in the client's preferred language and understanding how religion and culture play a role, while population-specific programs should make efforts to provide LGBTQ-competent services.
Native American	Native tribal language sustainment and revival help rekindle pride in identity and allow communities to convey stories, tribal concepts, and healing ceremonies that can be lost in translation. It's also a practice that elevates the importance of elders in the community and allows them to be recognized as leaders while passing valuable traditions to the next generations.

Note: Additional approaches and specific examples can be found in the five Population Reports, available at the following link:

https://www.cdph.ca.gov/Programs/OHE/Pages/CRDP.aspx

Appendix 7: Community Assets and Considerations to Address Lack of Insurance

Population	Examples
African American	Community-based prevention and early intervention approaches that bring services to hard-to-reach clients, including the homeless, addicts, and ex-offenders, through service delivery at churches, schools, and other community facilities, can positively impact mental health, increase resiliency in children and youth, and create a sense of family and belonging to reduce risky behaviors.
Asian and Pacific Islander	Due to cultural differences, symptoms for Asians and Pacific Islanders with mental health needs may differ from those commonly observed in Western culture. Eligibility requirements that determine what is covered by insurance may have to be adapted for this community. Additional resources have to be identified to provide services to uninsured or inadequately insured individuals.
Latino	Integrating mental and physical health services within community locations – including schools, community centers, and churches – will increase access to mental health services for those without insurance and a primary source of care. Taking the services to where people live and work enables organizations to collaborate and share resources to better serve the Latino community.
LGBTQ	LGBTQ focused or supportive clinics and service providers that can meet the specific needs of LGBTQ clients have provided services on a sliding scale to help make them easily accessible and available to everyone. Resources and referrals to other LGBTQ-affirming organizations also help.
Native American	Community-based resources such as directories of Native American focused community services can provide Native Americans with the opportunity to find mental health services when they are needed.

Note: Additional approaches and specific examples can be found in the five Population Reports, available at the following link:
https://www.cdph.ca.gov/Programs/OHE/Pages/CRDP.aspx

Appendix 8: Community Assets and Considerations to Address Social and Environmental Conditions

Population	Examples
African American	Programs that engage homeless, poor, and low-income individuals in activities to build community, engage in decision making and advocacy, and build self-sufficiency can address issues such as unemployment, housing, racism, classism, sexism, feelings of oppression, and intergenerational traumatic experiences, which all directly and indirectly impact mental health.
Asian and Pacific Islander	Limited office hours and lack of transportation has deterred many community members from accessing services. More flexible and expanded office hours and transportation assistance are critical to addressing these barriers.
Latino	Community-defined evidence programs and practices identified by Latino participants focus on accessibility, availability, appropriateness, affordability, and advocacy in order to address societal issues (e.g., transportation, poverty, education) that prevent Latinos from seeking treatment.
LGBTQ	Programs that provide social support and presentations through group meals for LGBTQ seniors with limited or no access to social programs can help to address issues of food insecurity and isolation.
Native American	Due to lack of transportation, poverty, and other lower socioeconomic conditions, community members have significant difficulty accessing services. Tribal, rural, and urban areas need adequate resources to overcome these barriers.

Note: Additional approaches and specific examples can be found in the five Population Reports, available at the following link:

https://www.cdph.ca.gov/Programs/OHE/Pages/CRDP.aspx

Appendix 9: Community Assets and Considerations to Address Quality of Care and Satisfaction

Population	Examples
African American	In its relationship to the African American population, the formal mental health system has offered inaccurate diagnoses, disproportionate findings of severe illness, greater usage of involuntary commitments, and inadequate service integration.[56] The public mental health system should establish a Black care paradigm and certify professionals in culturally congruent mental health care and programs.
Asian and Pacific Islander	Achieving high quality, culturally and linguistically competent care takes more than just hiring bilingual staff. To provide quality care to the API community, a program needs to consider cultural factors such as language, traditions, spirituality, and history, and these factors should be a critical part of what defines quality of care.
Latino	Protective factors such as *Personalismo* (relationships), *Familismo* (family), and *Respeto* (respect) are cultural values that speak to the importance of building trust and personal relationships. These person-centered approaches emphasize empathy, warmth, and attentiveness. Physical proximity, such as a hand on the shoulder to show concern, helps build strong relationships between providers and patients.
LGBTQ	Practitioners should honor the experiences of each individual LGBTQ client, learning that every person has their own unique story to tell. This does not mean, however, that professionals should rely on their LGBTQ clients to provide them with the education needed for culturally and linguistically competent practice. When working with LGBTQ individuals, mental health providers should not overly attribute a client's issues to their LGBTQ status, nor should their LGBTQ identity be dismissed or ignored.
Native American	Offering care only in a clinical setting might not always produce the best results. For group-oriented cultures like many Native American communities, group-based or community-oriented interventions are often effective, more accepted, and many times more appropriate. As widely documented in psychosocial literature, some of the protective factors embedded in Native American culture include belonging, feeling significant, and having a supportive social network of family and community members who serve as counselors, mentors, and friends.

Note: Additional approaches and specific examples can be found in the five Population Reports, available at the following link:
https://www.cdph.ca.gov/Programs/OHE/Pages/CRDP.aspx

Appendix 10: Community Assets and Considerations to Address Lack of Appropriate Data Collection

Population	Examples
African American	Due to limitations in the U.S. Census and other data collection efforts, additional data is needed to more clearly understand the needs of the African American population. As people of African ancestry are not homogenous, we need data to tell us not only how many clients are being served, but also how they are using the system and what mental health conditions are being presented. This will give us better insight into where to target early detection efforts.
Asian and Pacific Islander	It is important to examine each racial and ethnic subgroup within the Asian and Pacific Islander community, and collecting disaggregated data is crucial to uncovering the true disparities in AANHPI communities. Data collection is particularly important for Pacific Islanders and Native Hawaiians, and should include data on immigration history, acculturation level, socioeconomic status, and educational attainment in order to find the most effective ways to treat mental health issues for all individuals.
Latino	According to Latino SPW participants, providers need to develop accountability panels to develop culturally attuned evaluation instruments to measure the impact of services in the community, and identify baselines to better gauge penetration and retention rates over time. These panels should consist of clients, family members, legislators, and other civil servants; personnel from nonprofit organizations; representatives from educational institutions, law enforcement, and criminal justice systems; and community advocates.
LGBTQ	Whenever demographic data (e.g., race, ethnicity) is collected as a tool to evaluate and improve services, sexual orientation and gender identity data should be included. Intake, data collection, and reporting systems should be modified to count – and analyze data trends for – LGBTQ populations in order to identify possible mental and physical health disparities, gaps in service, and successes in service provision, and to support appropriate resource allocation. Data collection and analysis should not be predicated on the assumption that LGBTQ individuals will self-identify on intake forms or interviews. These systems should be designed with LGBTQ individuals' need for anonymity in mind.
Native American	Many Native American agencies and tribes have data sources that provide the most accurate information and have added insight into the mental health needs of Native communities. These should be viewed by the State as a resource for understanding the community's needs.

Note: Additional approaches and specific examples can be found in the five Population Reports, available at the following link:
https://www.cdph.ca.gov/Programs/OHE/Pages/CRDP.aspx

Appendix 11: Additional Community Approaches to Reduce Disparities

African American	• Recruiting, training, and supporting certified foster parents to care for children who have been removed from unsafe home situations, placing them in a loving, safe environment. • Embracing the concept of villages – churches, housing communities, schools, health clinics, probation sites, and welfare centers – as a model of service delivery to address the needs of families. • Engaging in aggressive outreach programs with dedicated staff that interfaces with multiple service providers to ensure culturally relevant services across the life span. • Using fashion design and business skills to increase self-esteem and personal development in young African American women who are at risk for gang involvement.
Asian and Pacific Islander	• Creating outreach efforts that target families and communities, and not just the individual. • Employing bilingual and bicultural staff to significantly increase penetration rates for the Asian population in California. • Counteracting stigma through innovative approaches such as tailored community services for specific cultures and age groups and the inclusion of social and recreational activities.
Latino	• Implementing approaches, such as peer support and mentoring programs, which focus on education and support services. • Developing family psychoeducational curricula to increase family and extended family involvement in health care and promote health and wellness. • Promoting wellness and illness management, and favoring community-based services that integrate mental health services with other health and social services. • Employing community capacity-building to build on community strengths to improve Latino behavioral health outcomes.

Appendix 11: Additional Community Approaches to Reduce Disparities

LGBTQ	• *The Family Assistance Project's FAPrisk Screener for Assessing Family Rejection & Related Health Risks in LGBT Youth* screens LGBTQ youth and young people to identify those experiencing harmful types of family rejection from parents, foster parents, and caregivers, and to guide practice and follow-up care. • Bringing together religious leaders, LGBTQ people of faith, and their allies from a wide range of religious traditions to act as agents of positive social change for LGBTQ people. • Gay-Straight Alliances are student-run clubs, typically in a high school or middle school, that bring together LGBTQ and straight students to support each other, provide a safe place to socialize, and create a platform for activism to fight homophobia, transphobia and other related oppressions such as racism, classism and sexism. • Offering domestic violence services that address the unique and complex needs of LGBTQ individuals and families, and those in traditionally unserved, underserved, and inappropriately served LGBTQ populations, including people of color who are also LGBTQ.
Native American	• Continuing traditional healing practices that include individual and group counseling, talking circles, seasonal ceremonies, sweat lodges, storytelling, pow-wows, roundhouse ceremonies, drumming, smudging, and educational and cultural activities led by traditional American Indian spiritual leaders. • Using established Native-specific curriculums, such as the "Gathering of Native Americans" (GONA), which focuses on the substance abuse and mental health issues underlying addiction and other self-destructive behavior. • Two-spirit GONA includes anyone who identifies as Native and LGBTQ/ two-spirit so they can discuss and address substance abuse issues in a safe, welcoming, and supportive space. The two-spirit GONA allows participants to talk about the impact of homophobia/biphobia/ transphobia and the complexities of gender, sexual orientation, and sexuality inside of a cultural context. • Engage Native American communities directly and uniquely as they will know best how to improve wellness in their own population.

Note: Additional approaches and specific examples can be found in the five Population Reports, available at the following link:
https://www.cdph.ca.gov/Programs/OHE/Pages/CRDP.aspx

Appendix 12: Implications of Health Care Reform

Thanks to the passage of the Patient Protection and Affordable Care Act (ACA) in March 2010, millions of Californians, many from the five targeted population groups, have found themselves newly eligible for health coverage since the law took full effect in January 2014. The ACA, in conjunction with the California Reducing Disparities Project, provides an opportunity to plan now for new ways to address disparities.

The ACA expanded eligibility for Medi-Cal (California's Medicaid program) to all individuals and families under 138% of the federal poverty level. Covered California, the state's insurance marketplace exchange, allows individuals and small businesses to shop for and buy health insurance, with tax credits for those between 138% and 400% FPL, to help make coverage affordable.

These coverage expansions are just one of the ways the ACA has improved mental health services across the country. With insurance, those previously uninsured now have access to providers who can diagnose and treat their mental health needs. The law also prevents insurance companies from denying coverage based on pre-existing conditions, which helps ensure that clients with histories of mental illness and substance use are not denied coverage.

The ACA also expands mental health services to those in public coverage programs. Mental health and substance use services are one of the essential health benefits that must be covered by plans participating in Medi-Cal Managed Care and Covered California. The law also requires providers to offer rehabilitative services and prescription drugs.

The law emphasizes prevention as well, including in mental and behavioral health. As part of the ACA's Prevention and Public Health fund, $70 million was allotted to help with the coordination and integration of primary care services into publicly-funded community mental health and other community-based behavioral health settings. These funds will also be used to expand suicide prevention activities and screenings for substance use disorders.[57]

Appendix 13: Social and Environmental Issues Impacting Mental Health

Mental health is significantly impacted by social and environmental factors encountered in our daily lives. These various factors, from income and housing to transportation and community safety, can be sources of added stress that affect our wellbeing.

Having access to transportation systems can impact our health in many ways. For those who are already in treatment for mental health conditions, public transportation can help them get to appointments on time. Living in a neighborhood with convenient public transportation makes it easier to access care and other important services.[58] Residents in low-income areas and communities of color are often less likely to own a car, so they may rely more on public transportation to go to the doctor.[59] Unequal access to public transportation, particularly in rural communities, can cause additional stress for those relying on it to get to work every day.

Housing options also play an important role in our wellbeing. Everyone wants to have a place to call home, where we spend time with family and feel safe and secure. Quality, affordable housing relieves our community members of the stress of struggling to make rent and ensures enough money is left over to pay for transportation, healthy foods, health care, and other necessities that contribute to our wellbeing. The housing crisis has disproportionately impacted communities of color. Though they represent just 30% of homeowners in California, African Americans and Latinos make up half of those who have gone through foreclosure.[60] The lack of quality, affordable housing can lead to family stress and poor mental health.

No matter where we live, it is important to feel safe. The safer our communities, the more likely we are to socialize with our neighbors and take public transit. But the fear of violence – real or perceived – leads to increased isolation, psychological distress, and prolonged elevated stress levels.[61] Increased violence also leads to high incarceration rates, which destabilize communities by removing parents, children, brothers, and sisters from their homes. Current research indicates that developing relationships, feeling a sense of belonging, and being able to rely on friends and neighbors for support all promote wellbeing by reducing stress, improving mental health, and increasing positive health-related behaviors.[62]

Not feeling safe in one's neighborhood is correlated with increased levels of psychological distress. For example, American Indians/Alaska Natives who perceive their neighborhood as unsafe are more than twice as likely to experience psychological distress as those who perceive their neighborhood as safe (25% vs.10%).[63]

In order to effectively reduce disparities, it is important to address many of these social and environmental factors. A comprehensive approach to reducing mental health disparities must take into account many of the added stressors faced by our communities and find ways to alleviate them so that everyone has the opportunity to lead healthy lives.

Appendix 14: Strategic Planning Process

To develop an effective approach to reducing disparities in mental health across the state, several entities came together to create this plan as the CRDP Partners, including CPEHN and the project leads from the five Strategic Planning Workgroups (SPWs) and the California MHSA Multicultural Coalition (CMMC).

As the first stage of the strategic plan's development, the State funded five agencies to create SPWs in five target populations: African Americans, API, Latinos, LGBTQ, and Native Americans. Each of the five SPWs was tasked with gathering information from their communities through an intensive community-based participatory research process, the first of its kind in California. Using focus groups, interviews, and surveys, community-based participatory research allowed community members the opportunity to be equally involved in this in-depth investigation into mental health services, community needs, and policy recommendations. Through this process, the SPWs have identified approaches taken by multicultural and LGBTQ communities for multicultural and LGBTQ communities. This community-defined evidence focuses on a set of practices found to have positive results as determined by community consensus over time. Community-defined evidence takes a number of factors into consideration, including historical and social contexts that are culturally rooted.[64] The practices highlighted within the Population Reports may or may not have been measured empirically but have been accepted within their respective communities. The SPW reports also include policy recommendations to transform the public mental health system to better serve their communities. Once they completed the initial drafts of their reports, the SPWs went back to their communities to solicit feedback on their findings and recommendations. The reports were then reviewed by CDPH and the California Health and Human Services Agency. All five reports have been reviewed, published, and are being disseminated throughout the state.

After their completion, CPEHN reviewed drafts of each of the Population Reports to identify overarching themes and strategies for reducing disparities. CPEHN developed an outline for the strategic plan based on previous statewide plans for suicide prevention and reducing stigma and discrimination, but with changes to reflect the community-based focus of this project. This outline was presented to and reviewed by the then-DMH Office of Multicultural Services, the SPWs, and the CMMC. The CMMC is tasked with helping integrate cultural and linguistic competence into the public mental health system, providing a new platform for racial, ethnic, and LGBTQ communities to jointly address historical systemic and community barriers to care, and identifying solutions to eliminate these barriers and mental health disparities. All of these entities provided thoughtful and vital feedback.

During the writing of the strategic plan, CPEHN regularly convened the CRDP Partners to strategize and prioritize themes. As the population-specific reports were completed, CPEHN compiled each SPW's recommendations for discussion with the CRDP Partners, and the CRDP Partners met during a full-day retreat to determine what should be included and expanded upon in the strategic plan.

After the draft strategic plan was developed, it was submitted for review to the California Department of Public Health and the California Health and Human Services Agency. Upon being reviewed by CDPH and CHHS, CPEHN posted the draft plan on its website, disseminated it, and began a 35-day public comment period in early 2015 to solicit input and feedback on the plan from communities that were not reached during the initial development of the Population Reports. During the public comment period, CPEHN hosted five town hall meetings in the following locations: Eureka, Fresno, Los Angeles, Oakland, and San Diego.

CPEHN took the comments collected during the town hall meetings and via email during the public comment period and developed a matrix to track the comments. Over the course of a month, CPEHN staff assessed feedback received, determined which feedback was relevant to include in the strategic plan, and updated the draft to resubmit to the State for review.

California Reducing Disparities Project Glossary of Acronyms

ACA Affordable Care Act

AI/AN American Indian/Alaska Natives

API Asians and Pacific Islanders

ASL American Sign Language

CalMHSA California Mental Health Services Authority

CBHDA County Behavioral Directors Association of California

CC/ESM Cultural Competence/Ethnic Service Managers

CCESJC Cultural Competency, Equity & Social Justice Committee

CCHCs Community Clinics and Health Centers

CCPRs Cultural Competence Plan Requirements

CDE California Department of Education

CDPH California Department of Public Health

CHIS California Health Interview Survey

CiBHS California Institute for Behavioral Health Solutions

CLAS Culturally and Linguistically Appropriate Services

CLCC Cultural and Linguistic Competence Committee

CMHPC California Mental Health Planning Council

CMMC California MHSA Multicultural Collation

CPEHN California Pan-Ethnic Health Network

CRDP California Reducing Disparities Project

DHCS Department of Health Care Services

DMH Department of Mental Health

FQHCs Federally Qualified Health Centers

GSA Gay-Straight Alliance

HHSA Health and Human Services Agency

LGBTQ Lesbian, Gay, Bisexual, Transgender, Queer, and Questioning

MHSA Mental Health Services Act (Also known as Proposition 63)

MHSOAC Mental Health Services Oversight and Accountability Commission

OHE Office of Health Equity

OSHPD Office of Statewide Health Planning and Development

PEI Prevention and Early Intervention

SPWs Strategic Planning Work Groups

TA Technical Assistance

WET Workforce Education and Training

WIC Women, Infants, and Children

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