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

Funded by the Mental Health Services Act (Proposition 63)

November 2014

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Chapter 1: Introduction and Background

The *Strategic Plan to Reduce Mental Health Disparities* was developed by the California Pan-Ethnic Health Network (CPEHN) in partnership with and as a member of the California Reducing Disparities Project Partners, which also includes the project directors of the Strategic Planning Workgroups (SPWs) from five populations – African Americans, Asians and Pacific Islanders (API), Latinos, Native Americans, and lesbian, gay, bisexual, transgender, queer, and questioning (LGBTQ) communities – and the California Multicultural MHSA Coalition (CMMC), and funded through the Mental Health Services Act (MHSA, or Proposition 63). 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 front lines. The focus of the strategic plan is on improving the delivery of prevention and early intervention services for California's unserved, underserved, and inappropriately served communities.

California's Rich Cultural History

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. The 2010 Census shows that communities of color are increasingly the majority in California (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 close to 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.

California Population by Race/Ethnicity 2010
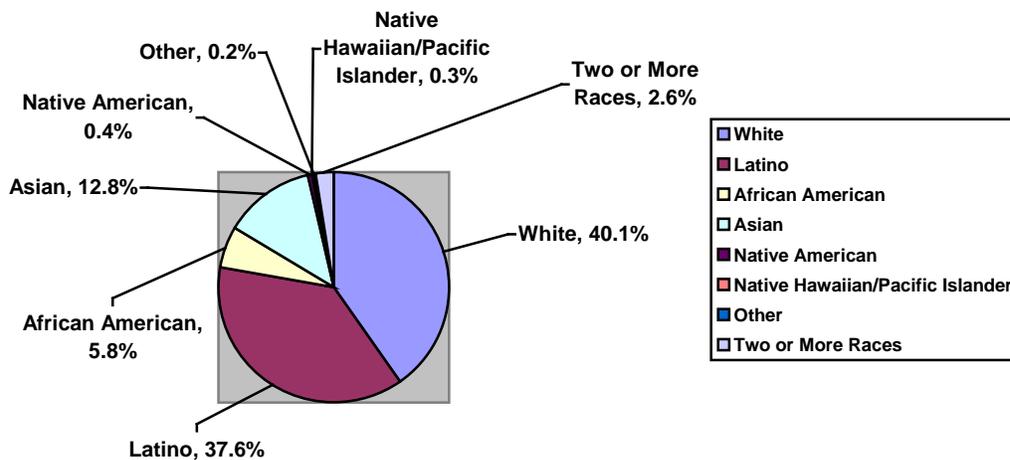
This data does not include lesbian, gay, bisexual, transgender, LGBTQ communities who are not included in current statewide or federal data collection systems. In addition, communities of color are often not accurately reported due to racial misclassification and under-reporting. As a result of the way 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 the state's current inequities in both physical health and mental wellbeing.

Accessing Mental Health Services in California

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 (i.e., they had symptoms consistent with severe psychological distress and their mental health interfered with their day-to-day functioning), the vast majority received either inadequate treatment or no treatment at all. Responses to the 2007 California Health Interview Survey (CHIS) showed that there are several factors that impact disparities in accessing mental health services, including age, gender, educational attainment, insurance status, race and ethnicity, nativity, and English proficiency.[3] See *Appendix 1* for more information.

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, and gender identities/expressions. The population reports developed by the five SPWs found that the history of racism, bigotry, heterosexism, 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, policies enacted over the past 400 years have resulted in mental health stresses continuing from generation to generation. Discrimination based on language and cultural assimilation adds significant stress in many populations, in particular the 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 faced by 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 is important to be familiar with the entities and organizations that support the State's public mental health system, which has gone through numerous changes over the past several years.

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, with those funds earmarked 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.[4] 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, and (5) Prevention and Early Intervention (PEI). The CRDP is focused on PEI programs, which emphasize approaches to reduce negative outcomes that may result from 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 also advises the governor and legislature on mental health policy. Several state agencies have oversight on 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).

The departments of mental health in each of California's 58 counties work closely with state agencies 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 (see *Current State and Local Efforts to Reduce Disparities* on page 7). The majority of the MHSA funding is distributed through county mental health programs. The California Behavioral Health Directors Association (CBHDA) represents the mental health directors from all of California's counties, and the California Mental Health Services Authority (CalMHSA), through its 47 member counties, funds a mental health programs at the state, local, and regional level. 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 statewide behavioral health system has become complicated, with multiple agencies serving overlapping populations. The former California DMH and Department of Alcohol and Drug Programs administered funding for services at the county level. DMH also administered care in five state-run mental hospitals and for the California Department of Corrections and Rehabilitation. 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 statewide 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.[5] In order for this realignment to be successful, each county must make it a priority to engage these populations and keep them involved throughout the stakeholder process.

This past year has seen a continued shift in the role of the state in mental health services. As of July 1, 2012, the former DMH transitioned into the Department of State Hospitals (DSH) as part of Governor Jerry Brown's plan to shift oversight of community mental health services to the local level while creating a new department dedicated to improving care at State hospitals.

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 Department of Health Care Services, including the Office of Suicide Prevention, Veterans Mental Health, and several other MHSA programs. The Office of Multicultural Services, which includes the CRDP, has moved to the new Office of Health Equity in the California Department of Public Health (CDPH), along with the Office of Women's Health, the Health in All Policies Task Force, the Healthy Places Team, and the Office of Multicultural Health.

In addition, the Early Mental Health Initiative has been transitioned to the Department of Education; Mental Health Rehabilitation Centers and Psychiatric Health Facilities Licensing is under the purview of the Department of Social Services; and 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 8).

Current State and Local Efforts to Reduce Disparities

Efforts to reduce disparities in mental health care are already underway, and the importance of this issue cannot be understated. In the summer of 2011, the former DMH held a number of 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. One of the key themes that emerged as essential and a priority in the state's public mental health system was reducing disparities.[6]

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:

MHSOAC Cultural and Linguistic Competence Committee (CLCC): One of five committees of the MHSOAC, the CLCC works to include the perspectives of racial, ethnic, and cultural communities in MHSOAC decisions and recommendations. The CLCC reviews MHSOAC processes and provides recommendation on how the Commission can achieve meaningful participation from these communities, how the MHSA reduces disparities and improves outcomes in these communities, and organizes activities and tasks to increase learning related to cultural and linguistic competence.

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

California Institute for Behavioral Health Solutions (CiBHS) Programs: CiBHS provides leadership and support to State and county public mental 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, with a focus on translating and bridging the gap between research and implementation in local systems of care and supporting the development and study of effective practices.

Cultural Competence/Ethnic Service Managers (CC/ESM): Every county has a CC/ESM who reports to and has direct access to the County Mental Health Director. Established in the 1990s, the CC/ESMs are responsible for ensuring that counties meet cultural and linguistic competence standards in the delivery of community-based mental health services. They function as 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 planning and activities in the county; identifying 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.

County Cultural Competence Plan Requirements: Each county must develop and submit to the Department of Health Care Services a cultural competence plan for the entire county public mental health system, including Medi-Cal services, MHSA programs, and realignment. Each county is required to submit a comprehensive plan every three years, with annual updates in the interim years. 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 Cultural Competence Plan Requirements (CCPR), it is not explicitly stated. 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

Workforce Education and Training (WET): 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. Prior to the passage of the MHSA, California was already facing 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 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 (MHLAP), 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 the existing disparities, the State must pursue other comprehensive approaches to build on the progress made by these programs and initiatives.

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 then-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, the former DMH launched a statewide PEI effort, the California Reducing Disparities Project, which focuses on five populations:
- African Americans
- Asians and Pacific Islanders (API)
- Latinos
- Lesbian, Gay, Bisexual, Transgender, Queer, and Questioning (LGBTQ)
- Native Americans

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 1 focuses on developing strategies to transform the public mental health system and identifying community-based promising practices in each of the five targeted populations. Phase 2 will focus on funding and evaluating the promising practices identified in Phase 1, 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 on the national stage 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 system of services that meets the mental health needs of all Californians. For example, **community resiliency** is developed as a result of families, friends, churches, schools, and community groups working together to strengthen both individuals and communities. This resiliency can help individuals develop a cultural identity and form a support network to strengthen prevention and early intervention programs and enhance access to care for mental health needs. In many unserved, underserved, and inappropriately served communities, **family involvement** is also key to improving mental health outcomes. Many people of color who 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 that have had successes in mental health treatment could share their experiences, knowledge, and skills with other families going through similar challenges.[7] Conversely, family rejection plays a large role in the mental health of LGBTQ youth and young adults. LGBTQ youth reporting high levels of family rejection are more likely to attempt suicide, experience depression, and use illegal drugs.[8] **Community resources**, such as school-based mental health programs and faith-based programs, can help build a strong response to 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 all parents on how rejection impacts the mental health of their children and other family members.

Strengths or protective factors that emerge from one's **culture and traditions** are assets that can deter and reduce mental health disparities if successfully infused into innovative efforts to engage community members in mental health services and programs. 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.[9] 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. Latino communities emphasized the use of "*platicas*" or meaningful conversations used in support groups which included people with similar experiences and or testimonials of Latino clients with successful recovery stories as an inspiration and sign of hope. Also vital is the need to integrate LGBTQ individuals into cultural practices where they will feel accepted and affirmed, as well as integrating cultural practices into LGBTQ-specific services.

Building on Strengths to Reduce Barriers

There are a number of innovative approaches that capitalize on these community assets to increase access to mental health services. By addressing barriers – stigma, discrimination, language, insurance status, social and environmental conditions, care quality and satisfaction, and lack of appropriate data collection – California can create a comprehensive system of services that improves mental health outcomes across race, ethnicity, sexual orientation, and

gender identity/expression. While many community organizations have implemented innovative and successful prevention and early intervention programs, more broad-based support is needed to sustain and expand these models. Throughout this section, the plan highlights several barriers, with a few examples of how communities are using their assets to address these issues.

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, it is important that system-level approaches acknowledge the importance of providing safe and welcoming environments that encourage clients to ask for help. Culturally and linguistically appropriate outreach and education can help confront negative 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 have eased the common fear that those seeking mental health services will be perceived as weak. One strategy that has proven effective are Black Barbershop and Beauty Shop Outreach Programs, which educate and engage African American communities about health issues in everyday settings. For other examples of how community assets and considerations can address stigma, see *Appendix 4*.

Discrimination and Social Exclusion
All five of the population groups face discrimination, which has not only compounded the stigma of having mental health issues, but also helped cause them. 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. 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 brought up 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. In order to treat the effects of discrimination and social exclusion, it is vital to ensure that the public mental health system is equipped and providers are 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 Native American culture and affected mental health. Strengthening cultural identity is a key way to counter this exclusion and discrimination while promoting wellness. Communities should 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.

Language Barriers
The lack of linguistically accessible services creates a barrier for many people of color 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 level, and other key factors can be useful in educating clients and the community about available services. Ethnic media outlets, including newspapers, radio, and television, can be effective at reaching large audiences in their preferred language.

Once they access services, individuals experiencing mental health issues often have a hard time talking about them, so it is important to create an environment where they can be comfortable. Clients must be able to receive services in their primary language. This should be considered when making staffing decisions, as bilingual staff that are not trained interpreters often do not have adequate proficiency in both languages and training on how to interpret.[10] The ability to fully communicate with their provider is vital for clients to receive appropriate services. 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, it is vital that interpreters and providers are trained on not only the language of the populations they are serving, but also on mental health issues and cultural considerations. In particular, interpreters must be able to interpret seamlessly, as often clients 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.

The key to addressing language barriers is leveraging the culture and community assets of the client 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.

Insurance Status
Cost of treatment has been found to be a significant barrier in mental health.[11] While there are differing opinions 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 benefitted mental health services in California. While it is unclear how many LGBTQ individuals lack health coverage, communities of color represented 75% of the state's 7 million who were formerly uninsured. Through the expansion of public coverage programs, as many as four million Californians could gain access to a primary care provider, who can diagnose and treat their mental health needs. The ACA also expands mental health services to those in public coverage programs. Mental health and substance use disorder services are now a part of the essential health benefits package that must be covered by plans participating in Medi-Cal Managed Care and Covered California, the state's health benefit exchange. The ACA also requires that rehabilitative services and prescription drugs are offered. (For more on mental health and the ACA, see *Appendix 12.*)

There are a number of community efforts 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.

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. The natural and built environments have a tremendous impact on health, including mental health. Variables such as income, poverty, employment, education, housing, transportation, and air quality can determine the health of community members. As a result, health disparities tend to reflect the underlying social and economic inequalities in society. 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, individuals who drop out of high school have a life expectancy 10 years shorter than those with a college degree.[12] These communities are also more likely to live in areas that are unsafe, which can have a negative impact on mental health. 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. Not feeling safe is correlated with increased levels of psychological distress. For example, African Americans who feel unsafe in their neighborhoods are nearly twice as likely to report psychological distress than those who feel safe.[13] (For more on social and environmental indicators and mental health, see *Appendix 13*.)

Transportation and hours of operation can be significant barriers. For example, in Asian and Pacific Islander communities, limited office hours and lack of transportation have deterred many community members from accessing services. More flexible and expanded office hours and assistance in transportation are critical to addressing these barriers. See *Appendix 8* for more community assets and considerations to address social and environmental conditions.

Quality of Care and Satisfaction
Even after entering treatment, many people of color and LGBTQ individuals are unsatisfied with the quality of care due to 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."[14] Client satisfaction can tremendously impact outcomes in physical and mental health. Embracing culture and engaging the community in outreach efforts and in treatment strategies provides an opportunity to build the trust necessary to improve health outcomes. Additionally, language barriers, particularly for limited-English proficient populations, impact the perception of care quality (see *Language Barriers* on page 12). 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. See *Appendix 9* for more community assets and considerations to address quality of care and satisfaction.

Lack of Appropriate Data Collection
One of the greatest challenges faced by many communities is the lack of data on their specific populations. Even though there are some similarities among the individuals within these communities in California, there are also many 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 the Native American community in particular, racial misclassification and historical undercounts have not given true representation of this population. The U.S. Census consistently undercounts Native Americans and is compounded by current political complexities around who can claim Native American heritage. Confounding the undercount of Native Americans is the misclassification into other racial categories by local, regional and statewide databases.

The lack of data collection and research is particularly challenging for LGBTQ communities. The LGBTQ communities are incredibly complex, with each population having its own needs as well as its own issues of diversity. A number of factors, including age, gender, sex assigned at birth, socioeconomic status, education, differences in abilities, religious upbringing, and ethnic and racial backgrounds, play a role in how an individual experiences their sexual orientation or gender identity/expression. While CHIS, relied upon as a comprehensive source of health research and information in the state, has made strides toward inclusion of more populations, there remains a need for 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. Data collection and analysis should not be predicated on the assumption that LGBTQ individuals will self-identify on intake forms or interviews. Due attention should also be given in the design of these systems to the need for anonymity among many LGBTQ individuals. 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 racial, ethnic, and LGBTQ communities know their community members better than most, and have developed innovative ways to address the many issues that friends, family members, and clients face daily. See *Appendix 11* for some additional community approaches to reduce disparities.

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 and funding should be tied to the effectiveness of the promising practices.

From the work of the Strategic Planning Workgroups, this is clear: 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

The *Strategic Plan to Reduce Mental Health Disparities*, developed by CPEHN in collaboration with and as a member of the CRDP Partners, includes 25 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 purpose of the groundbreaking CRDP statewide strategic plan is 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:

- 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 Request for Proposals for Phase 2 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 communities of color and LGBTQ communities at the statewide and local levels. Many partners – including the former DMH, the MHSOAC, the county departments of mental health, and many community organizations – have worked hand-in-hand to increase the level of wellbeing in unserved, underserved, and inappropriately served communities. Yet disparities remain. A broad-ranging, first-in-the-nation effort, the CRDP aims to look deeper into these communities 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 preventing the needs for mental health services 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 1 is just the first mile of the journey. California is deciding which roads to take and who should be behind the wheel. Our vision is 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 already 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 systems on the national level. The system is changing, and will continue to change as the ACA is implemented. 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, and every population, and must be addressed at the statewide, county, and local levels. The five goals will move us toward a system where all communities 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 25 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 2 of the CRDP and 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 hold important places within society. In Asian communities, the inclusion of family in treatment can help reduce stigma about mental health conditions. For African Americans, understanding historical trauma, as well as the importance of family and spiritual belief/practice, is imperative for effective treatment. A holistic approach that recognizes that an individual's health is inextricably connected to his or her culture and background will help foster a system that addresses mental wellbeing at its roots. Since LGBTQ individuals come from all cultures and backgrounds, it is important to focus on reducing harm from discrimination, shame, rejection, inequality, and other prejudices. Work must be done within each culture on affirming LGBTQ individuals; without such efforts, it will be difficult to achieve progress on the mental health needs of LGBTQ communities.

The following themes, goals, and strategies stem 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. 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.[15,16,17] The CRDP partners hope that these themes, goals, and strategies lead to a system that embraces culture and community, as well as affirmation of all sexual orientations, gender identities, and gender expressions, as fundamental to reducing mental health disparities.

Overarching Themes

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

Whether it is the delivery of mental health services, workforce education and training, or the implementation of prevention and early intervention 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? Capacity building must also be a key consideration: are community organizations being provided with the tools they need to be successful in implementing these programs? Do State agencies understand the needs of the community organizations with which they are working? In order to be able to have a sense of disparities and develop the solutions to overcome them, data collection is critical. 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 State will not be one step closer to reducing disparities.

Address and Incorporate Cultural and Linguistic Competence at All Levels
A comprehensive approach to cultural and linguistic competence is vital for improving mental health in these five populations. At the systems level, such an approach should build upon the work of county ESMs and the CCPRs, and should ensure the following components for both the county departments of mental health and their contractors:
- Culturally and linguistically appropriate community outreach and engagement efforts are vital to improving accessibility, availability, affordability, and advocacy of mental health issues in each community.
- Within a cultural context, focusing on early identification and accurate assessment of mental health needs is key to changing the course of mental illness in unserved, underserved, and inappropriately served communities.
- Collaboration with community organizations and Native American tribes that have the expertise, staffing, and programs needed to effectively engage their respective

populations is instrumental for providing culturally and linguistically appropriate services. Resources should be allocated to developing these relationships.

- Cultural knowledge gained through real-life interactions with communities and mental health clients is vital for training mechanisms that will improve county mental health staff's understanding of issues related to racism, sexism, and heterosexism.
- Cultural competency standards used in California – including the Culturally and Linguistically Appropriate Services (CLAS) standards used by the U.S. Department of Health and Human Services – should be updated and build upon county cultural competence plan requirements to include cultural and linguistic competency for all unique 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.

Implement Capacity Building at All Levels
Resources must be provided to support community capacity building efforts such as outreach and engagement, leadership development, technical assistance, community participation in decision-making, and the establishment of infrastructures to maximize resources. 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.

In addition, resources for capacity building should also be made available to the State departments and agencies, as well as other relevant partners at the systems level, to be able to work more closely with and understand the unique needs of local, community, and grassroots organizations with limited capacity.

Improve Data Collection Standards at all Levels
Improvements must be made to ensure appropriate data collection and reporting for all populations at the state, county, and local levels. In particular, for diverse communities such as Asian American, Native Hawaiian, and Pacific Islander, Native American, and LGBTQ communities, disaggregated data is necessary to identify disparities within subgroups of each population. Standardization of sexual orientation and gender identity measures should be developed for data collection and reporting at the State and county levels. Race, ethnicity, culture, language preference, and age should also be considered and the measures differentiated accordingly.

Address the Social and Environmental Determinants of Health
In order to effectively reduce disparities, it is important to address many of the social and environmental factors that impact the daily lives of Californians. Socioeconomic status is a fundamental factor in the ability to live healthy lives. Education, employment, and income all combine to directly influence access to both social and economic resources: better education leads to better jobs, and better jobs lead to higher incomes. These are some of the key factors that

impact health and the causes of California's health disparities. In addition to the socioeconomic factors that influence wellbeing, the environment also shapes our communities' health. Everything from the quality of the air people breathe to the safety of their communities impacts the wellbeing of California residents. A comprehensive approach to reducing mental health disparities must take into account many of the stressors experienced by California's communities and find ways to alleviate them so that everyone has the opportunity to lead healthy lives.

Goals and Strategies

Please note: The following strategies 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 the services more available to those in need. The State and county departments of mental health and their funding mechanisms can make it easier for community members to access services 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:
1. **Increase Opportunities for Co-Location of Services:** 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 funders of existing mental health services (including 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:
    a. Mental health agencies
    b. Community clinics and hospitals
    c. Churches and other faith-based organizations
    d. Local law enforcement agencies and units of the adult criminal justice system
    e. Juvenile justice agencies
    f. Child protective services
    g. Foster care agencies
    h. Elementary and secondary schools
    i. Colleges and universities
    j. The business community
    k. Native American tribes
    l. Non-traditional organizations (e.g., sports clubs, cultural arts sponsors, youth development programs)

    It is essential that network members 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

seeking 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 the convenience of the clients.

Equally important is emphasizing the benefits of co-locating mental health and primary care providers in the same setting. The CRDP Partners recommend the state, including the Department of Health Care Services and Covered California (California's Health Benefit Exchange) take advantage of opportunities available through health care reform to integrate mental health and primary care. One important benefit is the reduction in stigma, which would result in individuals and families seeking mental health care in a timelier manner.

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 to fund community-based organizations to develop a series of statewide resource guides that list agencies, programs, and services which are culturally and linguistically competent and LGBTQ-sensitive and affirming for each of the five targeted populations. 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 will not possibly be an exhaustive list, but should include listings in each region of the state.

3. **Elevate Schools as Centers for Wellness in the Community:** The state's public schools 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 a safe setting where children go almost every day and can be used to educate youth and their families about mental health, and provide interventions to decrease the risk of incarceration, drug use, and mental illness. Schools can also be used as portals to help adolescents 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 and other stakeholders to ensure that current funding for school-based mental health services, such as the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Program and other statewide projects, are reaching the communities with greatest need.

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 and avoid misdiagnoses that may result in mistreatment and school dropouts.
   - Statewide workforce training and technical assistance for all public school staff and administrators to improve culturally and linguistically competent treatment of all students, especially LGBTQ students. This 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 anti-bullying and anti-harassment programs 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 (GSA) 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 campuses should be eliminated.

4. **Ensure Ancillary Services are Eligible for Reimbursement:** To improve access to necessary mental health programs, the CRDP Partners recommend DHCS modify requirements to allow service providers to be reimbursed for ancillary services that support community engagement, such as transportation and interpretation. Categorizing these services as medically necessary will help increase access in unserved, underserved, and inappropriately served communities by making services more affordable.

5. **Prioritize Prison Re-Entry:** To improve mental health treatment for those returning from prison – the majority of whom are people of color – the CRDP Partners recommend county departments of mental health, in collaboration with the State Department of Corrections, recognize the role mental illness plays in many offenses and the contribution the mental health system can make in rehabilitating former offenders, and 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 to prevent recidivism.

6. **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 resources to DHCS, and the MHSOAC provide oversight, for the development of culturally and linguistically appropriate PEI outreach materials for the five populations through CalMHSA's statewide stigma and discrimination reduction project. CalMHSA should in turn fund community 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 bars and community centers.

There should also be funding available to engage ethnic media, which remain a trusted source of information for many racial and ethnic 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 also 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. In addition to increasing access to services, services must 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:
7. **Engage a Culturally and Linguistically Competent Workforce:** To improve the cultural and linguistic competence of mental health services, the CRDP Partners recommend that OSHPD focus on creating and supporting a well-trained, culturally and linguistically proficient workforce. The State must also ensure clear pathways for clients and family members to pursue careers in the field. In order to improve the mental health workforce on a systems level, the CRDP Partners ask OSHPD to implement, and the MHSOAC to provide oversight for:
   - Mandating cultural and linguistic 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 must prioritize loan repayment programs for individuals from each of these populations pursuing a career in the mental health field and for current providers looking for retraining opportunities.
   - Courses for individuals to become specialists in working with specific population groups. The State should identify the appropriate entity to train community organization within each population group.
   - Resources to support staff to attend ongoing training and technical assistance in mental health and all related fields for providers serving within the five target populations. Technical assistance should also be provided by the State to those offering traditional cultural practices and natural helpers and healers within each community.
   - Promoting mental health careers through outreach to youth and parents in all racial, ethnic, and LGBTQ communities, including mentorship opportunities for future workforce development.
   - 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 available opportunities 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.

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

8. **Ensure Culturally and Linguistically Competent Services:** In order to have culturally and linguistically 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. It is also necessary to conduct an analysis of assessment and screening tools used for mental health services to ensure cultural and linguistic appropriateness, followed by the implementation of standardized culturally-adapted tools. A culturally and linguistically competent provider must also be able to work with the community and other agencies, and provide proper linkages to available resources.

9. **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 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:
   - Enforcement of 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 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.
- 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"). Interpreters must also know and be comfortable using terms regarding sexual orientation and gender identity. Providers must not utilize bilingual staff that are not trained or have not been evaluated for language proficiencies as interpreters, nor should friends or families ever be utilized. Counties should use their MHSA WET funding for these training purposes.
- 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 hearing-impaired clients whose first language is American Sign Language (ASL). Plans should be in place to assist Deaf 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 make available to 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:
10. **Engage 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 to develop and implement pathways to wellness, reduce mental health stigma, and advocate for the importance of spirituality in reducing mental health disparities. It is necessary that these faith-based organizations be LGBTQ-affirming in order to be a part of the consortium, meaning they go beyond tolerance and acceptance, and welcome and celebrate people who are LGBTQ as vital 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.

11. **Working with Parents, Foster Parents, and Families to Reduce Disparities:** Parents and foster parents should be involved in helping to ensure that adolescent mental health needs are met. The CRDP Partners recommend county departments of mental health offer parenting classes or seminars that educate parents and foster parents about the school system and the availability of free or low-cost academic and mental health services. Training should also be

offered for all parents of LGBTQ youth and young adults on the dangers of rejection. 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 community. 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 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.

12. **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 available resources to the MHSOAC to support and enhance recruitment of underserved communities on local mental health boards, particularly from the five targeted populations and/or other unserved, underserved, and inappropriately served racial/ethnic/cultural populations. 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.[18] 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.

13. **Go Beyond Community Engagement:** It is essential that providers earn and establish credibility in the community by not just engaging and serving the community, but also by advocating for the needs of the community in ways that will improve overall wellness. At the provider level, it is important that service organizations have Boards of Directors that reflect the racial, ethnic, and LGBTQ composition of the community served by the provider. Culture-specific or population-specific factors should also be included in program design and mission statements.

Providers should also work with the community to create networks for linkages to appropriate services. When implementing these networks, providers should work with community members to ensure that they are implementing programs that will have the most impact on their communities. Providers should also work with community researchers to make sure there is adequate data collection and analysis of program effectiveness.

14. **Develop and Support Community Leadership:** The CRDP Partners recommend the CDPH Office of Health Equity 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 2 of the CRDP, and apply to all MHSA-funded Prevention and Early Intervention programs.

Strategies:
15. **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 networks 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 that have not been part of the traditional public mental health system are familiar with the needs of their communities and it is vital that their efforts are funded, possibly as pilot projects in each region, to evaluate the efficacy of alternative approaches to mental health integration.

16. **Fund Culturally-Specific Research:** The CRDP Partners recognize that Phase 1 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 1 of the CRDP. As in Phase 1, these efforts should be implemented by culturally-congruent researchers with experience in the targeted populations 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 transgendered individuals, and those at the intersection of identities.

17. **Develop Culturally-Specific Mental Health Practice Models:** While the $60 million made available during Phase 2 is a good first step, this funding is a drop in the bucket in the fight against health disparities, amounting to only $3 million per population over the four years of Phase 2. 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 2. Particular effort should be made to reach areas of the state not addressed during Phase 2. Funding should be made available to develop practice models in each of the targeted populations to build alternatives to mainstream mental health models to create a more holistic approach toward mental health tailored to each population.

18. **Allocate MHSA Prevention and Early Intervention Funding According to Community Need:** The CRDP Partners recommend DHCS, CBHDA, and the MHSOAC work together to develop methods to determine community need and base 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 of local demographics and need, so that all communities, regardless of size, are served.

19. **Conduct Culturally-Congruent Evaluation of Community-Defined Practices:** The CRDP Partners recommend the State ensure that there is adequate support to conduct community-based evaluation of current mental health services, including all MHSA-funded programs and Phase 2 of the CRDP. Evaluation should include both qualitative (e.g., case studies, in-depth interviews, and focus groups) and quantitative measures, and involve community members who are part of the target population receiving services. For Phase 2 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.

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 1 of the CRDP, the State must support an infrastructure to ensure that the recommendations, strategies, and promising practices in the five population reports are implemented and incorporated in MHSA-funded programs. This support should allow for the replication of the structures developed by the SPWs and the CMMC on a state, regional, and local level; engage communities in the planning, implementation, and evaluation of Phase 2; and build the capacity of local community members to collaborate with county departments of mental health and advocate on the local and statewide level.

Strategies:
20. **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 lack adequate representation from unserved, underserved, and inappropriately served communities – communities that need to be represented in work groups to support the strategies in this plan. The CRDP Partners recommend the State legislature make available resources to the MHSOAC to support and enhance recruitment 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 as they are involved in the implementation of the CRDP (see *Strategy 12: Support Community Involvement and Engagement*).

21. **Replicate Models for Community Engagement on the Local Level:** Community engagement models implemented by the SPWs and 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 engage on a statewide policy level. 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 evaluation of MHSA-funded programs. If local resources are limited, county departments of mental health should form regional partnerships for collaboration and leveraging of resources (see *Strategy 12: Support Community Involvement and Engagement*).

22. **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 have traditionally worked with to adopt and implement the community-defined strategies from this plan and the five population reports. Counties should seek community engagement when designing and implementing the identified strategies, including working closely with community-based programs which exemplify MHSA prevention and early intervention plans. In counties where good working relationships with community-based organizations have been developed by ESMs and others, these relationships should be strengthened.

23. **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 2 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 the four-year pilot program outlined for Phase 2; 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.

24. **Monitor the Implementation of the California Reducing Disparities Project:** The CRDP Partners recommend the State legislature provide resources through the Office of Health Equity to fund community organizations to monitor the implementation of Phase 1 and Phase 2 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 the development of this plan.

25. **Continue the Work of the California Reducing Disparities Project:** The CRDP Partners recommend that the State legislature make additional resources available to OHE so that other unserved, underserved, and inappropriately served communities are able to identify promising practices and recommendations for reducing disparities, similar to the process that these five populations undertook during Phase 1 of the CRDP. These other communities may include the Arab American community; ethnic communities such as the Slavic, Russian, Armenian, and other Middle Eastern communities; 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, transition-age youth, and older adults.

Implementation of the Strategies

Implementation of the 25 strategies outlined above requires long-term planning and commitment. The CRDP Partners recommend these strategies should be implemented over the next 10 years, with the commitment and involvement of all stakeholders in the public mental health system. While the $60 million in CRDP funds over the next four years is a good start, additional resources to continue long-term efforts to accomplish these goals are necessary. 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 next four years, there needs to be collaboration among all parties – statewide and local policymakers and community members – 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, one way to ensure that these strategies are addressed is to embed them into the planning and implementation of CRDP Phase 2.

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

- **Lack of funding:** The remaining funding available for CRDP includes a proposed $60 million over four years, which will primarily be used to implement promising practices as part of a pilot program, as well as additional supports including evaluation and technical assistance. This will leave very little funding available to support the implementation of the 25 strategies in this plan.
- **Involvement from all stakeholders:** While there is agreement to move forward with implementing these strategies among the CRDP partners, there must be further collaboration among all parties (e.g., MHSOAC, DHCS, CDPH, county departments of mental health) in the next four years to develop a plan to move forward together and implement the 25 strategies listed in this plan.

In order to accomplish these strategies, reducing disparities cannot be seen 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, one way to ensure that these strategies are addressed is to use them as a framework for the planning and implementation of CRDP Phase 2.

Chapter 4: Recommendations for CRDP Phase 2

While implementing the goals and strategies of the strategic plan is a long-term approach to reducing disparities, the next phase of the CRDP presents an opportunity to employ promising practices over the next four years to have a more immediate impact on disparities. CRDP Phase 2 includes several approaches to achieve the goal of reducing disparities. The first approach is to fund selected prevention and early intervention approaches across these five populations for four years with a strong community-based participatory evaluation component to elevate them to the level of evidence-based practice. In addition to funding and evaluating these programs, Phase 2 should also include technical assistance and capacity building for the funded pilots, and ongoing work to implement the policy-level strategies in this plan.

An allocation of $15 million for 2012-13 has been set aside for these pilot programs, with the intention of an additional $15 million each year for the following three years. After the successful completion of 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 be a role model for the nation.

In addition, implementation of Phase 2 requires close collaboration with county departments of mental health. The largest sources of local funding for public mental health service in the state, counties are vital to the ongoing sustainability of the promising practices identified by the population reports, and counties must be a part of all components of Phase 2.

The strategic plan lays out recommendations from the CRDP Partners for implementing Phase 2, 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 implementation of the pilots such as evaluation, technical assistance, and ongoing work to implement the 25 strategies. Also included are recommendations for after Phase 2, and potential risks and challenges associated with sustaining and replicating the funded pilots. It should be noted that these initial recommendations are still being vetted, and feedback from stakeholders is still being solicited.

Funding of Promising Practices

The success of the CRDP depends in large part on how the funds for Phase 2 are allocated. With that in mind, the CRDP Partners recommend the vast majority (70-80%) of the Phase 2 funds be allocated for the development and implementation of prevention and early intervention promising practices. PEI is the key to transforming California's public mental health system to a "help-first" system, bringing 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. These are the types of programs that need to

be implemented across the state, with organizations that know their communities and have their trust.

Phase 2 funds should be made available to those 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. In addition, these funds should be made available equally (i.e., one-fifth of the funds to each of the five populations) to all five CRDP Phase 1 identified targeted populations: African American, Asian/Pacific Islander, Latino, Native American, and LGBTQ communities.

The Request for Proposals (RFP) for the CRDP Phase 2 pilot program should be developed to closely mirror the strategies identified in the strategic plan and recommendations and promising practices from the five population reports. The RFP should be developed with the goal of reducing disparities in racial, ethnic, and LGBTQ communities, with an emphasis on employing community-defined practices like those highlighted in the five population reports. The awards should be granted following the strategies identified in this plan, with a preference for organizations and programs that value:

- Culture as the cornerstone for mental health and wellbeing
- Community-defined practices
- Collaboration with community services and resources, such as faith-based communities and schools
- Culturally competent and linguistically appropriate services
- Workforce diversity that reflects the community being served
- Engaging and supporting the involvement of clients and family members
- Continuing community participatory evaluation
- Engaging in data collection at all levels
- Culturally-congruent evaluation that involves the community
- Collaboration with local county departments of mental health and other local government officials

Priority in funding should be granted to applicants with knowledge of and experience working with the target population and in the geographic area. They should be able to list relevant programs and services conducted; a description of the project and target population; the need their existing program(s) meet; the number reached through the program; staff with three to five years working with the target population; and a commitment to partnering with other community organization. The applicant should be able to provide a thorough narrative of the proposed project, specifying its relevance to the community it proposes to serve; highlighting the connection to the evidence and recommendations provided in the relevant population report; outlining the activities to be conducted; and including a timeline/work plan and an evaluation plan that involves community participation.

The CRDP Partners recommend Phase 2 fund no more than 10 practices in each of the populations, with a minimum of $200,000 for each program per year. The intent would be to fund each program for the four-year Phase 2 period, with a commitment from the grantee to leverage this funding with additional support from local funders, foundations, and other sources. These matching funds could be used to advocate for systems change at the State and local levels

and to sustain the work beyond Phase 2. The funds allocated to each grantee would be used to administer and implement the promising practices, including oversight and administration, staffing, 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 the contracting and awarding of funds for Phase 2. 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 2 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 *Evaluation*, *Technical Assistance*, and *Ongoing Implementation* below.)

Evaluation

A key part of Phase 2 is the evaluation of the pilot programs in order to elevate them from community-defined best practices to evidence-based practices, which would facilitate the replication of the programs beyond Phase 2. The intention of Phase 2 is to prove that the promising programs identified during Phase 1 – activities developed by and for unserved, underserved, and inappropriately served communities across the state – are 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 take a community-based, community-driven approach to ensure that the unique challenges faced by each population – including stigma, discrimination, and marginalization – are addressed in the most effective way. It is also necessary to consider the culture and language of each population when conducting an evaluation of services. When appropriate, consultants with experience conducting evaluation in specific racial, ethnic, and LGBTQ communities should be engaged. 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 2 funds. This evaluation could happen in three components:

- Each funded organization must incorporate an evaluation component in its program plan. The RFP 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, sexual orientation, and gender identity); 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 and its future.

- The State should fund a culturally and linguistically 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, Native American, and LGBTQ 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.
- 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.

It is important to note that 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 would provide data that are not observed or measured by self-reporting scales. In addition, pre-Phase 2 implementation baseline data must be collected before pilot programs begin operation. For this to happen, the evaluation component of the Phase 2 RFP should be released before the pilot program component.

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 2. Through technical assistance, funders can provide grantees an opportunity to build their capacity to better serve their clients and improve the services being offered. A vital component of most funded initiatives, TA should be provided by the funder at no cost and with no bearing on the grantee's ability to continue performing its tasks. Often, asking for help can be seen by the grantee as admitting a weakness, and might hold them back from asking for help. For this reason, it should be offered in a culturally and linguistically competent manner, and the State must reframe 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 being conducted through Phase 2.

There should be at least one TA provider for each of the identified populations. 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. They should be able to assist with both programmatic and organizational issues, including program development and implementation; marketing and outreach; evaluation; strategic planning; board development; fiscal management; and grant writing and resource development. 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.

Ongoing Implementation

Finally, funding for ongoing implementation of the 25 strategies is needed. The hallmark of Phase 1, community engagement should is a vital component throughout Phase 2, from implementing and evaluating the promising practices to ensuring that the voices of unserved, underserved, and inappropriately served communities are heard in the state capitol. To do so, the State should sustain and replicate on a regional or county level the community engagement infrastructures developed through the SPWs and the CMMC. By bringing together local advisory boards unaffiliated with any existing government agency or funder, local communities will have an opportunity to 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 to 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, 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 2 funds. A local, regional, or statewide organization with the experience and capacity to engage in ongoing implementation of the 25 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. (See *Strategies 12* and *21* for more information.)

What Comes Next

After the completion of Phase 2, there is an opportunity to continue this work through the replication of promising practices by county departments of mental health and their grantees; and the expansion of the Phase 1 process to additional populations. The State should prioritize the replication of the new evidence-based practices from Phase 2 and put in place a mechanism to ensure that county departments of mental health 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. Elevating the promising practices to a level where they are recognized as evidence-based and eligible for Medicaid reimbursement would allow an opportunity to serve more unserved, underserved, and inappropriately served communities. There must also be a level of accountability to encourage counties to undertake these activities. Collaboration between CDPH, DHCS, the MHSOAC, and CBHDA is needed to develop an accountability mechanism agreeable to all parties. It is our hope that after the conclusion of Phase 2, each county in California will undertake to implement a number of the promising practices across all five target populations.

CPEHN also recommends a third phase (Phase 3) of CRDP where additional unserved, underserved, and inappropriately served communities, especially other immigrant groups, are afforded the opportunity to go through their own process of identifying 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; 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 3.

Finally, unserved, underserved, and inappropriately served communities should have a place at the policymaking table by the time Phase 2 is complete, serving on local and statewide boards and commissions and having a voice in the funding and evaluation of activities to reduce disparities.

Chapter 5: Conclusion and Implications

As illustrated in this strategic plan, the current public mental health system in California is in need of transformation. With people of color representing 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 25 strategies outlined in this strategic plan highlight the importance of culture in mental health. As the State moves forward, it must incorporate cultural and linguistic competence, capacity building, data collection, and addressing the social and environmental factors that impact our daily lives into all Phase 2 and MHSA-funded activities. In order to reduce disparities in mental health in California, the State must:

- Make it easier for community members to access services by expanding options and locations of services and making it easier to know where to find them.
- Improve the quality of services by ensuring they are culturally and linguistically competent and have staff that reflects the community being served.
- Ensure that the faith community, parents, and the unserved, underserved, and inappropriately served are engaged in the public mental health system, and have the opportunity to be involved in policymaking and program development, implementation, and evaluation at a statewide and local level.
- Commit to support, research, implement, and evaluate community-defined approaches such as those identified in the five population reports beyond CRDP Phase 2.
- Build on the CRDP's momentum and support an infrastructure to ensure that the 25 strategies and promising practices from CRDP Phase 1 are implemented and incorporated across the board in MHSA-funded programs.

The 25 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 2 presents an immediate opportunity to implement promising practices in unserved, underserved, and inappropriately served communities. Funding selected approaches across the five populations for four years with a 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

Age	Eleven of every twelve young adults ages 18-24 and three-quarters of adults 65 and older have unmet mental health needs
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	Asians, African Americans, and Latinos 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
English proficiency	Those with limited English proficiency have the highest rate of unmet needs

Note: The statistics in Table 1 are for the 2.2 million adults who report mental health needs. While the study did measure mental health needs by sexual orientation, finding that those in a sexual minority were more than twice as likely to report mental health needs, the study did not record unmet needs for this population. Therefore, it was not possible through this study to find disparities in unmet mental health needs among LGBTQ populations.

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

African Americans: There are significant mental health disparities in the African American community, as members of this population are far more likely than Whites to be diagnosed with serious psychological distress and to report symptoms of depression. 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. Due to a lack of access to quality care, African Americans are much more likely to have their first mental health treatment in an emergency room. They are underrepresented in outpatient care.[19]

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%).[20]

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 will soon represent 39% of California 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.[21] 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.[22]

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 the prevalence of societal heterosexism, homophobia and rejection has led to higher rates of mental health needs for this population. 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.[23]

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 impacts 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 to have experienced serious psychological distress during the past year as Whites (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.[24] In addition to facing high rates of psychological distress and difficulty accessing care, they are also hampered in seeking care 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.[25]

The Mental Health Services Act (MHSA): One of the key initiatives to improve Californians' mental and behavioral health began in November 2004, when California voters passed Proposition 63, now known as the MHSA. The MHSA set a 1% tax on adjusted gross income above $1 million, with those funds earmarked 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.[26] At the time of Proposition 63's passage, California's public mental health funding was struggling to meet demands. Counties estimated that they were only serving about half of those needing services, with the majority of funding directed toward services for severe and persistent mental illness, State hospitals, and the criminal justice system. This resulted in what was frequently called a "fail first" model.[27] Proposition 63 was brought about to change that.

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, and (5) Prevention and Early Intervention (PEI). Each component has explicit guidelines for how the funds are to be used, with 20% of MHSA funds specifically allocated for PEI approaches to improve timely access for unserved, underserved, and inappropriately served populations and prevent mental illness from becoming severe and disabling.[28]

Prevention and Early Intervention (PEI): PEI programs emphasize approaches to reduce negative outcomes that may result from lack of timely treatment – including suicide, incarceration, school dropout, unemployment, homelessness, and the removal of children from their home. The purpose of PEI is to help move California from a "fail first" system to a "help first" system, identifying those at risk for mental illness and linking them to treatment and other resources. According to the MHSA, PEI programs must include:
- Outreach to families, employers, primary care providers, and others to recognize the early signs of potentially severe and disabling mental illness
- Access and linkage to medically necessary care as early in the onset of mental illness conditions as practicable
- Reduction in stigma and discrimination associated with either being diagnosed with a mental illness or seeking mental health services [29]

Since half of all mental disorders start by age 14 and three-fourths start by age 24, most counties are required to spend 51% of PEI funds on individuals ages 0-25.[30] In addition to the CRDP, other statewide PEI projects have focused on suicide prevention,[31] stigma and discrimination,[32] and student mental health.[33]

Mental Health Services Oversight and Accountability Commission (MHSOAC): The MHSOAC was formed after the passage of Proposition 63 in 2004. An independent body, the primary function of the MHSOAC is to oversee implementation of the MHSA. In the past, the MHSOAC was the entity that reviewed and approved county PEI and Innovation Program component plans. Since the passage of AB 100 (Committee on Budget), the role of the MHSOAC has shifted from review and approval of county plans to providing training and

technical assistance for county mental health planning as needed. The MHSOAC also consults with the governor and legislature on mental health policy, and evaluates MHSA-funded programs throughout the State.

Department of Health Care Services (DHCS): Within DHCS, mental health services are managed by the Mental Health Services Division (MHSD). DHCS works closely with county departments of mental health to provide mental health services. DHCS also oversees many of the state's prevention and early intervention programs, which include efforts to prevent suicide, implement school programs through the Student Mental Health Initiative, reduce stigma and discrimination, and eliminate disparities. In 2012, all Medi-Cal related mental health functions were transferred from the former DMH to DHCS.

California Department of Public Health (CDPH): CDPH oversees the new Office of Health Equity (OHE), which was recently established 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 DMH is now part of the OHE.

California Department of Education (CDE): CDE oversees mental health services in schools, which seek to meet individual needs for learning or behavior problems with a multifaceted strategy that includes different services, settings, and approaches. School psychologists facilitate prevention and intervention programs, and manage a student support services team that provides crisis intervention, suicide prevention, and other mental health services. Students can receive academic counseling, interventions to address behavior issues, and referrals to other treatment. By delivering mental health services in schools, the CDE helps students have easy access to support in a familiar setting.

Office of Statewide Health Planning & Development (OSHPD): OSHPD strives to enhance 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 to provide services to address 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; grants to entities that engage in activities to increase the employment of consumers and family members; and funding 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.

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.

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 (see *Current State and Local Efforts to Reduce Disparities* below). The counties work with DHCS and the MHSOAC on all Medi-Cal related treatment, including Early and Periodic Screening, Treatment, and Diagnosis programs for youth and homeless and substance abuse assistance for adults. The majority of funding for mental health flows through the counties, which deliver services directly and through contractors.

Much of the MHSA funding is distributed to county mental health programs upon the approval of required Three-Year Program and Expenditure Plans and Annual Updates for MHSA programs by the respective county Boards of Supervisors. The MHSA provides funding to expand community mental health services for various components, including PEI funds to reduce the stigma and discrimination associated with mental illness and to offer preventive services to avert mental health crises.[34] 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 board of health holds a public hearing. All substantive public recommendations are included in the Annual Update before it is 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.[35]

California Behavioral Health Directors Association (CBHDA): A non-profit organization, the CBHDA represents the mental health directors from California's 58 counties. CBHDA's work focuses on increasing the resources available to people with mental illness and tracking best practices to provide information, guidance, and technical assistance to its members.

California Mental Health Services Authority (CalMHSA): CalMHSA is an independent agency that, through its 47 member counties, develops, funds, and implements mental health services, projects, and educational programs at the state, regional, and local levels. The suicide prevention, school-based programs, and stigma and discrimination reduction statewide PEI projects are administered by CalMHSA.

MHSA Partners Forum: An informal group that meets monthly to share information and discuss emerging policy issues related to the MHSA, the MHSA Partners Forum represents a wide range of stakeholder constituencies, including client, family, and parent advocates, providers of mental health services, and advocates for ethnic and cultural communities that have been unserved, underserved, or inappropriately served in the public mental health system.

Appendix 4: Examples of Community Assets and Considerations to Address Stigma

Population	Examples
African American	Black Barbershop and Beauty Shop Outreach Programs have proven to be effective ways to educate and engage African American communities about health issues in everyday settings.
Asian & 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 very 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 alienate LGBTQ clients and/or cause 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.

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

Population	Examples
African American	Programs that develop a positive sense of self and racial identity will help to foster resilience and strength, and improve the wellbeing of African American children in a society that often devalues them with negative stereotypes and assumptions.
Asian & Pacific Islander	Community-based programs or centers that provide culturally and linguistically appropriate outreach, engagement, and services 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, and comfortable for clients. Co-location also increases the likelihood that individuals and families will seek care and adhere to their treatment.
LGBTQ	The LGBTQ Youth Advocacy Collaborative through the Rainbow Community Center has developed a community-based partnership that includes participation from over two dozen local churches, schools, mental health centers and community-based agencies. They are using concepts from the Family Acceptance Project (FAP) to highlight the impact of rejection on LGBTQ youth. They have expanded the FAP model beyond the family to incorporate social settings—addressing 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.

Appendix 6: Examples of Community Assets and Considerations to Address Language Barriers

Population	Examples
Asian & 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. Adding additional time for appointments when interpretation services are used can help clients feel that they have time to discuss their needs, and 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. 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.
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. For example, the *De Ambiente* program at the Outlet in Santa Clara County began as an HIV and STD prevention program for young, Spanish-speaking Latino men. It has grown to address the socio-cultural contextual factors that affect the risk for HIV and STDs among all Spanish-speaking LGBTQ youth.
Native American	Native tribal language sustainment and revival help rekindle pride in identity and allows communities to convey stories, tribal concepts, and healing ceremonies that can be lost in translation. It is also a practice that elevates the importance of the role of elders in the community and allows them to be recognized as leaders while passing valuable traditions to the next generations.

Note: Since not all population reports featured examples to highlight their work on each issue, not all populations are listed in this table.

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

Population	Examples
African American	Community-based prevention and early intervention approaches, like those at the Knotts Family and Parenting Institute in San Bernardino County, bring services to a population of hard-to-reach clients, including the homeless, addicts, and ex-offenders. These approaches, including creating villages for service delivery at churches, schools, and other community facilities, positively impact mental health, increase resiliency in children and youth, and create a sense of family and belonging to reduce risky behaviors.
Asian & Pacific Islander	Due to cultural differences, symptoms for Asian 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 the 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 the people are enables organizations to collaborate and share resources to better serve the Latino community.
LGBTQ	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.
Native American	Community-based resources like the Red Pages in the Los Angeles area, a directory of community services, provide Native Americans with the opportunity to find mental health services when they are needed.

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

Population	Examples
African American	*Just Therapy* is a practice model that addresses the external stressors and injustices that can lead to mental health issues, including unemployment; bad housing; and racist, sexist, or heterosexist experiences.
Asian & Pacific Islander	The issue of limited office hours and lack of transportation has deterred many community members from accessing services. More flexible and expanded office hours and assistance in transportation 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	Congregate Meals were developed by Lavender Seniors as a means of providing social support to LGBTQ seniors in Alameda County that had no access to social programs. Each meal is one hour followed by a one-hour educational, interactive, or entertaining presentation.
Native American	Due to lack of transportation, poverty, and other lower socioeconomic conditions community members have significant difficulty accessing services. Adequate resources should be made available in tribal, rural, and urban areas to overcome this barrier.

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

Population	Examples
Asian & 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 regarding 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. In addition, 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: Since not all population reports featured examples to highlight their work on each issue, not all populations are listed in this table.

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

Population	Examples
Asian & 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 participants, there needs to be 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, 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. Due attention should also be given in the design of these systems to the need for anonymity among many LGBTQ individuals.
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 in understanding the community's needs.

Note: Since not all population reports featured examples to highlight their work on each issue, not all populations are listed in this table.

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 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.
LGBTQ	*The FAPrisk Screener for Assessing Family Rejection & Related Health Risks in LGBT Youth* is a research-generated screening instrument based on findings from Family Acceptance Project studies. The studies have identified and measured family and caregiver behaviors which are highly predictive of negative physical and mental health outcomes for LGBTQ youth. This new instrument is intended to screen LGBTQ youth and young people to identify those who are experiencing especially 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 connect local religious leaders, religious congregations and communities, and individuals of faith who are highly motivated 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. • For many LGBTQ individuals, peer-support groups are often the first and sometimes the only contact they have with other LGBTQ community members. Anecdotal feedback shows that peer-support groups can be a vital and sometimes life-saving support for LGBTQ individuals. • 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 is limited to anyone who identifies as Native and LGBT/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. • Employing the "Holistic System of Care," a community-focused intervention that provides behavioral health care, promotes health, and prevents disease. • Engage Native American communities directly and uniquely as they will know best how to improve wellness in their own population.

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 133% of the federal poverty level (about $1,246/month for individual or $2,536/month for family of four). And Covered California, the state's Health Benefit Exchange, allows individuals and small businesses to shop for and buy health insurance, with tax credits for those between 133% 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 rehabilitative services and prescription drugs to be offered.

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.[36]

The ACA improves mental health treatment and primary care coordination, in particular for those on Medicaid, the single-largest payer for mental health services in the country.[37] Effective in 2010, the ACA offered a Medicaid State plan option so that Medicaid enrollees with at least two chronic conditions or at least one serious mental health condition can designate a provider (which could be a community mental health center) as a health home, allowing clients to develop an ongoing relationship of trust and communication with their physician, and hopefully leading to proactive treatment and coordination of care with other health professionals. This comprehensive approach helps clients feel more comfortable discussing mental health needs with their physician, and facilitates referrals to appropriate mental health professionals.

The ACA takes additional measures to promote coordination of care by investing in a new grant program to support co-location of primary and specialty care services in community-based mental and behavioral health settings. This will strengthen the ability of primary care physicians to work closely with mental health providers on treatment options. Another new grant program aimed at improving coordination of care will fund community health teams to support primary

care practices with combined resources including access to mental health and addiction treatment specialists.

The ACA also makes a significant investment in building the mental and behavioral health workforce by establishing education and training grants and loan repayment programs targeted to mental health and addiction treatment providers.

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.[38] 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.[39] Unequal access to public transportation 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 left over to pay for transportation, 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.[40] 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.[41] 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.[42]

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%).

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, which includes CPEHN, and the project directors from the five Strategic Planning Workgroups (SPWs) and the California MHSA Multicultural Coalition (CMMC).

The first stage of the strategic plan's development was the creation of 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.[43] 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 approved, 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.

through the many surveys, focus groups, and interviews conducted by the Strategic Planning Workgroups. We hope that you hear your voice in this report.

[1] "Table 19. California – Race and Hispanic Origin: 1850 to 1990." U.S. Census Bureau. September 2002. March 16, 2012
<www.census.gov/population/www/documentation/twps0056/tab19.pdf>.

[2] "2010 U.S. Census." U.S. Census Bureau. March 16, 2012 <2010.census.gov/2010census/>.

[3] Grant, D. et al. *Adult Mental Health Needs in California: Findings from the 2007 California Health Interview Survey*. The UCLA Center for Health Policy Research. November 2011. Accessed at
http://healthpolicy.ucla.edu/pubs/Publication.aspx?pubID=529.

[4] Cashin, C., Scheffler, R., Felton, M., Adams, N., & Miller, L. (2008). Transformation of California public mental health system: Stakeholder-driven planning as a transformational activity. *Psychiatric Services, 59*(10), 1107–1114.

[5] CMMC State of the State Report, 2011.

[6] California Department of Mental Health Community Stakeholder Summer Draft Report. Accessed February 3, 2013 at:
www.dmh.ca.gov/services_and_programs/medi_cal/docs/Meetings/2011/Sep/StakeholderFinalSummaryReport.pdf.

[7] Aguilar-Gaxiola, S., Loera, G., Méndez, L., Sala, M., Latino Mental Health Concilio, and Nakamoto, J. (2012). Community-Defined Solutions for Latino Mental Health Care Disparities: California Reducing Disparities Project, Latino Strategic Planning Workgroup Population Report. Sacramento, CA: UC Davis.

[8] Mikalson, P., Pardo, S., & Green, J. (2012) *First, do no harm: Reducing disparities for lesbian, gay, bisexual, transgender, queer and questioning populations in California*. Sacramento, CA: Mental Health America of Northern California and Equality California Institute.

[9] Fresno Bee, July 30, 2012. Accessed on September 3, 2012 <
http://www.fresnobee.com/2012/07/30/2929985/fresno-hmong-garden-praised.html>

[10] Aguilar-Gaxiola, S., Loera, G., Méndez, L., Sala, M., Latino Mental Health Concilio, and Nakamoto, J. (2012). Community-Defined Solutions for Latino Mental Health Care Disparities: California Reducing Disparities Project, Latino Strategic Planning Workgroup Population Report. Sacramento, CA: UC Davis.

[11] *We Ain't Crazy! Just Coping With a Crazy System: Pathways into the Black Population for Eliminating Mental Health Disparities.*

[12] Oshansky SJ, et al. "Differences In Life Expectancy Due To Race And Educational Differences Are Widening, And Many May Not Catch Up." *Health Affairs*, vol. 31, no. 8. August 2012. Accessed at
http://content.healthaffairs.org/content/31/8/1803.full.

[13] California Health Interview Survey. 2009. UCLA Center for Health Policy Research.

[14] Crossing the Quality Chasm: The IOM Health Care Quality Initiative. Institute of Medicine. <
www.iom.edu/Global/News%20Announcements/Crossing-the-Quality-Chasm-The-IOM-Health-Care-Quality-Initiative.aspx>

[15] Mikalson, P., Pardo, S., & Green, J. (2012) *First, do no harm: Reducing disparities for lesbian, gay, bisexual, transgender, queer and questioning populations in California*. Sacramento, CA: Mental Health America of Northern California and Equality California Institute. Page 171.

[16] Native American Health Center. 2012. *Native Vision: A Focus on Improving Behavioral Health Wellness for California Native Americans*. California Reducing Disparities Project Native American Strategic Planning Workgroup Report. Oakland, CA. Page 33.

[17] *We Ain't Crazy! Just Coping With a Crazy System: Pathways into the Black Population for Eliminating Mental Health Disparities.* Pages 251-253.

[18] California Welfare and Institutions Code 5604. (a) (2). Accessed at www.leginfo.ca.gov/cgi-bin/displaycode?section=wic&group=05001-06000&file=5600-5623.5.

[19] *We Ain't Crazy! Just Coping With a Crazy System: Pathways into the Black Population for Eliminating Mental Health Disparities.*

[20] Cheng, Chienhung Rocco (2012). *In Our Own Words: Asian and Pacific Islander Population Report.*

[21] Aguilar-Gaxiola, S., Loera, G., Méndez, L., Sala, M., Latino Mental Health Concilio, and Nakamoto, J. (2012). Community-Defined Solutions for Latino Mental Health Care Disparities: California Reducing Disparities Project, Latino Strategic Planning Workgroup Population Report. Sacramento, CA: UC Davis.

[22] Vega, Kolody, Aguilar-Gaxiola, et al., 1999.

[23] Mikalson, P., Pardo, S., & Green, J. (2012) *First, do no harm: Reducing disparities for lesbian, gay, bisexual, transgender, queer and questioning populations in California*. Sacramento, CA: Mental Health America of Northern California and Equality California Institute.

[24] California Health Interview Survey. AskCHIS Website accessed August 2012. Los Angeles, CA: UCLA Center for Health Policy Research.

[25] Native American Health Center. 2012. *Native Vision: A Focus on Improving Behavioral Health Wellness for California Native Americans*. California Reducing Disparities Project Native American Strategic Planning Workgroup Report. Oakland, CA.

[26] Cashin, C., Scheffler, R., Felton, M., Adams, N., & Miller, L. (2008). Transformation of California public mental health system: Stakeholder-driven planning as a transformational activity. *Psychiatric Services, 59*(10), 1107–1114.

[27] Mental Health Services Act (MHSA) Overview Fact Sheet**.** Mental Health Services Oversight and Accountability Commission. **<**www.mhsoac.ca.gov/About_MHSOAC/docs/FactSheet1.pdf> Accessed August 7, 2012.

[28] Mental Health Services Act Prevention and Early Intervention Fact Sheet. Mental Health Services Oversight and Accountability Commission. < www.mhsoac.ca.gov/About_MHSOAC/docs/FactSheet7_3-18-11.pdf> Accessed on August 7, 2012.

[29] MHSA, Section 4, Welfare and Institutions Code (WIC) § 5840(b).

[30] Mental Health Services Act Prevention and Early Intervention Fact Sheet. Mental Health Services Oversight and Accountability Commission. < www.mhsoac.ca.gov/About_MHSOAC/docs/FactSheet7_3-18-11.pdf> Accessed on August 7, 2012.

[31] California Strategic Plan on Suicide Prevention: Every Californian is Part of the Solution. <www.dmh.ca.gov/prop_63/MHSA/Prevention_and_Early_Intervention/docs/SuicidePreventionCommittee/FINAL_CalSPSP_V9.pdf> Accessed on August 7, 2012.

[32] California Strategic Plan on Reducing Mental Health Stigma and Discrimination. <www.dmh.ca.gov/peistatewideprojects/docs/Reducing_Disparities/CDMH_MH_Stigma_Plan_09_V5.pdf> Accessed on August 7, 2012.

[33] Student Mental Health Initiative. <www.dmh.ca.gov/peistatewideprojects/StudentMentalHealthInitiative.asp> Accessed on August 7, 2012.

[34] Department of Health Care Services <http://www.dhcs.ca.gov/services/MH/Pages/MHSAFunding.aspx>

[35] Mental Health Services Oversight and Accountability Commission. FY 2013-2014 MHSA Annual Update Instructions.

[36] "Building Healthier Communities by Investing in Prevention." *HealthCare.gov*. February 9, 2011. May 2, 2012 < http://www.healthcare.gov/news/factsheets/2011/02/prevention02092011b.html>

[37] Shirk C. "Medicaid and Mental Health Services." *Background Paper – No. 66*. National Health Policy Forum. October 23, 2008. May 1, 2012 <http://www.nhpf.org/library/background-papers/BP66_MedicaidMentalHealth_10-23-08.pdf>

[38] "What are the Benefits of Complete Streets?" National Complete Streets Coalition. 2005. April 24, 2009 www.completestreets.org/benefits.html.

[39] "Roadblocks to Health: Transportation Barriers to Healthy Communities." Center for Third World Organizing, People United for a Better Oakland, and the Transportation and Land Use Coalition (now known as TransForm). 2002. April 8, 2009 www.transformca.org/files/reports/roadblocks-to-health.pdf.

[40] "2009 California Health Interview Survey." UCLA Center for Health Policy Research. March 19, 2012 www.chis.ucla.edu/main/default.asp.

[41] "Backgrounders from the Unnatural Causes Health Equity Database" California Newsreel. April 10, 2009 www.unnaturalcauses.org/assets/uploads/file/primers.pdf.

[42] Beyers, M., Brown, J., Cho, S., Desautels, A., Gaska, K., Horsley, K., Iton, T., Lee, T., Maker, L., Martin, J., Murgai, N., Schaff, K., Witt, S., and Anderson, S. "Life and Death from Unnatural Causes." Alameda County Public Health Department. August 2008. April 9, 2012 www.barhii.org/press/download/unnatural_causes_report.pdf

[43] Centers for Disease Control and Prevention.

Prepared for the:
Office of Health Equity
California Department of Public Health
Under California Department of Public Health contract: #12-10325
Through funds made possible by the Mental Health Services Act