



A RIGHT TO HEAL: MENTAL HEALTH IN DIVERSE COMMUNITIES



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Acknowledgments

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Introduction

In the early 2000s, mental health consumers, family members, and providers banded together to gather signatures, advocate for, and ultimately propel the passage of Proposition 63, the Mental Health Services Act (MHSA), in 2004. The purpose of the MHSA was to provide an infusion of funds that would expand and transform the public mental health system in order to become 1) wellness, recovery, and resiliency focused, 2) consumer and family driven, 3) integrated, 4) culturally responsive, and 5) collaborative with the community. This advocacy effort and the MHSA itself arose out of a mental health system that was underfunded, illness driven, and clinician directed with minimal consideration for consumers, their families, stakeholders in general, and particularly communities of color.

“What is mental health? What is a mental health service? What could it be?”
- Reimagining Black Mental Health Participant

MHSA Programs and Expenditures

The MHSA was designed to fund the full spectrum of mental health services. To this end, the Act set forth five (5) components for funding, three of which result in ongoing revenue.

- **Community Services and Supports (CSS)** is the largest of the MHSA components and provides funding for those with the most significant mental health needs. It is approximately 85% of a County's MHSA allocation and at least half of the CSS funding must go towards Full Service Partnership programs, which provide “whatever it takes” to support individuals who are experiencing homelessness, crisis and hospitalization, foster care or emancipation from foster care, criminal justice involvement, and/or other institutionalization.
- **Prevention and Early Intervention (PEI)** funds are slated for programs to prevent the development or progression of a mental health issue and are generally 10% of the MHSA allocation. PEI funds provide prevention, early intervention, suicide prevention, stigma discrimination and reduction, and access and linkage services; at least 50% of PEI funds must be spent on children and youth.
- **Innovation (INN)** provides approximately 5% of a county's allocation to pilot new interventions for a period of 3-5 years. These projects must be approved by the Mental Health Services Oversight and Accountability Commission (MHSOAC) and must contribute to learning.

The MHSA also set forth two (2) time-limited funds that provided funding for up to 10 years including Workforce

Education and Training (WET) to support workforce development, and Capital Facilities and Technological Needs (CFTN) for infrastructure. Currently, counties can choose to allocate a portion of CSS towards CFTN or WET given that the dedicated 10 year allocations have expired. In addition, \$65 million was allocated to launch the California Reducing Disparities Project (CRPD) in 2009, which identifies and alleviates disparities in mental health for five priority populations: African American, Asian and Pacific Islander, Latino, LGBTQ+, and Native American.

One of the benefits of the MHPA was that it provided some flexibility with funding that did not have the same restrictions as Medi-Cal or other federal funding. However, most counties use a portion of their MHPA funds as the local contribution for the Short-Doyle Medi-Cal specialty mental health program. This allows for MHPA funds to be used to leverage additional federal Medi-Cal dollars and results in increased funding for mental health services (e.g., two dollars of service for every one MHPA dollar expended). However, this practice also obligates counties to comply with Medi-Cal requirements for those MHPA expenditures, which may not always align with the spirit of the MHPA. Counties may be incentivized to use more of their dollars for Medi-Cal match instead of services not billable or matchable by Medi-Cal, like community-defined services or services focused on a family or community rather than an individual. Additionally, this can make it harder for community members to participate in and influence the MHPA planning process because they must also have some understanding of the Medi-Cal specialty mental health rules to fully participate.

Most MHPA dollars are allocated directly to county mental health systems. The County Behavioral Health Departments also serve as the Mental Health Plan (MHP) that provides specialty mental health services through the Short-Doyle Medi-Cal program for people who meet the criteria for a serious or severe mental health issue.¹ Mental health care for mild to moderate needs, which became a consistent health care benefit as a result of the Affordable Care Act, is generally managed by an individual's Medi-Cal managed care plan. This level of care can be a tremendous resource, and it may also complicate both service access and CPP participation. Community members may not know whether to access mental health benefits through the County mental health system or some other mechanism, and CPP participants must understand which of these benefits may be relevant to the CPP process and which may not be.

MHPA Community Program Planning

The passage of the MHPA in 2004 ushered in new opportunities for stakeholders to plan, design, implement, and evaluate programs and services funded by the MHPA. The original purpose of the community planning process (CPP) was codified in the California Welfare Institutions Code:

"Planning for services shall be consistent with the philosophy, principles and practices of the Recovery Vision for mental health consumers:

- To promote concepts key to the recovery for individuals who have mental illness -- hope, personal empowerment, respect, social connections, self-responsibility, and self-determination.
- To promote consumer-operated services as a way to support recovery.
- **To reflect the cultural, ethnic, and racial diversity of mental health consumers.**
- To plan for each consumer's individual needs."²

¹According to Medi-Cal, a person would meet medical necessity for specialty mental health services if they had both a diagnosis of a serious mental illness and significant functional impairments as a result.

²CA WIC Section 7, 5813.5 (d)

The MHSA also allows for county mental health programs and state administrative funds to support consumers, families, and other stakeholders to participate in the CPP process and to ensure that state and county agencies give full consideration to stakeholder concerns about quality, structure of service delivery, and access to care.

“My anxiety sits on my shoulder while I write/ And instead of shrugging her off/ I learn to ask her what she wants to say/ Most days she wants to be written free/ To dissolve into bliss.”

– Danyeli Rodriguez Del Orbe

With this mandate, communities came together with state and local governments and envisioned a wellness and recovery focused mental health system that centered the experiences and expertise of consumers, their families, and their communities. From these efforts, a redesigned mental health system emerged that included Full Service Partnership programs in every county, in addition to other Community Services and Supports; prevention and early intervention efforts that did not require someone to be “ill” in order to receive support; and people with lived experience were listened to as advocates and employed throughout the system. While counties and the State attempted to engage with and provide services for Black, Indigenous, People of Color (BIPOC) and their communities over the past fifteen (15) years, the MHSA has not resulted in adequate participation within the MHSA for BIPOC communities, in terms of community program planning (CPP) and service delivery. While there were initial efforts to engage with myriad MHSA stakeholders, these efforts have dwindled over time, which disproportionately affects BIPOC communities and their ability to advocate on their own behalf.

“They have to effectively demonstrate that they’re concerned for the people seeking services and that they want to help people achieve wellbeing.”

- Mental Health Matters Participant

While the MHSA has resulted in some additional opportunities for BIPOC communities, it has largely been segregated from the mental health system overall. In many counties, there is some sort of MHSA committee that leads the CPP process and activities, and there are separate committees or discussions that focus on BIPOC communities. In many communities, this limits BIPOC stakeholders from influencing the overall CPP process and resulting MHSA Program and Expenditure Plans. One outcome of this type of siloing is that many counties fund Prevention and Early Intervention (PEI) programs that offer culturally specific programming, but those same culturally responsive principles are rarely applied to treatment services funded by the Community Services and Supports component of the MHSA.

Approach

Founded in 1992, CPEHN’s mission is to advance health equity by advocating for public policies and sufficient resources to address the needs of communities of color in California. As an organization, CPEHN was founded on the premise that diverse racial and ethnic communities can and should come together in support of a unified health agenda – inclusive of physical, mental, and oral health access, services, and quality – that would support a collective vision as well as amplify the unique needs of each community. Four culturally-specific statewide organizations representing the African American,

Asian and Pacific Islander, Latino, and Native American communities came together in service of their collective vision to create CPEHN. CPEHN and our partner organizations work to advance and support the overall health needs of BIPOC communities by building the capacity of our communities and community-based organizations to advocate on our own behalf. As advocacy organizations, we have been entrusted to work with and for our own communities towards greater health and mental health equity. Inherent in our roots is the foundation of partnership within our communities and an interdependent relationship between state and local level partners and policy efforts. As a part of or organizing efforts, we strive to gather and amplify the opportunity for local community-based organizations who have long served these underserved groups to provide their expertise in developing policies that close these disparities. We equip them to directly advocate locally, provide research and data to inform the conversation, and amplify their voices at the state level.

In 2020, the Mental Health Services Oversight and Accountability Commission (MHSOAC) contracted with CPEHN for three years in order to engage “Diverse Racial and Ethnic Communities” and build the capacity of local community members, advocates, community-based organizations, and trusted representatives to engage with their local public mental health system. Given that the majority of MHSA funds for programs and services are decided locally through a legislatively defined community program planning (CPP) process, there is tremendous opportunity to influence not only the way in which the CPP process occurs but also the outcomes of what programs and services are funded and how. This initiative seeks to: 1) equip local advocates and communities to participate in and influence MHSA decision-making through leadership and advocacy development as well as 2) promote openness and accountability from MHSA staff and public officials to listen, seek to understand, and incorporate our perspectives into MHSA plans and funding allocations. By taking this approach, we increase access to the democratic process, ensuring that communities who have historically been marginalized are the agents calling for change.

Since our inception, CPEHN’s approach to statewide community engagement has been to amplify the voices of multiple BIPOC communities of color by bringing together statewide partners with local partners to strengthen opportunities for advocacy cohesion, policy change, and strengthened regional/local impact. To this end, statewide agencies worked with local partner agencies to prepare local advocates and communities on how to participate and influence MHSA decision-making and how to support community members' discussion of mental health needs from a system perspective.

Statewide Partner	Local Partner	Population of Focus	Location	Event	Total Participants
California Black Health Network	Restorative Justice for Oakland Youth	Black/African American /African-Ancestry	Alameda	Reimagining Black Mental Health	204
California Consortium for Urban Indian Health	Bakersfield American Indian Health Project	American Indian	Kern	Advocacy for American Indian Health and Equity	109
Latino Coalition for a Healthy California	Visión y Compromiso	Latino and Migrant Indigenous Residents	Kern	Mental health Matters	73
Southeast Asia Resource Action Center	Hmong Community center	Southeast Asian	Butte	Advocating for Hmong Mental Health Needs	163
California Pan-Ethnic Health Network	California Black Women’s Health Project	Multi-cultural	Los Angeles	Mental Health Matters: Culture as a Social Determinant	140

Across the state, statewide partners worked with local organizations to convene 689 community members at in-person and virtual listening sessions in Alameda, Kern, Butte, and Los Angeles counties. The listening sessions were an opportunity to explore how BIPOC communities express their cultural perceptions of mental health and hear about their experiences with the mental health systems.

From targeted MHSA education advocacy events created to inspire and build momentum for stakeholders to participate more with their local public mental health system, to expansive Land Acknowledgments that reflected upon the impact of settler colonialism, these culturally responsive events embodied both the spirit of advocacy and the wisdom of their respective communities.

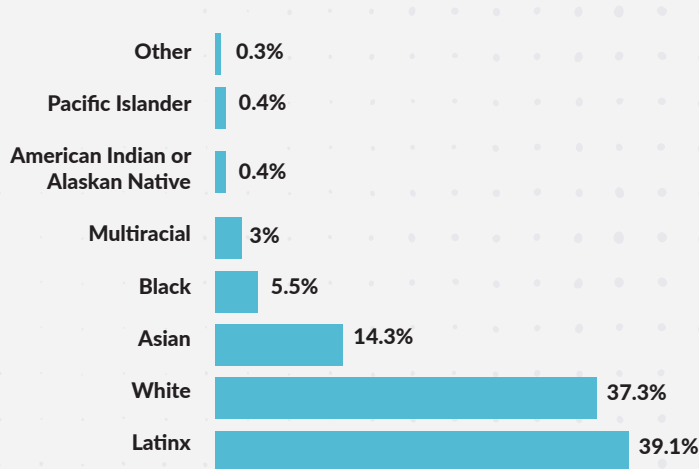
Participants were invited to share about their personal experiences trying to access care in the local mental health system, explore barriers to care, and openly discuss how structural racism, stigma, and cultural identity play a role in mental health care. Educational opportunities around the MHSA and CPP were provided and suggestions for improvement beyond better outreach engagement were encouraged.

These life-affirming events created space for dialogue that was infused with cultural healing and artistic expressive experiences like guided meditations, breath work, spoken word, drumming and other musical performances. Below are conversation highlights and recommendations that emerged from the listening sessions and local events.

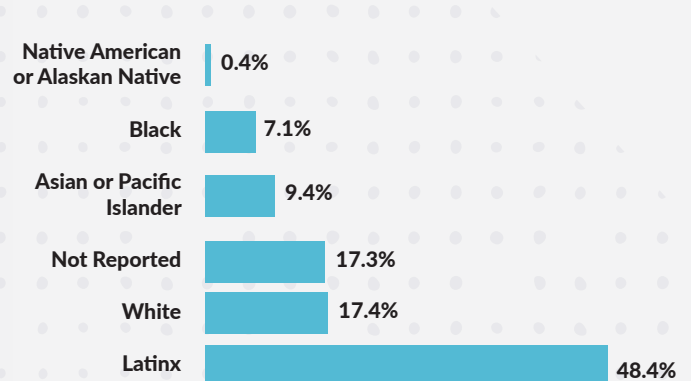
State of the Community

California is the most diverse and populous state in the nation with almost 40 million residents, and no one group that constitutes a racial or ethnic majority. Almost 25 million California residents (63%) are from communities of color.³

California Population by Race/Ethnicity



Medi-Cal Enrollment by Race/Ethnicity



³US Census, 2020

“Living in poor Black communities, there was just not that language, or the information given to us [about mental health].”

-Reimagining Black Mental Health Participant

Approximately 46% of Californians speak a language other than English at home, and 18% of those older than age 5 have limited English proficiency.⁴ Additionally, California has the largest proportion of immigrants of any state in the nation, at 27%.⁵ More than one-third of Californians (13.6 million) are enrolled in the Medi-Cal program and receive publicly funded health insurance, and 77% of Medi-Cal recipients are people of color.⁶

The National Survey on Drug Use and Health estimates that 21% of the population has a mental health issue and 5% has a serious mental health issue.⁷ While there is data that attempts to disaggregate prevalence estimates by race/ethnicity, the data collected are not grounded in any cultural framework and dramatically underestimates the rate of mental health issues in communities of color. Communities of color experience increased risk of mental health issues as a result of the effects of experiencing both interpersonal and institutional racism and oppression. As the country faces an ever-evolving pandemic and a growing call to fix the deeply embedded systemic and structural discrimination faced by racially, ethnically, culturally, and linguistically diverse communities, it is clear that structural and institutional racism are the key issues impacting the mental health and physical health of communities. This includes the individual toll that racism and oppression have on individuals and their communities as well as the structural and systemic barriers that impede access to care, result in culturally inappropriate services, and drive poorer mental health outcomes. At the individual level, individuals of color experience an increased risk of depression, anxiety, and other mental health problems that result from the toll that exposure to racism takes on a person. This includes the effects of micro-aggressions and overt racism; the hypervigilance and associated stress that results from the continuous fear of danger for oneself, loved ones, and community; and the ongoing grief and trauma reactions that come from witnessing violence perpetrated upon other people of color.

Over the past year, BIPOC communities across the state shared their perspectives on mental health issues affecting their communities, including the variety of challenges related to access, with language and other barriers deterring individuals from seeking treatment either because they are not aware of available services, due to limited culturally and linguistically appropriate outreach, or because they do not feel they can adequately communicate with or be understood by their mental health providers. For some BIPOC communities, even the stigmatization of mental illness is so pervasive it prevents them from attempting to access care, let alone experience the quality of care. Below is a summary of key themes and issues raised by BIPOC communities in the listening sessions hosted by CPEHN and statewide partners.

“I know there are a lot of services and resources in Butte County, but I’m not sure where to seek help. Some people are afraid of a provider’s judgment on an individual, so we don’t plan or look for help with services.”

- Advocating for Hmong Mental Health Needs Participant

⁴Ibid.

⁵Public Policy Institute of California. California’s Population. Just the Facts, March 2021. Retrieved from: <https://www.ppic.org/publication/californias-population/>

⁶California Department of Health Care Services, Medi-Cal Monthly Eligible Fast Facts, April 2021. Retrieved from: <https://www.dhcs.ca.gov/dataandstats/statistics/Documents/FastFacts-January2021.pdf>

⁷Substance Abuse and Mental Health Services Administration, 2019 National Survey on Drug Use and Health. Retrieved from: <https://www.nimh.nih.gov/health/statistics/mental-illness>

Statewide Themes

“La ayuda existe pero necesitamos luchar mucho para conseguirla.”
- *Mental Health Matters Participant*

Access: People of color, their loved ones, and community experience barriers in accessing mental health services that go beyond stigma within the community itself and include complex access portals and pathways; lack of culturally responsive outreach; and fear that the process of asking for help or attempting to obtain services for oneself or a loved one may be dangerous or result in harm, especially in times of crisis. These delays in access to care are generally associated with continued worsening of the mental health issue.

Initial Access: Public mental health services across California are difficult to access, and each local mental health system has its own access portal and processes as well as a complex network of in-house and contracted mental health services that may be available to a person based on their assessed need. However, the screening and assessment process does not operate from a cultural framework, may not be completed in a person’s preferred language or may be translated improperly, and may not adequately capture actual BIPOC needs. Additionally, the initial screenings and assessment processes do not typically focus on trust and rapport-building, which is especially important when there is both pervasive mistrust and fear of the system and stigma associated with seeking mental health support.

“We need to know how to provide the right services, at the right time, for the right people in order for us to meet the needs of the many diverse cultures within each community.”

- *Advocacy for American Indian Health and Equity Participant*

Crisis Response: Crisis response and the policing of mental illness and substance use disorders, especially in Black communities, perpetrates structural violence manifesting as police brutality and incarceration under the guise of aid. Continued reliance on police as mental health first responders in Black and other minoritized/marginalized communities leads directly to unnecessary injuries, deaths, and incarceration, and decreases the likelihood that those in need will reach out for help.

“There is a way that the community, and Black men in particular, didn’t have the language to unpack what was really going on with those folks [mental health] and would often laugh and joke.”

- *Reimagining Black Mental Health Participant*

Misrepresentation of Involuntary and Jail-Based Services: However, these issues are difficult to fully explore, given how public mental health service data are typically presented. Many times, access and service data from a county mental health department combine services provided on a voluntary basis with services provided on an involuntary basis, including those services provided in jail settings. These types of visualizations tend to suggest that people of color are accessing mental health services at similar rates as their white counterparts. However, this can be misleading, particularly for Black and other minoritized/marginalized communities who are over incarcerated and are more likely to be receiving mental health services

when in jail. In reality, people of color are less likely to seek out or gain access to mental health services in the community. For many, mental health services are something that they are subjected to while in jail or otherwise confined. As noted in the community events, these mental health services provided in-custody are likely to rely heavily upon psychiatric medication and have other forms of treatment and healing less available, if at all.

Quality

Once care is able to be obtained, there are significant issues with the mental health services available. This includes issues with the cultural competency of mental health providers, a lack of culturally responsive treatment options, and problems with language access.

“They went for an hour and they didn’t understand, and they weren’t understood.”

- Mental Health Matters Participant

Lack of Cultural Framework: The mental health system and practitioners are grounded in implicit biases that include stereotypes and discriminatory ideas about people of color, and there are few to no checks and balances when these biases are applied to people of color in what is supposed to be a healing environment. BIPOC communities in the listening sessions do not feel their assets or strengths are valued, recognized, or supported by the mental health system. BIPOC participants highlighted their fears, distrust, and hesitation about accessing services because of the deficit-based approach the mental health system often uses to treat their mental health.

Underrepresentation: BIPOC communities also shared how challenging it was, regardless of county or region, to find a trusted and qualified mental health professional who shared their cultural identity and background. BIPOC communities shared that mental health providers do not understand their background and culture. For some BIPOC communities, they are discouraged from accessing services because navigating to a provider who is clearly culturally and linguistically concordant is too difficult, not a guarantee, time-consuming, and potentially unsafe. Many spoke to the nuances of their experience, whether it was their experience as a person with multiple intersectional identities (e.g., Black, gay, man), cultural nuances, language, or experience as a person of color. While shortages of providers who look like BIPOC communities persist, there may be opportunities to 1) expand the types of qualified mental health professionals who can provide mental health care (i.e., Community Health Workers, Promotoras, Peer Support Specialists and other traditional health workers), and 2) further engage, educate, and increase the capacity of existing mental health providers to operate from relevant cultural frameworks.

“I would like policy makers and stakeholders and providers to hire Hmong staff members, so it won’t be so stressful to find an interpreter when we go seek services. A lot of providers don’t have Hmong speaking staff, so we are afraid to seek services, because we don’t know how to explain our struggles or issues.”

- Advocating for Hmong Mental Health Needs Participant

“People have sought services at [the clinic] but the way they treated them was very curt; the person [patient] talks to the counselor but they [patients] are left unsatisfied. The people I know who sought help there [for mental health services] felt it was a waste of time.”

- Mental Health Matters Participant

Overreliance on Evidence-Based Practices Lacking Cultural Awareness: Structural racism has also resulted in the exclusion of behavioral health interventions developed and tested by and for BIPOC communities' health and wellbeing. Research institutions and clearinghouses, which review the existing evidence on different programs, policies and practices, continue to overlook questions related to race, ethnicity, culture, sexual orientation, and gender identity during the formation of behavioral health interventions. California, through the California Reducing Disparities Project (CRDP), gathered the evidence base for culturally defined practices and engaged in a process of community-defined evidence, an alternative method for documenting the efficacy of an intervention or approach, in order to justify practices that communities of color have relied upon for generations in order to promote healing and wellness. While communities of color have long-standing, established practices to support their behavioral health and wellbeing and the CRDP built the evidence base for Community-Defined Evidence Based Practices (CDEP), they are neither valued nor accepted by the dominant culture, and there remains an overreliance across California to fund evidence-based practices that exclude CDEPs and other practices likely to be effective within and across communities of color.

“If we struggle, we struggle alone.”

- Advocating for Hmong Mental Health Needs Participant

Lack of Language Access: Many BIPOC communities talked about the lack of language access in both translation and interpretation, especially for communities of color who do not speak more common languages other than English. Although federal and state legislation have greatly improved language access for LEP communities, community members continue to not have their language access needs met in physical health and mental health. Due to complex and technical terminology, confusing interfaces, or lack of consumer testing, many Medi-Cal beneficiaries do not understand the materials they receive that explain their benefits. Additionally, translated materials are often not culturally adapted and tested among the populations that they are intended to serve. Even if a translation is technically accurate, it may be written at too high of a reading level or use confusing word choices that are not culturally appropriate. Finally, translated materials often are not culturally sensitive to the ethnically and linguistically diverse Medi-Cal population. These problems limit an individual's ability to navigate an already complex health system, which creates a significant barrier to accessing meaningful health care and attaining positive health outcomes. Stakeholders from the BIPOC listening sessions explained that to truly promote cultural and linguistic outreach and services, all materials should be written in plain, simple, and culturally appropriate language and receive field testing for readability and cultural appropriateness of all translated materials

Technology: Telehealth has proliferated due to the stay-at-home mandates associated with COVID-19. However, having access to technology, including broadband and phone minutes, is a health equity issue. Telehealth has the potential to enhance patient-centered care, but only if consumers have equitable access. People with low incomes, those living in rural areas, and Black and Latino households are most likely to lack a broadband subscription.

While telehealth has existed for many years, research on its impact on communities of color and evaluation of its ability to reduce behavioral health disparities is limited.

Structural and Systemic Issues

In addition to the above issues regarding risk, service access, and quality of care, there are pervasive structural and systemic issues within the mental health system and beyond that contribute to mental health disparities among communities of color.

Accountability: Stakeholders are frustrated with the lack of accountability within the mental health system. There is a sense that the original spirit of the MHSA has been lost over time and that consumer and community partnerships are no longer valued. Stakeholders are tired of the blame game and fingerpointing and are desperate to have the mental system take responsibility to use the funds that they do have in more just and equitable ways and invest the funds for the people who need mental health services.

Parity: There continues to be a lack of parity between physical and mental health in California, which is particularly harmful to communities of color seeking care. Mental health referrals are still not treated with the same urgency as specialty care referrals. BIPOC communities face obstacles such as lack of education about how to access behavioral health care, health plan denials, long wait times, shortages of culturally and linguistically appropriate providers, and poor quality of care. Additionally, the COVID-19 pandemic disproportionately impacted communities of color and will have lasting effects on the behavioral health of BIPOC communities.

Funding: State departments, health plans, and providers continue to minimize the importance of community partners. Stronger linkages between community-based organizations and mental health providers are needed to increase awareness and access to services in BIPOC communities. BIPOC communities identify community-based organizations, including faith-based organizations, as safe spaces for services. Culturally specific organizations are often underfunded and unable to provide ongoing, reliable services.

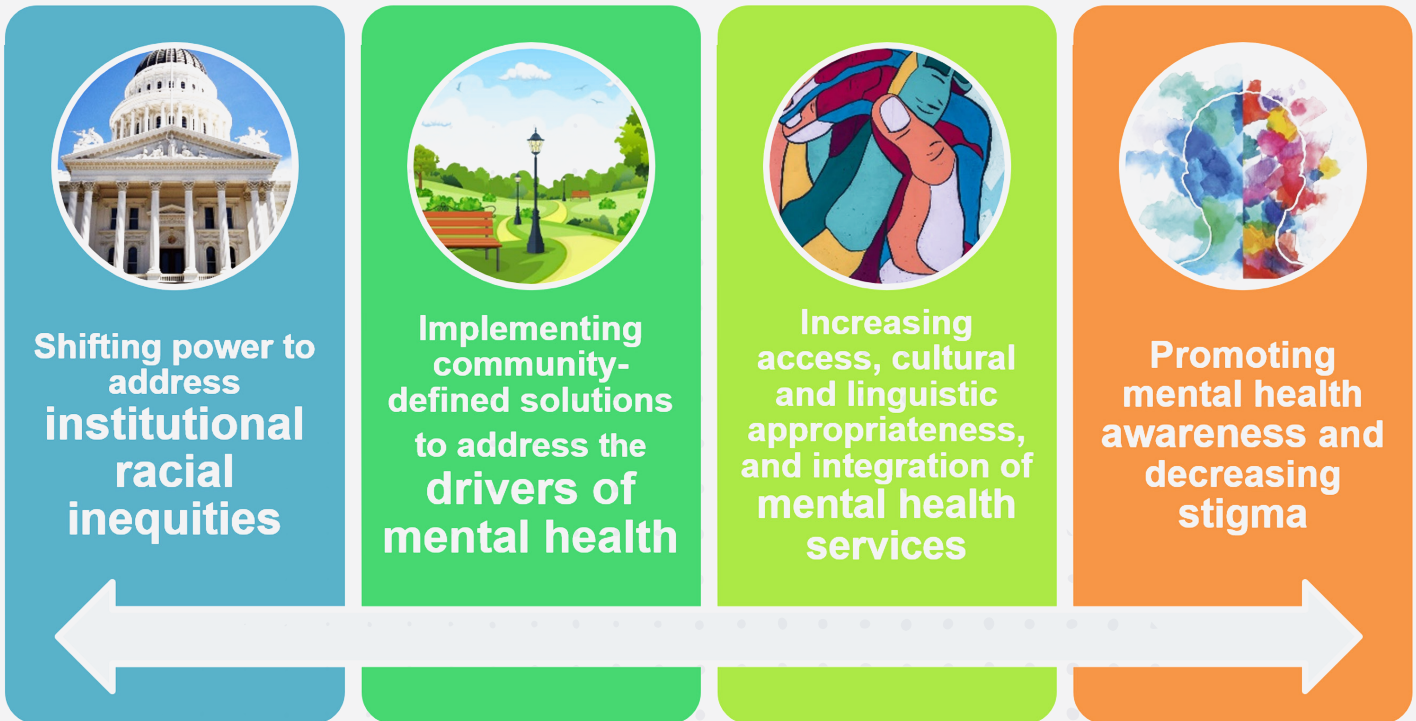
"I was trying to find a new psychiatrist, and I wanted a woman of color. Well, the only one I could find, I couldn't believe how her front office was treating me as a new patient coming in. First time, you're late so you have to come back. Second time, you don't have the paperwork so you can't have the appointment today. You have to come back. But they never sent me the paperwork. The third attempt, they said you're late, and I said you told me a certain amount of time that you could be late, and you changed the time. And then they said, if you don't make this next appointment, we are not giving you another appointment, ever. I was frustrated and feeling low emotionally, and my tone of voice changed. When I was told I couldn't have the appointment, I was labeled 'the angry Black woman'."

- Reimagining Black Mental Health Participant

Outcomes

The effects of exposure to racism and oppression have dire consequences for communities of color. The increased risks, problems with access to care, and service quality itself result in poorer mental health outcomes for communities of color. This is further exacerbated by the other drivers of health that disproportionately affect communities of color, such as issues with housing, food, and economic security that contribute to overall health and mental health outcomes.

State Recommendations



Shifting Power to Address Institutional Racial Inequities

The MHSA is unique in that it explicitly holds consumer voice to be a central value of the funding and implementation of mental health services. The law contains specific requirements for stakeholder engagement, including partnership with individual consumers and family members, and a reflection of the racial and ethnic diversity of consumers. Despite this, and due to institutional and system racism, the vision and commitment for a consumer-driven mental health system is far from realized, particularly for communities of color. The CPP process is a starting point, but it must be reformed to shift power into the hands of communities in order to be effective.

IAP2 Spectrum of Public Participation

IAP2's Spectrum of Public Participation was designed to assist with the selection of the level of participation that defines the public's role in any public participation process. The Spectrum is used internationally, and it is found in public participation plans around the world.

INCREASING IMPACT ON THE DECISION					
	INFORM	CONSULT	INVOLVE	COLLABORATE	EMPOWER
PUBLIC PARTICIPATION GOAL	To provide the public with balanced and objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions.	To obtain public feedback on analysis, alternatives and/or decisions.	To work directly with the public throughout the process to ensure that public concerns and aspirations are consistently understood and considered.	To partner with the public in each aspect of the decision including the development of alternatives and the identification of the preferred solution.	To place final decision making in the hands of the public.
PROMISE TO THE PUBLIC	We will keep you informed.	We will keep you informed, listen to and acknowledge concerns and aspirations, and provide feedback on how public input influenced the decision.	We will work with you to ensure that your concerns and aspirations are directly reflected in the alternatives developed and provide feedback on how public input influenced the decision.	We will look to you for advice and innovation in formulating solutions and incorporate your advice and recommendations into the decisions to the maximum extent possible.	We will implement what you decide.

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The International Association for Public Participation provides a useful framework for evaluating the level of community participation that is present in the current CPP process versus the aspiration of the MHSA. Most BIPOC stakeholders describe the CPP process as largely consultation, with county staff creating forums to receive public input on their programmatic and funding plans, and subsequently reporting out on how feedback was incorporated in the three-year plan. Some stakeholders describe the process as more informing than even consultation because the consultation venues are inaccessible. However, the MHSA aspires to have a stakeholder process that embodies collaboration. In order to get there, the MHSOAC and counties, in collaboration with stakeholders, should consider:

1. **Adequately resource the process.** Resources should include time commitment from staff and leadership, financial resources, and information. The MHSA requires counties to spend a portion of their annual MHSA revenues on the planning process, but caps this at 5%. This may or may not be sufficient, depending on the county revenues. Counties currently utilize CSS funds for this purpose, but could also consider INN projects that tackle institutional inequities by strengthening stakeholder engagement.
2. **Engage expert facilitators to develop public processes that solicit and synthesize actionable feedback.** Neutral facilitators or community leaders can help to build trust and create a welcoming environment for community residents who may be distrustful of county government.

3. **Commit to genuine transparency and provide adequate information to allow the public to make meaningful contributions to the process.** Counties should be transparent about their own limitations in accepting stakeholder input and should provide leadership development opportunities for community residents to have a full understanding of the architecture of county government and operations.
4. **With community residents, co-develop evaluation measures to assess the health of the CPP process and engage in continuous learning and improvement.**
5. **Consider approaching shared-decision making models that empower communities to make certain decisions.** An example of this is participatory budgeting, which commits to invest certain resources in the self-identified priorities of community residents through a rigorous engagement process.

Implementing Community-Defined Solutions to Address the Drivers of Mental Health

BIPOC stakeholders point to the shortage of mental health practices designed for or appropriately standardized on BIPOC communities as a root cause of mental health disparities.^{8,9} Services must account for the role of race, ethnicity, culture, sexual orientation and gender identity in mental health. New evidence developed by the California Reducing Disparities Project (CRDP) aims to demonstrate that services which center the role of race, ethnicity, culture, sexual orientation and gender identity are effective at preventing or reducing the severity of mental illness in BIPOC communities. These services are commonly referred to as community-defined evidence practices, or CDEPs, as opposed to the traditionally funded behavioral health services based on Western clinical models.

The MHSAs provides California's communities with an important opportunity to build evidence for CDEPs, many of which have been in practice for years, even centuries before the Western Medical model existed. The INN component of the MHSAs provides stakeholders with the option to introduce either new mental health practices or approaches, or make changes to existing practices or approaches with the potential to significantly improve mental health services and outcomes. PEI focuses on services like education, support, and outreach to help inform and identify individuals and their families who may be affected by a mental health issue.

While the MHSAs can pay for CDEPs, they are rarely included in the delivery system as a core service. To integrate CDEPs as a core service, the MHSOAC should work with stakeholders to:

1. **Form a CDEP Advisory Committee:** California should create a CDEP Advisory Committee comprised of experts in CDEPs, the California Department of Public Health (DPH), the California Department of Health Care Services (DHCS), providers, and consumers. The Committee would draft a plan to reimburse for mental health services based on community-defined evidence. In so doing, however, policymakers must be careful to avoid creating perverse incentives and outcomes caused by conforming community-defined evidence practices to the Mental Health Services Act framework. As such, the design of the core service should be based upon CDEP criteria and not on the typical Western medical model.

⁸Abe, J., Grills, C., Ghavami, N., Xiong, G., Davis, C., & Johnson, C. (2018, August 14). Making the Invisible Visible: Identifying and Articulating Culture articulating culture in Practice-Based Evidence practice-based evidence. Retrieved February 04, 2021, from <https://pubmed.ncbi.nlm.nih.gov/30106473/>

⁹Gordon, J. (2020, June 19). Racism and Mental Health Research: Steps Toward Equity. <https://www.nimh.nih.gov/about/director/messages/2020/racism-and-mental-healthresearch-steps-toward-equity.shtml>. National Institute of Mental Health. Retrieved February 04, 2021,

2. **Require services funded by the INN component of the MHSA to demonstrate how they will address disparities in BIPOC communities.** Though reducing disparities is an explicit goal of the MHSA, an ongoing review of approved INN plans by the Mental Health Services Oversight and Accountability Commission (MHSOAC) found that more than half of the plans identified reducing disparities as a goal but did not explicitly support CDEPs or provide robust metrics for evaluating their success in reducing racial disparities. INN should be used to test and evaluate new CDEPs or adaptations of CDEPs, but is not a sustainable funding stream because the funding is one-time. To remedy gaps, the MHSOAC could drive toward statewide changes in INN, possibly even allowing for counties to opt into a statewide disparity reduction plan.

It is important to note that some counties are leveraging INN funds to test and evaluate different aspects of CDEPs. For example, Fresno County recently proposed an INN project to evaluate whether CDEPs under the California Reducing Disparities Project (CRDP) can be adapted through community planning to adhere to PEI funding requirements without compromising the effectiveness of the original CDEP. Other counties have implemented INN plans to test and evaluate the efficacy of CDEPs in their communities, including Ventura County, which is currently evaluating a program that integrates indigenous healing practices traditionally used by Mixteco / Indigenous communities to improve symptoms of mental health associated with stress, anxiety and depression.

3. **Require PEI reporting to include outcomes that are important to disparities reduction efforts, such as connection to culture.** Though CDEPs speak to the goals and intent of PEI, regulations and outcome measures do not always align with the work. PEI regulations are set to be revised due to recent legislation and could become narrower. Regulations will need to be expanded in these circumstances, or CDEPs would likely need to adapt part of their program to better meet the regulations.

Because the MHSOAC has the power to approve INN plans and oversee PEI requirements, it could lead the revision of the above MHSA requirements. The MHSOAC can play a powerful role in the redirection of MHSA funding toward CDEPs.

Increasing Access, Cultural and Linguistic Appropriateness, and Integration of Mental Health Services

Many counties appear to focus their programs specific to diverse racial and ethnic communities on prevention and early intervention. While critical, this does not ensure that people of color have access to culturally and linguistically appropriate services across the continuum of care. The CSS portion of the MHSA, which primarily funds Full Service Partnerships (FSPs), is an important area of focus for increasing access and improving both the cultural and linguistic appropriateness of services, as well as the integration of mental health services. Currently, Asian or Pacific Islanders and Latinos are significantly underserved by FSPs. According to the MHSOAC Transparency Dashboard, Asian and Pacific Islanders are 3.5% of FSP recipients but nearly 10% of Medi-Cal members. Similarly, Latinos are only 38.7% of FSP recipients despite being nearly 50% of Medi-Cal members. FSPs have been shown to have a positive impact on criminal justice involvement, decreasing arrest rates for those currently engaged in an FSP and, to a lesser extent, for those who have completed an FSP.

However, the results are less profound for Black, Latino, and API participants, who have a smaller percentage decrease in arrest rate following FSP engagement. While biased policing, racism, and over-incarceration certainly contribute to high arrest rates for people of color, it is also possible that FSPs are less impactful for people of color due to a lack of cultural and linguistic competence. Beyond FSPs, communities of color have lower rates of engagement with county mental health services overall, despite having similar rates of access. Engagement is defined as five or more visits, while access is one visit or assessment. This likely points to people of color having a poorer experience of care, ultimately resulting in less willingness to continue with mental health treatment and poorer outcomes. The MHSOAC and counties, in collaboration with stakeholders, should consider the following recommendations to improve cultural and linguistic access across the continuum of mental health services:

1. **Invest in care teams that include peers, community health workers, traditional healers, and patient advocates.** BIPOC consumers strongly prefer mental health providers who have an understanding, and optimally personal experience, of their culture, community, and language. Yet, mental health providers do not reflect the diversity of Californians and BIPOC consumers often report stigmatizing, disrespectful, or discriminatory treatment. Non-traditional or non-licensed mental health providers have a strong history of providing recovery-oriented, culturally and linguistically competent services that result in positive outcomes for consumers.
2. **Increase capacity of county systems to collect, analyze, and utilize patient-centered outcome data.** While counties collect and report myriad data, very little of it helps to paint a picture of value, quality, and disparities. Because counties bill for services rendered on a “per minute” basis, the state does not effectively capture or drive for outcomes, including those that reflect consumer priorities and equity. Payment structures, data systems, and quality measurement must all be reformed in order to have the mechanisms necessary to conduct targeted system improvement.
3. **Strengthen the integration of county mental health services, particularly FSPs and hospital-based care, with primary care, substance use disorder treatment, and programs to address social risk factors.**
4. **Rigorously enforce consumer rights to non-discrimination, language access, timely access, and evidence-based care.** California has strong laws to protect consumers, including mental health consumers, from discrimination and to require timely and linguistically appropriate care. However, there continues to be a gap between the law and the reality for consumers. Throughout the listening sessions, consumers describing stigmatizing, discriminatory, and disrespectful treatment. In addition, those Californians who speak a language other than English continue to describe language barriers. State agencies should rigorously and proactively enforce existing law, and should not rely solely on complaints to do so.
5. **End policies with deeply embedded racism that result in people of color living with mental health challenges being disproportionately impacted by involuntary detention and treatment, including in jails, prisons, psychiatric hospitals, and conservatorships.** Due to a range of discriminatory policies, people of color are most likely to have their mental health challenges met with involuntary treatment or incarceration. An expansion of accessible and equitable community-based mental health treatment must be coupled with the elimination of discriminatory policies throughout mental health, criminal justice, housing, and other areas of society.

Promoting Mental Health Awareness and Decreasing Stigma.

1. **Tailor public health messaging to be culturally and linguistically appropriate.** Partner with cultural brokers and culturally specific community-based organizations to understand how the community views mental health, what language may deter them from connecting to mental health services, and then adjust language and approach to meet diverse communities where they are. Because of historical trauma, cultural beliefs, and the stigma of mental illness, it is important to be flexible with language as an initial step to building trust and a bridge to connect with overall wellbeing/wellness.
2. **Integrate holistic and traditional approaches.** Some diverse communities may need a 'stealth mental health approach' that integrates spiritual, emotional, and physical health to make the content more accessible culturally. For example, in the Black community, it may look like sharing stories and focusing on 'experiences' rather than diagnostic labels/clinical language. For American Indian/Alaska Native communities, it may be providing context on generational trauma and traditional healing as a foreground before connecting to mental health. Creative approaches to decreasing stigma, such as providing talking circles or vignettes, may be helpful. In API communities, having cultural experts that are bilingual and bicultural and can talk to the issue of stigma with both an educational and cultural vantage point may be more culturally relevant and accepting.
3. **Invest in community-based organizations and other trusted messengers like peers.** Partner with peers and/or peer run organizations that have trained peers who tell their stories of mental health recovery and resiliency specifically to promote mental health awareness and decrease stigma. Ensure that this approach is culturally relevant to the population being served and that the speaker matches the cultural background of the community being targeted for stigma reduction and mental health awareness. Engaging with peers who share their stories and speakers' bureau with targeted messages around their experience with mental health issues and how stigma has impacted them. Messages should include what is helpful from their cultural community and not helpful from traditional beliefs, and how engaging in mental health support has helped them.
4. **Build an educational integrative cultural mental health campaign and fund CDEPs** to extrapolate what 'mental health looks like in cultural communities' and what about their programming serves 'mental health' to make the concept more tangible, accessible, and inviting for the diverse communities to respond to.

Conversation Highlights and Recommendations from the Local Listening Sessions

Reimagining Black Mental Health

Statewide Partner: California Black Health Network (CBHN)

Local Partner: Restorative Justice for Oakland Youth (RJOY)

Region: Bay Area (Alameda)

Conversation Highlights

- The stigma of mental illness and the fear/mistrust of the mental health system impact how the Black community engages in mental health treatment and conversations about mental health.
- Navigating the system, understanding cost, finding culturally appropriate providers and services, and the right level of care remain barriers for access.
- The impact of institutional racism, provider bias/lack of competency to address racism, and the criminalization of Black mental health by the overrepresentation of Black people in the criminal justice continue to be systemic barriers that negatively impact Black mental health.

Recommendations

1. The mental health system could deepen its partnerships with the church and support them to build their skills related to mental health and intersectionality. Faith-based leaders and churches do not need to become mental health practitioners, but they are a point of intervention that could work on becoming safer and more effective in addressing mental health issues.
2. Cultural competency needs to encompass more than just race, and the mental health system should focus more on intersectionality and diversity within the Black community.
3. Overall, the mental health system should work towards behaving in more trustworthy ways so that when people can access a service, they will choose to do so.

Advocating for Hmong Mental Health Needs

Statewide Partner: Southeast Asia Resource Action Center (SEARAC)

Local Partner: Hmong Cultural Center of Butte County (HCCBC)

Region: Superior (Butte)

Population of Focus: Southeast Asian

Conversation Highlights

- The combination of the stigma of mental illness, traditional Hmong values of privacy, and the Western clinical approach to mental health services that does not integrate mind, body, and spirit are barriers for the Hmong community to connect with mental health treatment.
- Bilingual/bicultural providers and/or providers who truly understand the Hmong culture, connection to spirits, and generational trauma, is an area of need. There is also a need for mental health materials to use an overall health education framework in order to combat stigma.
- Barriers include mental health services not being embedded in the community, not knowing what services are available, language access barriers, and the overreliance of individual therapy as a modality instead of a group modality that is more culturally appropriate for the Hmong community.

Recommendations

1. The County should support and directly fund community resources that provide culturally and linguistically appropriate mental health information and mental health services, and then route community members to these community resources rather than trying to get people into traditional mental health services. These community-based organizations tend to be more integrated and promote an increased level of trust and comfort. Also, the County should recognize the non-traditional, non-Western approaches to mental health care that are or could be provided in these locations.
2. The County should consider prioritizing group interventions, particularly for elders. Often it is easier for Hmong elders to unite with individuals that have the same issues and experiences so that they can learn to cope together.
3. It can be hard to reach and sustain engagement with youth. Time-limited or unstable funding from the County creates additional uncertainty in community-based organizations. When funding reductions impact staff departures, Hmong youth often retreat and stop participating. To this end, the County should provide sustainable funding for Hmong youth programs.

4. The County should also better invest in how it provides information to the Hmong community. It is very difficult to read or write Hmong, and information is better presented orally. Having information or flyers shared on social media or ethnic media with 'sound bites' so that outreach materials can be listened to would likely work better.
5. The County should attempt to hire more Hmong staff that are representative of the community, train other staff in the Hmong culture so that they are able to operate with that cultural understanding, and do more outreach to recruit, hire, and train future mental health providers. This includes youth as well as community leaders who run mental health programs.
6. When providing written information to the Hmong community, it would be useful to have someone who is actually literate in Hmong language and culture do the translation so that the translation is accurate. In Hmong, there are not a lot of words that translate to mental health, so leaving an English word in materials is confusing when the word could be better described with an explanation or scenario.

The Advocacy for American Indian Health and Equity in Kern County Conference

Statewide Partner: California Consortium for Urban Indian Health (CCUIH)

Local Partner: Bakersfield American Indian Health Project (BAIHP)

Region: Southern (Kern)

Population of Focus: American Indian & Alaska Native (AIAN)

Conversation Highlights

- American Indian and Alaska Native community members pointed to the disconnect between the mental health system and their culture and the need for holistic services to include the four domains of health: physical, mental, emotional, and spiritual.
- Barriers include the overreliance on non-culturally validated evidence-based practices (EBP) and lack of acknowledgment and respect of traditional healing practices and funding support for community-defined evidence practices (CDEPs).
- Culturally reflective providers and/or providers deeply immersed in understanding generational trauma and the AIAN experience who can “slow down” to form enduring and trusting relationships is a true area of need. Further, community members want embedded providers to demonstrate care and trustworthiness.

Recommendations

1. The County should recognize the value and need for CDEPs. This act to elevate CDEPs should be supported with funding for CDEP implementation.
2. The County should work towards facilitating a change in meeting norms, including facilitating more inclusive meetings and specifically more accessible and inclusive language. This could include a land acknowledgment, a space for tribal representatives to support the ways in which the meetings are opened, and using less technical or clinical jargon.
3. The County should also consider how to include youth voice in the discussion. This could include appointing a youth representative to an MHSA planning council or cultural competency committee or subcommittee or adding youth needs as a standing agenda item.
4. The County should start to recognize the intersection of mental health with the other forms of health and look for opportunities to support a more holistic approach to health and wellness, including the physical, mental, emotional, and spiritual.
5. BAIHP has healing services and would like to be able to provide or influence the larger mental health system. The County should work towards deepening the partnership with BAIHP and the AIAN communities, including being more proactive and intentional about inviting AIAN peoples into the discussion and looking for ways to increase transparency and accountability to the entirety of people that they are charged to serve.

Mental Health Matters

Statewide Partner: Latino Coalition for a Healthy California

Local Partner: Visión y Compromiso, Comité de Promotoras en Kern

Region: Southern (Kern)

Population of Focus: Latino and Migrant Indigenous Residents

Conversation Highlights

- Barriers to connecting with mental health care include experiencing a discriminatory and unresponsive system, long waits for appointments, and exclusion of family members in care.
- The lack of bicultural and language proficient providers for Spanish speakers and Indigenous languages and the erasure of Migrant Indigenous residents was a noted challenge to feeling cared about and receiving culturally responsive care. Stakeholders also highlighted the need for culturally translated educational materials on mental health to combat stigma.
- Community members in historically underserved regions faced provider proximity barriers, further exacerbated by the lack of investment in telehealth and satellite services.

Recommendations

1. Kern BHRS should work towards more accessible meetings. This includes better publicizing of MHSA meetings to ensure that they are truly public meetings. Meetings should be announced through diverse outlets, and community members should be invited and encouraged to attend. MHSA meetings should have interpretation available for Spanish-speaking participants to promote accessibility for all, and they should not be solely held in the middle of the day, to include working-class community members. BHRS should also consider providing incentives and childcare so that community members can participate.
2. Kern BHRS may wish to invest in restructuring the MHSA and Cultural Competency Committee meetings to normalize community participation and promote more substantive discussion and consideration of the issues at hand. They should consider developing an MHSA 101 training for new stakeholders so that they can meaningfully participate in the process. Many counties offer this type of orientation in the 30 minutes prior to an MHSA meeting.
3. Kern BHRS may wish to more intentionally include Visión y Compromiso and other community-based organizations in the process, especially those that are representative of unserved, underserved, and inappropriately served communities.

4. Having a dedicated outreach staff with cultural competence training may help enhance all the preceding recommendations.
5. Finally, there is a desire to promote accountability and re-align the County's MHSa efforts with the original spirit and intention of the Act, which was to leverage community participation in order to design, plan, implement, and evaluate efforts that transform mental health services into a wellness and resiliency focused, consumer and family-driven, culturally responsive, integrated mental health system of care.

Mental Health Matters: Culture as a Social Determinant

Statewide Partner: California Pan-Ethnic Health Network (CPEHN)

Local Partner: California Black Women's Health Project (CABWHP)

Region: Los Angeles

Population of Focus: Multi-cultural

Conversation Highlights

- Even when multicultural communities find culturally reflective providers, they experience racism and discrimination by front office staff or other gatekeepers.
- Culturally specific organizations receive less funding and are overly reliant on clinical interns who have less experience and turnover quickly, making it difficult to build trust.
- There are barriers due to navigating a complex and confusing system, lack of language proficiency, unattractive and unwelcoming physical environments, and lack of understanding cultural perspectives on healing make it difficult to engage in mental health support.

Recommendations

1. The LACDMH website is confusing and hard to navigate; it appears bureaucratic and not intended for the community to use. LACDMH could invest in making their website more inclusive (e.g., gender identities), more easily accessible, and easier to navigate.
2. When someone calls the LACDMH Helpline, a 1-800 number, there should be an option for someone to select the language of the voice prompts so that they can listen in their own language.
3. LACDMH should engage in more intentional collaboration with the communities it serves, including inviting more diverse communities to MHSa and other committee meetings, providing training to newer stakeholders to support their participation, and openly considering community feedback when making decisions.

4. LACDMH should invest in culturally specific organizations and stop the practice of underfunding. In order to accomplish this, they should also make the application and contracting process more accessible and consider what technical assistance and payment schedules might be needed to better support these organizations.

Detailed Overview of the Five Counties and Local Listening Sessions

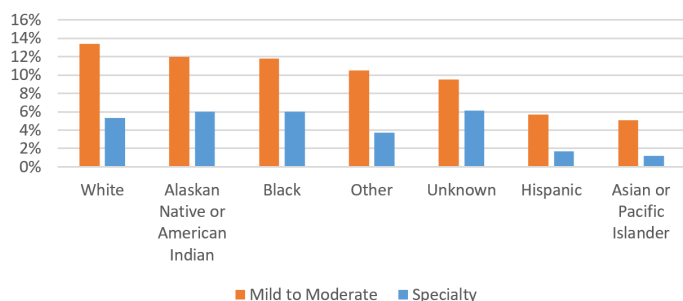
Across California, this project’s inaugural year sought to 1) equip local advocates and communities to participate in and influence MHS decision-making through leadership and advocacy development as well as 2) promote openness and accountability from MHS staff and public officials to listen, seek to understand, and incorporate our perspectives into MHS plans and funding allocations. Collectively, our efforts sought to provide support to help build community members and organizations abilities to participate in the MHS process, demystify the local CPP process and equip local advocates with the data and information they need, document local needs and priorities, disseminate information about mental health and mental health services, as well as promote accountability and support MHS staff and decision-makers to not just listen to our communities’ needs and interests but also welcome and seek our participation.

The following sections present an overview of five counties, identified needs within their mental health system, how their CPP process works, and a summary of the local capacity building events. These local events also summarize the key issues reported by communities of color in terms of access, services, and quality of care.

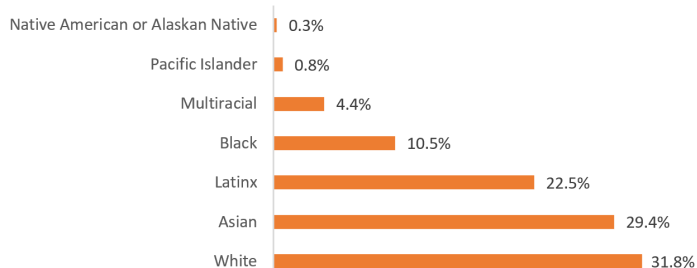
Alameda County Profile

Alameda County, located in the East Bay Area region of California, is classified as a large county with a population of 1,501,271.¹⁰ Alameda County is the fourth most racially diverse county in the United States as well as the most diverse county in California. Alameda County struggles with high rates of segregation, homelessness, and other inequities that influence health disparities.

Alameda County Medi-Cal Mental Health Utilization by System - FY 2019-2020

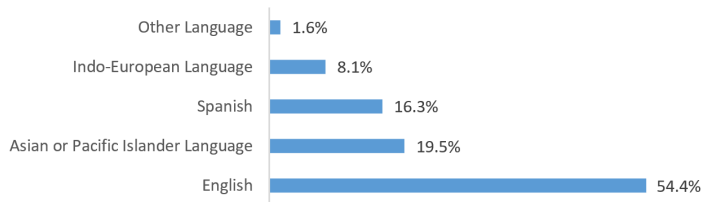


Alameda County - Population by Race and Ethnicity

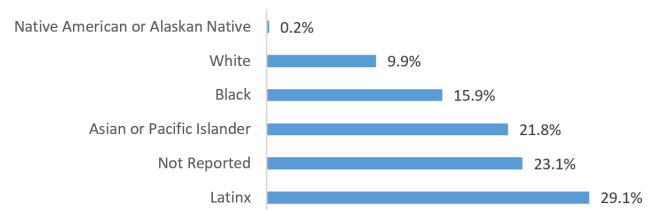


¹⁰US Census, 2020

Alameda County - Language Spoken at Home



Alameda County - Medi-Cal Enrollment by Race and Ethnicity



Alameda County Behavioral Health (ACBH) is responsible for public mental health services in Alameda County, including serving as the Specialty Mental Health Plan and administering the MHP. They are party to a class-action lawsuit regarding the lack of adequate mental health care that contributes to avoidable crises, hospitalization, and incarceration. According to the most recent EQRO¹¹, the following issues related to access, penetration, quality, and outcomes were noted:

- Alameda County performs better than most of the state in serving Latino consumers – Latinos make up 28% of consumers and 30% of the county Medi-Cal population. However, the county underserves API consumers.
- Prevention, early intervention, and services for people with mild to moderate mental health issues appear to be very limited in Alameda County. This contributes to consumers being unable to access services early and potentially enduring more severe but preventable symptoms. This may be a particular concern for Black consumers, who access the most intensive levels of specialty mental health services at a high rate, possibly due to limited access to prevention and early intervention.
- Children particularly struggle to access care in the county. The department met the need for children’s urgent mental health appointments only one third of the time. Stakeholders pointed to the need for increased parent and caregiver inclusion in treatment planning.

According to the most recent MHP Program and Expenditure Plan¹², Alameda County established an MHP CPPP Steering Committee in 2020 to develop an outreach mobilization strategy and assure transparency and accessibility of the planning process. The department utilizes multiple leadership groups to conduct the planning process, providing leaders with training and stipends to support their participation and increase community input. ACBH also conducted a survey to gather feedback, and 627 survey responses were submitted throughout the process; however, 90% were in English. Only 6 responses were submitted in Spanish. Nearly a quarter of survey respondents were Black, a strong response rate compared to the county population of approximately 10%. Over half of the participants identified as providers; only a third identified as consumers.

¹¹ <https://www.caleqro.com/data/MH/Reports%20and%20Summaries/Fiscal%20Year%202020-2021%20Reports/MHP%20Reports/Alameda%20MHP%20EQRO%20Final%20FY20-21%2003.06.21.pdf>

¹² https://acmhsa.org/wp-content/uploads/2021/03/MHP2020Plan_FINAL_WEB_update_02.pdf

Alameda County Listening Session: Reimagining Black Mental Health

Statewide Partner: California Black Health Network (CBHN)

Local Partner: Restorative Justice for Oakland Youth (RJOY)

Region: Bay Area (Alameda)

Population of Focus: Black/African Ancestry

Dates: Listening Session: March 26, 2021

Listening Session: April 4, 2021

Listening Session: April 7, 2021

Conference: March 31, 2021

No. of Listening Session Participants: 24

No. of Conference Participants: 180

“The outer experience of a person does not dictate what they are experiencing.”

Overview of Event: Restorative Justice for Oakland Youth (RJOY), in partnership with California Black Health Network (CBHN), facilitated three community listening sessions and one larger convening in the Spring of 2021 focused on healing and wellness in the Black communities of Alameda County. All events were facilitated virtually. The listening sessions were conducted as a part of existing healing circles. These healing circles were from the “voices on the margins that we’re not hearing from” and included formerly incarcerated individuals, Black women and children, and Queer and Trans People of Color; they were inclusive of consumers of services as well as providers. The listening sessions focused on access and mental health services in Alameda County. The Community Program Planning (CPP) process was not discussed, given the level of disconnection and mistrust being expressed about the larger mental health system.

The larger convening in March entitled ‘Reimagining Black Mental Health’ welcomed all interested stakeholders and hosted approximately 180 individuals. The event explored the mind, body, and spiritual health by infusing African-centered rituals and educational presentations on Black wellness. The spirit of the event was grounded in the question, “how do you define mental health and mental wellness?” The event opened with drumming, poetry, and a guided meditation. Throughout the event, there were intentional efforts to create a sense of community with free-flowing discussions. In addition to the keynote address, there were multiple breakout sessions where people would explore different questions and topics related to Black mental health. Topics included: the impact of childhood trauma and how to build resiliency, Black mental health and African spirituality, emotional self-awareness and male vulnerability, connecting with queer youth, Black geriatric mental health, restorative trauma healing, storytelling as medicine, and more. RJOY wanted to create multiple ways for communities on the margins to access mental health information and resources. For example, if participants didn’t attend the live event, they could interact with the presentations through the RJOY YouTube. Some of the videos captured the experiences of individuals with mental health challenges as well as practitioner knowledge. The videos continue to be accessed and viewed post-event.

Key Highlights

Mental Health System

The collective events sought to deepen the narrative and name the ways in which Black communities can transform systems of care to become anti-racist. Participants shared that historically the Black community has had a negative view of the label of mental illness and that stigma has impacted how people relate to, speak about, or engage with mental health treatment or even conversations about mental health. Participants suggested teaching mental health in the schools, beginning in the elementary schools, with more seminars and assemblies to share mental health information, especially to “teach kids that it’s okay to have feelings and then teach appropriate responses to those feelings.” There was also a specific interest in promoting social and emotional learning for Black men to be able to have the mental health conversations with boys and work within the Black community to support fathers and sons.

Conversation Highlights

- The stigma of mental illness and the fear/mistrust of the mental health system impact how the Black community engages in mental health treatment and conversations about mental health.
- Navigating the system, understanding cost, finding culturally appropriate providers and services, and the right level of care remain barriers for access.
- The impact of institutional racism, provider bias/lack of competency to address racism, and the criminalization of Black mental health by the overrepresentation of Black people in the criminal justice continue to be systemic barriers that negatively impact Black mental health.

“There is a way that the community, and Black men in particular, didn’t have the language to unpack what was really going on with those folks [mental health] and would often laugh and joke.”

There was also discussion about how there is a pervasive lack of trust with the mental health system and that people have reasonable worries regarding 1) am I going to be safe, 2) am I going to be protected, and 3) how much will this cost? It became clear through the discussion that people are detached from the systems of care, even those that want to be more connected. And the system is hard to navigate, even for a provider. It is incredibly challenging to find the appropriate service, determine the cost, and figure out which may be culturally competent or safe. With this, participants acknowledged that they chose to access a healing circle rather than a formal mental health service because they know it’s safe. There was concern, however, about what might happen for someone who needed more than the healing space, who had need for more intensive services, and how would the healing circle facilitators and participants respond to untreated mental health needs when there isn’t a practitioner in the room and how they might manage without pushing someone out of the community. Given how challenging the system is to navigate, there was a lack of confidence that the healing circles would know how to respond or how to help a person connect with formalized mental health services.

One participant explained that because he was taught to keep his feelings inside, he believed that he was only able to express himself through violence and reflected on how that belief impacted his mental health. This participant’s experience

with only feeling that it was culturally acceptable to express emotions through violence is a symptom of a much larger issue impacting Black communities; the systemic conditions that contribute to community violence and impact mental health like institutional and interpersonal racism, discrimination, oppression, poverty, and lack of affordable housing. This recognition uplifts the way in which community violence is connected to social inequities, which may further contribute to mental health and substance use issues.

With the overrepresentation of Black people in the criminal justice system, jails, and prisons, there was also an acknowledgment that a lot of mental health services, specifically for Black men, are provided while in custody, and that psychiatric intervention, as well as increased suicidality, are clear issues. There was also some discussion about being cautious about how to engage with a mental health provider if they work for the criminal justice system and are sharing information with them. Specifically, there was the acknowledgment that you can't fully trust a mental health provider when they're working for the jail or prison and that the information held in your file could be used against you when in terms of probation or parole decisions. Participants did note how important it would be to have more and better post-release support that includes housing, mental health services that don't interfere with the ability to look for or maintain employment, and services that won't take a long time to set up post-release.

Participants discussed that while they may not identify with mental health, they may identify with an experience, such as being a veteran or having post-partum depression. This is even more important given the traumas experienced by Black communities. Participants talked about how important it is to have their experiences validated and acknowledged in terms of it being 1) real, and 2) difficult. There was also discussion about how Black people may present differently given the need to project strength, and that there is a need to recognize the need and/or request for help, even when it's not paired with clear "vulnerability" or "distress." Specific issues and the associated stress and trauma were acknowledged in terms of health disparities related to mothers and babies and the increased rates of Black women dying in childbirth, infant mortality, and postpartum depression. Regardless, people shared about the importance of being able to see a therapist and wanting to "break intergenerational curses," but they also want those healing spaces to feel "real" and authentic and not feel like a "program." The church was also mentioned as a source of refuge or strength for many in the Black community, and that church leaders can and do provide counseling and guidance to their communities. While the church had the trust of the community, it was also noted by some that the church is an imperfect institution and that it may be a source of additional pain and trauma for BIPOC who are also members of the LGBTQ+ community, who experienced rejection from their church community because of their identity and/or gender expression. In this regard, the discussion centered around what it would look like to have mental health services in the church and support pastors and faith-based leaders to build mental health skills and understand the ways in which they may also inflict harm (i.e., "pray it out"). The importance of intersectional experience underscores that the Black community is not a monolith, and all identities must be taken in account when considering approaching their mental health needs and treatment preferences (e.g., having a Black trans provider to match with a Black trans consumer).

One request to the mental health system was to become anti-racist, and specifically help mental health providers address their own internalized racism as well as become competent in talking with their clients about oppression and how to cope with the impact of racism and discrimination that they experience. In this regard, there was also a conversation about how to shift away from the formal mental health system and build Black mental health practitioners within the Black community. Additionally, there was some discussion about how to hold providers accountable for the racist, biased, and/or otherwise harmful things that they say.

Other requests for the mental health system were to allow for and provide more family-inclusive and family-focused interventions. Participants acknowledged the importance of working through issues that are shared across a family, but there are limited referrals for free or low-cost family interventions, particularly with people with higher levels of mental health need. There was also discussion about bridging the space between Indigenous and Afro-centric forms of healing alongside traditional forms of therapy. There was interest in building coalitions and partnerships with other organizations in order to work towards this.

Post Event

Since the event, RJOY has deepened its staff support and training. They have set up additional training for their staff, have a new social worker, and are participating in some of the Alameda County trainings. Additionally, there has been continued promotion of the session content on social media as well as some earned media promotion with RJOY's executive director.

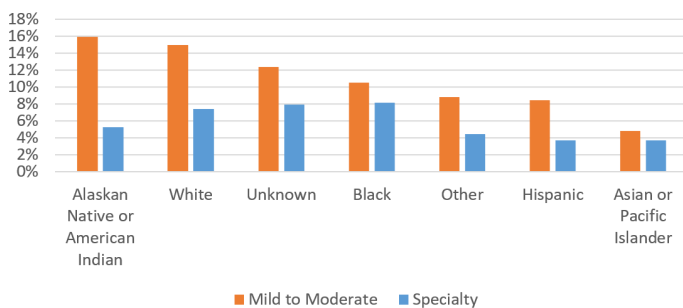
Recommendations

1. The mental health system could deepen its partnerships with the church and support them to build their skills related to mental health and intersectionality. Faith-based leaders and churches do not need to become mental health practitioners, but they are a point of intervention that could work on becoming safer and more effective in addressing mental health issues.
2. Cultural competency needs to encompass more than just race, and the mental health system should focus more on intersectionality and diversity within the Black community.
3. Overall, the mental health system should work towards behaving in more trustworthy ways, so that even if people could access a service, they would choose to.

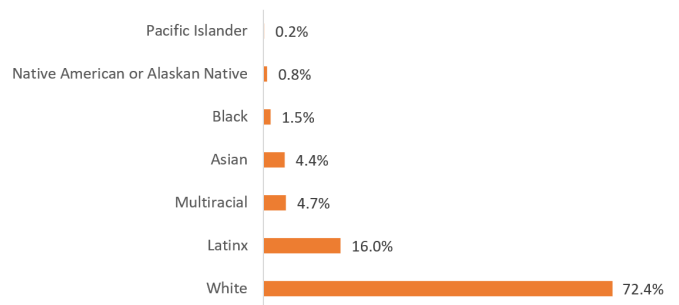
Butte County Profile

Butte County, located in the Superior region of California, is classified as a mid-size county with a population of 220,000.

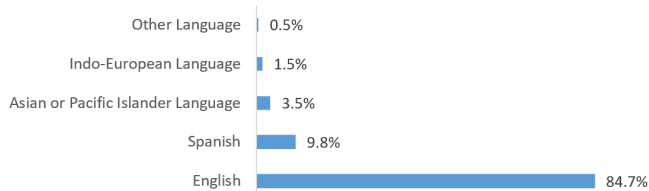
Butte County Medi-Cal Mental Health Utilization by System - FY 2019-2020



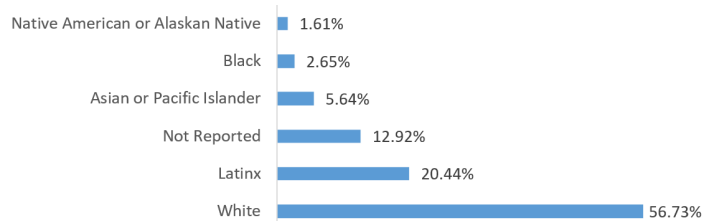
Butte County - Population by Race and Ethnicity



Butte County - Language Spoken at Home



Butte County - Medi-Cal Enrollment by Race and Ethnicity



Butte County Behavioral Health (BCBH) is responsible for public mental health services in Butte County, including serving as the Specialty Mental Health Plan and administering the MHSA. According to the most recent EQRO¹³, the following issues related to access, penetration, quality and outcomes were noted:

- Consistent with state trends, Latino and API consumers are underserved by the county. However, the penetration rate for Latinos has improved from 2017 to 2019.
- The January 2020 update to the cultural competence plan included very few updates on what was implemented or completed in the prior year. However, the county noted that much of the activity to update the plan in partnership with the Cultural Competence Subcommittee would take place in the latter half of the year.
- The referral process to local Medi-Cal Managed Care Plans (MCPs) is ineffective, with most clients being bounced back to the county.
- Consumers report difficulty transitioning between providers as well, particularly those with language assistance needs.

According to the most recent MHSA Program and Expenditure Plan¹⁴, Butte utilizes community meetings, focus groups, and surveys to obtain broad community input. The county does not specify priority populations for the outreach or feedback beyond those specified in the MHSA. In 2019, a total of 169 community members participated. Only five self-identified as API. Butte also leverages the Behavioral Health Board and Quality Improvement Committee meetings as a part of the process. In 2020, meetings were held virtually with a total of 116 participants. Race and ethnicity information does not appear to have been collected. In 2019, the county established an MHSA Steering Committee. This group is selected by the Behavioral Health Advisory Board and meets monthly with the MHSA coordinator to discuss a wide range of topics.

Butte County Listening Session: Advocating for Hmong Mental Health Needs

Statewide Partner: Southeast Asia Resource Action Center (SEARAC)

Local Partner: Hmong Cultural Center of Butte County (HCCBC)

Region: Superior (Butte)

Population of Focus: Southeast Asian

Dates:

March 16, 2021: Mental Health in the Hmong Community: A Listening Session for Youth and Young Adults

No. of Participants: 32

March 26, 2021: Mental Health in the Hmong Community: A Listening Session for Older Adults and Seniors

No. of Participants: 10

April 16, 2021: Effective Mental Health Engagement with the Hmong Community

No. of Participants: 84

April 23, 2021: Effective Mental Health Advocacy with the Hmong Community

¹³<https://www.buttecounty.net/Portals/5/Administration/MHSA/20-21/2020-2023MHSAThreeYearPlan.pdf?ver=2020-08-10-162041-770>

¹⁴Ibid.

Overview of Event

The Hmong Cultural Center of Butte County (HCCBC), in partnership with Southeast Asia Resource Action Center (SEARAC), hosted two listening sessions and two advocacy events in Butte County focused on Advocating for Hmong Mental Health Needs. All events were facilitated virtually. SEARAC staff supported the HCCBC with guidance and support to organize and prioritize the events.

All events opened with a welcome by HCCBC's Executive Director, Seng Yang, were facilitated by Dr. Ghia Xiong, a Hmong clinical psychologist, and included Hmong dance performances. In the listening sessions, the discussion focused on hearing directly from Hmong community members on their knowledge of and experiences with mental health services in Butte County and learning about key mental health challenges and ways to improve access to and quality of services. The first listening session and the first Advocacy event were facilitated in English, and the second listening session and engagement event were facilitated in Hmong. The engagement-focused event targeted mental health providers that serve the Hmong community to help improve how they work with Hmong clients and community members in mental health settings. The event covered Hmong cultural beliefs about illnesses and treatment, mental health services, and effective practices for building rapport and engagement. The advocacy-focused event invited the Hmong community to learn about how to be more involved in shaping mental health services and in improving access and quality of mental health in the County. Hmong community members received a presentation by the Butte MHSa Coordinator, Holli Drobny, and topics covered included California's mental health system, how the local government implements mental health funding, and effective skills and strategies to advocate for better mental health services in the community. The presentation was interpreted live from English to Hmong.

A unique aspect of the HCCBC approach is that they also held an event to better support providers already working with people from the Hmong community to understand their mental health needs and advocate on their behalf. Participants were overwhelmingly receptive and appreciative and commented that they were able to gain a more nuanced understanding of the issues and approaches that may be more successful with Hmong individuals. The event itself allowed a lot of time for people to ask questions and apply the knowledge that they were learning. Several learning-based activities and health and mental health scenarios were presented so that they could apply the knowledge or reshape their perspectives. During the activities, participants were able to learn a different perspective, know how to approach these scenarios, and better anticipate how the Hmong community would respond to it. This gave them the opportunity to rethink the quality of work that they are doing and rethink and resolve the situations that they're noticing in their work. This also provided some additional information about how to understand issues that Hmong clients may present with from a cultural perspective rather than a Western diagnostic lens.

Key Highlights

Mental Health System: The discussion centered around issues related to stigma. While there was an acknowledgment that mental health issues can happen to anyone, participants discussed the need to keep mental health and mental health service participation private. Participants also discussed that as a result of this strong desire for privacy, 1) services should be embedded within the local community, which is different than placing a mental health clinic in the local community; and 2) providers should not assume that a family-inclusive approach will be appreciated, an approach often taught in cultural competency trainings. In many cases, there may be a desire to not share mental health challenges or service participation with family, especially with elders who may not be as open or receptive to the discussion.

"People do not come to the public health clinic. They come to see [an] individual. Clients miss the individual who helped them."

Conversation Highlights:

- The combination of the stigma of mental illness, Hmong traditional values of privacy, and the Western clinical approach to mental health services that does not integrate mind, body, and spirit are barriers for the Hmong community to connect with mental health treatment.
- The lack of bilingual/bicultural providers and/or providers who truly understand the Hmong culture, connection to spirits, and generational trauma, was an area of need. Also, the need for mental health materials to use an overall health education framework to help combat stigma.
- Barriers included mental health services not being embedded in the community, not knowing what services are available, language access barriers, and the overreliance of individual therapy as modality instead of a group modality which is more culturally appropriate for the Hmong community.

There was also an acknowledgment of the generational and acculturation gaps, particularly amongst families where children are first generation and have attended school in the United States and the influence that this has on stigma as well as family relationships regarding mental health. This was also described regarding sexual orientation and gender/gender identity. Further, participants shared the need for the system to partner with cultural brokers because people will build trust and come to rely on an individual for support, rather than the system itself.\

“I would like policy makers and stakeholders and providers to hire Hmong staff members, so it won’t be so stressful to find an interpreter when we go seek services. A lot of providers don’t have Hmong speaking staff, so we are afraid to seek services, because we don’t know how to explain our struggles or issues.”

Youth and providers discussed that it can be hard to engage youth in mental health services. Often times youth may be experiencing a cultural identity crisis. Many Hmong and other Southeast Asian youth are trying to adapt and live their life with the modern culture, but experience pressure from their elders and family members to keep alive their traditional culture. One youth participant explained that when she tried to get mental health services at her high school, all of the counselors were white and could not relate to her, understand her culture, and respect her need to not involve her parents because in Hmong culture, sharing personal struggles is viewed as inappropriate.

During the session for older adults, there was also a lot of conversation about people not knowing that mental health services were available or where to go to access services. Some youth participants suggested that reframing the conversation from a treatment perspective to an education perspective may make it more accessible. This health education lens may help to create a culture that talks about and processes the need for mental health services in ways that shift stigma.

The events also included a discussion about the need for a wellness-focused approach that includes the whole body. Specifically, this included the acknowledgment that mental, physical, spiritual health must be in balance, which is antithetical to the typical Western approach. Participants noted that one may not get services even if they ask for them, and that the services may not be effective or helpful if they are able to obtain services. Older adults also discussed how individual or 1:1 consultation about mental health isn’t really something that one would do, especially with a therapist who

does not share the culture and experiences of trauma. There is an experience that this makes it harder to open up, may make their troubles worse, and actually keep these memories in their thoughts.

There was also a recognition of the burden on someone seeking mental health services to educate the therapist in their culture and cultural framework, and that this expectation takes away from the person getting what they need or feeling connected to the therapist. While there is no expectation that all therapists will be bilingual and bicultural, participants discussed needing and wanting a provider who has integrated their cultural understanding (i.e., mind, body, spirit) and can translate that into clinical practice while letting go of any mental health stigma that may come from the cultural framework. There was a desire from the older adult discussion to help promote or advocate for culturally competent staff or individuals who can better serve the Hmong community.

Mental Health Services Act, Community Program Planning: None of the participants were well versed in the MHSA or the CPP process, but many did express a desire to be included. There was interest in being invited and respectfully welcomed into the process. Similarly, it would be important to honor their contributions if they attended. The event facilitators noted that the groups with whom they engaged would be unlikely to attend a large group event and would be unlikely to actively participate in a mixed group with a lot of providers.

The Hmong community is a close tight-knit and private group that requires a different and slower approach to outreach and engagement and respect. The 'listening session' was facilitated by a well-known and respected Hmong provider, and there is a level of cultural brokerage and trust that needs to happen (e.g., Hmong Cultural Center of Butte County) to even start the process. It was also noted that the typical practice in the mental health community about sharing one's story as a way to reduce stigma may not be useful in this setting because of the cultural stigma around mental illness and the priority of privacy and respect.

Post Event

Since the event, HCCBC has received follow-up requests from other providers to further explore how to apply a cultural lens and implement cultural practices in their programs. A program manager from Northern Valley Catholic Social Services connected with HCCBC on how she might better be able to approach Hmong teens and how to help them feel included and that they're valuable and important. A representative of the Adverse Childhood Experiences (ACEs) intervention program requested more information on cultural approaches with families that have children with very high ACEs scores and how to better handle those cases and those families. HCCBC was also able to provide follow-up information about the types of mental health issues that occur in a household that would lead to high ACEs scores and also provided some cultural expertise about what families may be experiencing that would lead to a high ACEs score.

HCCBC had an increase of individuals and family members calling in to ask about the Zoosiab Program that supports elders. Seng Yang, the HCCBC Executive Director, is on the First 5 Commission and is also a part of the Behavioral Health Committee. Seng Yang has continued those collaborations.

Recommendations

Overall, there is a need for more culturally responsive outreach, engagement, and services to the Hmong community. Below are community-generated recommendations towards that goal.

1. The County should support and directly fund community resources that provide mental health information and mental

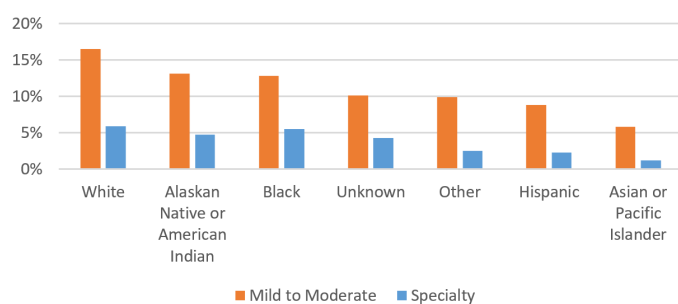
health services in language and in culturally and linguistically appropriate ways, and then route community members to these community resources rather than trying to get people into traditional mental health services. These community-based organizations tend to be more integrated and promote an increased level of trust and comfort. Also, the County should recognize the non-traditional, non-Western approaches to mental health care that are or could be provided in these locations.

2. The County should consider prioritizing group interventions, particularly for elders. Often, it's easier for Hmong elders to unite with individuals that have the same issues and experiences so that they can learn to cope together.
3. It can be hard to reach and sustain engagement with youth. Time-limited or unstable funding from the County creates additional uncertainty in community-based organizations. When funding reductions impact staff departures, Hmong youth often retreat and stop participating. To this end, the County should provide sustainable funding for Hmong youth programs.
4. The County should also better invest in how they provide information to the Hmong community. It is very difficult to read or write Hmong, and information is better presented out loud. Having information or flyers shared on social media or ethnic media with 'sound bites' so outreach materials can be listened to would likely work better.
5. The County should attempt to hire more Hmong staff that are representative of the community, train other staff in the Hmong culture so that they are able to operate with that cultural understanding, and do more outreach to recruit, hire, and train future mental health providers. This includes youth as well as community leaders who run mental health programs.
6. When providing written information to the Hmong community, it would be useful to have someone who is actually literate in Hmong language and culture do the translation so that the translation is accurate. In Hmong, there are not a lot of words that translate to mental health, so leaving in an English word in materials is confusing, when the word could be better described with an explanation or scenario.

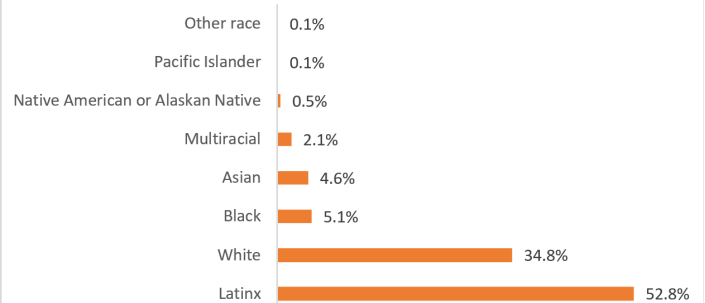
Kern County Profile

Kern County, located in the Central Valley region of California, is classified as a mid-size county with a population of 839,631. The County has a large agricultural base and is a significant producer of oil and other forms of energy. Kern is also home to Edwards Air Force Base and the China Lake Naval Air Station as well as a medium-security prison in Delano.

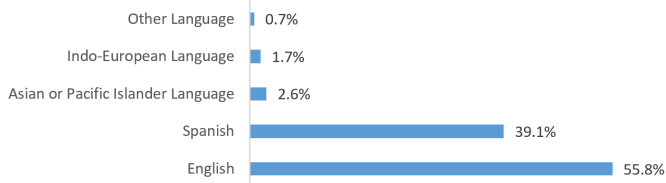
Kern County Medi-Cal Mental Health Utilization by System - FY 2019-2020



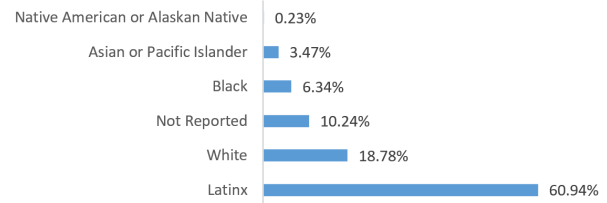
Kern County - Population by Race and Ethnicity



Kern County - Language Spoken at Home



Kern County - Medi-Cal Enrollment by Race and Ethnicity



Kern County Behavioral Health and Recovery Services (BHRS) is responsible for public mental health services in Kern County, including serving as the Specialty Mental Health Plan and administering the MHP. According to the most recent EQRO¹⁵, the following issues related to access, penetration, quality, and outcomes were noted:

- Very few urgent appointments are completed, and BHRS needs to strengthen access to urgent/crisis care as well as initial psychiatry appointments;
- No-show rates have decreased, which might be related to the increased use of telepsychiatry;
- There has been a significant increase in homelessness in the county, and BHRS should explore how to strengthen access to care for this population, including both mental health and substance use disorder services;
- Consistent with state trends, Latino and API consumers are underserved by the county, and BHRS should explore ways to increase penetration rates for these underserved communities.

According to the most recent MHP Program and Expenditure Plan¹⁶, Kern holds series of community meetings to gather feedback, including meetings focused on specific groups including consumers, family members, providers, youth, Spanish speakers, and law enforcement. In 2021, 576 people attended these meetings which were all held virtually. Kern County reports some demographic information on the attendees, but the information is incomplete due to a low response rate. The MHP 3-year plan indicates that meetings are held in English and Spanish. Information about standing committees or ongoing engagement is not clear from the BHRS website.

Kern County Listening Session: The Advocacy for American Indian Health and Equity in Kern County Conference

Statewide Partner: California Consortium for Urban Indian Health (CCUIH)

Local Partner: Bakersfield American Indian Health Project (BAIHP)

Region: Southern (Kern)

Population of Focus: American Indian & Alaska Native (AIAN)

Date: May 14, 2021

No. of Participants: 109 (98 in-person, 11 virtual)

¹⁵<https://www.caleqro.com/data/MH/Reports%20and%20Summaries/Fiscal%20Year%202020-2021%20Reports/MHP%20Reports/Kern%20MHP%20EQRO%20Final%20FY%202020-21%2002.12.21.pdf>

¹⁶https://b289acfd-f20d-4c8f-9af7-8d9fba5412e8.filesusr.com/ugd/ae18ee_427707eb59ea4efd8730fe313c452d03.pdf

Overview of Event

Bakersfield American Indian Health Project (BAIHP) partnered with the California Consortium for Urban Indian Health (CCUIH), to convene the Advocacy for American Indian Health and Equity in Kern County Conference in Bakersfield, CA on May 14, 2021. The event was planned with an in-person option to respond to the community's cultural need to hold space together and be responsive to the fact that many in their community do not have access to technology or have the digital literacy to participate in a virtual event. Due to the current COVID-19 restrictions, the conference provided a digital platform option for attendees for those who preferred to attend virtually.

The purpose of the event was to bring together community and local government and raise awareness of mental health needs and resources for the local AIAN community in and around Kern County. Specifically, the event sought to create space for the following:

- Government and nonprofit organizations could hear from the communities they serve;
- Deepen ties between community, government, and nonprofit organizations;
- Raise awareness of mental health resources available; and
- Increase comfort with the mental health conversation

The conference welcomed participants by creating a positive, respectful, and uniting atmosphere by opening with prayers from a respected elder of the AIAN community and songs from the Eagle Heart Drummers. The prayers and drum circle grounded the participants in an atmosphere of connectivity. In addition to the prayer and drum circle, the conference sought to bring the community together with both food and engaging activities like raffles in order to foster the communal experience and the set the stage for the common purpose, to contribute to the holistic health and wellness of the American Indian and Alaska Native communities.

A panel presentation followed the opening activities. Each panelist introduced themselves and gave a brief overview of their organization and their involvement with the AIAN community.

Panelist Presenters:

- California Consortium for Urban Indian Health
- Kern County Behavioral Health and Recovery Services
- National Alliance on Mental Illness
- Owens Valley Career Development Center
- Tejon Indian Tribe

During the presentation, each organization used the questions as a guide to freely discuss the services each organization provides to the public and their priority populations. In addition, panelists also shared their emerging challenges. The top three common themes were:

- COVID-19 had a negative impact on serving communities. Many services changed from in-person to telehealth. Many programs were put on hold, while others were canceled. There were also health centers that closed permanently.
- Some panelists shared that they are currently training their organizations on cultural awareness and sensitivity. The panelists are interested in creating or continuing the partnership with the AIAN community to better serve and meet their needs.
- Most expressed that state and federal funding is limited or does not provide specific funding for the AIAN community.

The afternoon portion began with a keynote address from J. Carlos Rivera, the Behavioral Health Director for the American Indian Health & Services Santa Barbara and founder of Generation Red Road. Rivera shared his personal story as being a person who suffered from trauma and mental health. He explained how receiving mental health services along with implementing his American Indian traditional beliefs saved his life. It brought him to a place of not only survival, but also granted him the capacity to thrive. As a result of his personal experience and success, he fused mental health practices and traditional beliefs to create a curriculum for his organization. He continuously shared his passion for his life, his beliefs, and the importance of bringing healing to the American Indian community.

After the keynote, the panelists returned to the stage to listen to the needs of the community and answer questions from the audience. The audience questions varied from personal, organizational to political. Also, in the audience were representatives of other local organizations who attended to share their services and express interest in becoming partners with the AIAN community.

Key Highlights

Mental Health System: Participants discussed that the County mental health system, as a whole, is not grounded in practices that are relevant to the AIAN community, even if there are specific county mental health funded services provided at the BAIHP. This includes the lack of acknowledgment of the four domains of health, including physical, mental, emotional, and spiritual. Participants noted that the county-funded mental health system should make traditional practices like drum circles and sweat lodges available in addition to talk therapy or psychiatry. If the mental health system were more responsive to American Indian and Alaska Native needs, they would implement and realize the importance of having a balanced and more holistic approach that addresses physical, mental, emotional, and spiritual needs.

Conversation Highlights:

- American Indian and Alaska Native community members pointed to disconnect between the mental health system and their culture and the need for holistic services to include the four domains of health: physical, mental, emotional, and spiritual.
- Barriers included the overreliance on non-culturally validated evidence-based practices (EBPs) and lack of acknowledgement and respect of traditional healing practices and funding support for community-defined evidence practices (CDEPs).
- The lack of culturally reflective providers and/or providers deeply immersed in understanding generational trauma and the AIAN experience who could slow down to form longstanding trusting relationships was a true area of need. Further, community members wanted embedded providers to demonstrate care and trustworthiness.

Another barrier discussed was that the overreliance on evidence-based practices (EBPs) made the system less welcoming

and effective for American Indian and Alaska Native peoples; most EBPs being implemented were not normed or validated with people who are American Indian and Alaska Native and are generally not culturally responsive. However, participants acknowledged that there are both EBPs as well as community-defined evidence practices (CDEPs) for the AIAN communities that differ from the EBPs currently being implemented by the County. There is great interest in working with the County to align their funding with these EBPs and CDEPs that are more responsive to the needs of AIAN peoples.

“We need to know how to provide the right services, at the right time, for the right people in order for us to meet the needs of the many diverse cultures within each community.”

Mental health providers should also embed themselves more in the community rather than expecting the community to come to them. Participants noted one agency representative who was “everywhere,” and that people were more willing to have the “difficult conversation” with someone who was becoming a trusted mental health ally. They also noted the importance of slowing down and allowing time for trusted relationships and a foundation for healing to build. Participants highlighted the importance of making time to bridge-build with elders to better understand the cultural components of the communities. In many ways, slowing down is antithetical to the public mental health system’s approach to time and service provision.

The discussion also included the importance of having providers that “look like you, that live like you, that understand and have the awareness and sensitivity.” While there was recognition that that was not always available, there was a desire to have providers really educate themselves in generational trauma and the experience of AIAN in order to really incorporate those cultural frameworks into their practice. Participants mentioned wanting providers to have a greater depth of understanding that moved beyond just trainings and awareness to doing their own internal work to help American Indian and Alaska Native community members feel that they could be truly supported by them.

“I need you (providers) to understand me, my cultural background and ethnicity in order for me to open up.”

There was some discussion about stigma and although there continues to be a stigma related to mental health, there was an acknowledgement that everyone is or will be affected by mental health in some way. Participants shared that using language like ‘mental health’ instead of ‘mental illness’ feels more positive and aligned to their experience. Further, the use of language that felt more empowering and like the individual had the ability to make changes in their mental health journey resonated more than deficit-based language.

Mental Health Services Act, Community Program Planning: Panelists expressed the importance of having a “voice at the table,” meaning that it is imperative that the AIAN are represented at the board meetings, community meetings, and

political organizations to represent AIAN perspectives on health and wellness – including the physical, mental, emotional, and spiritual – and share concerns so that appropriate services and funding are allocated to the AIAN communities. The discussion included not only “coming to the table” but “staying at the table.” Community members noted that transportation and technology were barriers to participating in meetings and events. They also noted that there was a need to change the vocabulary in those discussions so that it is less clinical and jargony and more accessible and culturally relevant. Land acknowledgments in government meetings were recommended to communicate a recognition that the Indigenous peoples, [past, present, and emerging] are the original stewards of the lands on which we now occupy.

Post Event

BAIHP is currently engaging in a community mental health assessment that includes feedback from this event as well as additional focus groups, town hall discussions, and interviews with community stakeholders, including community leaders, family members, consumers, and providers. The results of this assessment will be shared with Kern County Behavioral Health and inform next steps and support advocacy opportunities. BAIHP has also identified individuals that can serve as “Mental Health Champions” for the AIAN communities in Kern County. The goal is for these Champions to continue the mental health conversation and represent the AIAN voices at the county and other events.

Recommendations

1. The County should recognize the value and need for CDEPs. This act to elevate CDEPs should be supported with funding for CDEP implementation.
2. The County should work towards facilitating a change in meeting norms, including facilitating more inclusive meetings and specifically more accessible and inclusive language. This could include a land acknowledgment, a space for tribal representatives to support the ways in which the meetings are opened and using less technical or clinical jargon.
3. The County could also consider how to include youth voice in the discussion. This could include appointing a youth representative to an MHSA planning council or cultural competency committee or subcommittee or adding youth needs as a standing agenda item.
4. The County should start to recognize the intersection of mental health with the other forms of health and look for opportunities to support a more holistic approach to health and wellness, including the physical, mental, emotional, and spiritual.
5. BAIHP has healing services and would like to be able to provide or influence the larger mental health system. The County should work towards deepening the partnership with BAIHP and the AIAN communities, including being more proactive and intentional about inviting AIAN peoples into the discussion and looking for ways to increase transparency and accountability to the entirety of people that they are charged to serve.

Kern County Listening Session: Mental Health Matters

Statewide Partner: Latino Coalition for a Healthy California

Local Partner: Visión y Compromiso, Comité de Promotoras en Kern

Region: Southern (Kern)

Population of Focus: Latino and Migrant Indigenous Residents

Dates: March 30, 2021: Mental Health Matters: Kern Listening Session

April 22, 2021: Mental Health Matters: Kern Listening Session

May 6, 2021: Foro Virtual Comunitario de Salud Mental/Virtual Townhall on Mental Health

No. of Participants: 73

“La ayuda existe pero necesitamos luchar mucho para conseguirla.”

“There’s help but we need to fight to acquire it.”

-Listening Session Participant

Overview of Event

Visión y Compromiso, in partnership with Latino Coalition for a Healthy California (LCHC), facilitated two community listening sessions and one larger convening in the Spring of 2021. Both events focused on mental health in the Latino & Migrant Indigenous communities in Kern County. Due to COVID-19, all events were facilitated virtually. While both LCHC and Visión y Compromiso understood the importance of pivoting to a virtual platform, it should be noted that Visión y Compromiso expressed deep concern about community unfamiliarity with virtual events and platforms. Visión y Compromiso has a long history of hosting successful statewide and local events in person and knew that a virtual platform would pose challenges for the target audience many of whom have limited access to internet connectivity and/or knowledge of navigating online platforms.

The March and April listening sessions had a cumulative total of 21 participants who engaged in a discussion about mental health. Of these 21 participants, 11 were able to complete a demographic survey and disclosed that they are residents of Kern County. All were of Mexican nationality, with about a third additionally identifying as Mixteco. The majority were first generation, meaning they are children of immigrant parents, and most lived below the poverty line. Most participants were women between the ages of 25-54, and two-thirds stated they had full Medi-Cal coverage.

The Virtual Townhall on Mental Health (Foro Virtual de Salud Mental) took place on May 6, 2021. The event was held via Zoom with simultaneous interpretation in English and Spanish. To support access to the event, the townhall event was also broadcast on Facebook Live. Both LCHC and Visión y Compromiso shared via their Facebook pages. Of 63 registered participants, there were a total of 52 active participants on the Zoom platform and the Facebook Live broadcast reached 82 viewers. As of July 30th, the Facebook data demonstrates 1,131 people reached, 180 engagements, 22 comments, 21 shares, and 500 views.

The purpose of the event was to:

- Provide an intentional space for Promotoras and community members to inform/elevate the diverse voices around mental health in the communities we live in
- Promote the importance of mental health and wellbeing for Latino & Migrant Indigenous communities
- Increase awareness of the diversity within the Latino experience and uplift the diverse voices and needs amongst the Latino communities
- Address the stigmas that exist in the Latino & Migrant Indigenous communities when it comes to seeking mental health support
- Share mental health resources and information on navigating programs and services offered by Kern Behavioral Health and Recovery Services (BHRS)
- Build a bridge and strengthen relationships between Kern residents, CBOs, and Kern BHRS

Norma Benitez from Visión y Compromiso opened the event and welcomed all participants. Rosa Flores from LCHC contextualized the purpose of the event and explained the role of the Mental Health Services Oversight and Accountability Commission (MHSOAC) with this project. Nataly Santamaría, Promotora Network Manager with and Mary Urbano, Promotora volunteer, both from Visión y Compromiso of Kern, welcomed Kern residents and participants, as well as emphasized the theme of mental health. Jose Betancourt, the Mental Health Advocacy Manager from Visión y Compromiso, gave a talk about ¿Qué es la Salud Mental? (Mental Health 101). Olivia Trujillo, the Mayor of Arvin gave a keynote address. Afterwards, Gladys Flores from Centro Unidad Popular Benito Juarez explained the barriers of mental health stigma and services that Indigenous communities in Kern face. There was then a discussion about the impact of COVID-19 on Latino families co-led by Gladys Flores from Unidad Popular Benito Juarez, Olivia Trujillo, and Mary Urbano, Kern Committee Coordinator, from Visión y Compromiso. There was a panel of local agencies, including Kern County Behavioral Health and Recovery Services (BHRS), who engaged in a discussion about accessing local resources. The presentation also included content around how the Latino community experiences disparities when trying to access mental health services, including lack of insurance and language barriers and are deterred from seeking services because of cultural perspectives around privacy. Presenters educated community members around confidentiality, reducing stigma in the community, and how to advocate for care.

Key Highlights

Mental Health System: Throughout the discussions, there was an acknowledgement that the mental health system is difficult to access and that one can't get help unless it's an emergency, and even then, participants experienced barriers to obtain emergency services. In terms of logistics, participants expressed that obtaining approval from their Primary Care Provider (PCP) for mental health services proved to be a barrier, as many have to wait months for an appointment and need immediate help. There was also discussion that the mental health system doesn't respect the people who come in for services, doesn't listen to their needs, and doesn't consider their wishes. Other participants noted that services may exclude the family, but that the family is affected and needs help as well. Overall, participants suggested that because the system is inaccessible and that folks were met with unhelpful and/or dismissive responses, that they felt that it was a waste of time. This is despite the real mental health needs that community members had, including concerns about suicide and the impact of the social stigma that community members experienced related to sexual orientation and gender/gender identity.

Conversation Highlights:

- Barriers to connecting with mental health care included experiencing a discriminatory and unresponsive system, long waits for appointments, and exclusion of family members in care.
- The lack of bicultural and language proficient providers for Spanish speakers and Indigenous languages and the erasure of Migrant Indigenous residents was a noted challenge to feeling cared about and receiving culturally responsive care. Stakeholders also highlighted the need for culturally translated educational materials on mental health to combat stigma.
- Community members in historically underserved regions faced provider proximity barriers, further exacerbated by the lack of investment in telehealth and satellite services.

“They went for an hour and they didn’t understand, and they weren’t understood.”

-Listening Session Participant

One of the themes that emerged was related to provider proximity and availability. Specifically, participants discussed that it would be helpful to have dedicated providers placed in different regions throughout the County so that more clients could be seen on an ongoing basis for improved continuity of care.

Partner organizations suggested increasing the number of bilingual staff on the Outreach and Engagement (O & E) Team and requested that the O&E Team ensure that they are conducting in-person outreach whenever and wherever possible and to pay particular attention to outreaching to historically underserved regions and limited English proficiency (LEP) populations. This includes not only Spanish-speaking individuals but also those that speak an Indigenous language, who are assumed to speak Spanish or are otherwise ignored. This is a group that should not be ignored or erased within this discussion. There was also discussion about the language of mental health and that it doesn’t always translate into Spanish or the Indigenous languages. Some participants suggested creating accessible community educational information/campaigns/trainings to help normalize getting help and interrupt mental health stigma.

Participants also requested that there be more County-led mental health promotion events in historically underserved regions and that they expand their digital outreach with TV/Radio and ethnic media outlets. Partner organizations also suggested increasing the required training hours for cultural competency. Visión y Compromiso has since engaged in a discussion with Kern County BHRS about the integration of Promotoras to further support the language access and cultural competency measures.

“People have sought services at [the clinic] but the way they treated them was very curt; the person [patient] talks to the counselor but they [patients] are left unsatisfied. The people I know who sought help there [for mental health services] felt it was a waste of time.”

-Listening Session Participant

Participants and partner organizations have requested that there be permanent financial investments in telehealth and satellite services in order to increase coverage throughout the County while minimizing the burden on those seeking service. While the community prefers in-person visits and there is concern that they don't get the same quality of care when not in person, there is also recognition that telehealth provides an opportunity to expand the network of providers and services for the Latino communities, specifically in outlying areas of the County. They also suggested that the County should partner with other public organizations, such as libraries, that are trusted by the community in order to develop fixed telehealth stations, such as a kiosk that is reliable where someone could go if technology were a barrier to participating in telehealth appointments.

“They have to effectively demonstrate that they’re concerned for the people seeking services and that they want to help people achieve wellbeing.”

-Listening Session Participant

Mental Health Services Act, Community Program Planning (CPP): In terms of the CPP process and participation, there was no knowledge of the CPP process, and there has been minimal participation in it. Visión y Compromiso and LCHC asked for information about the CPP committee and meetings and has offered to work collectively with BHRS to ensure that more limited English proficiency (LEP) and working-class families can engage in the CPP process. Participants stated that they want the County to be more receptive to the community. However, participants noted that they wanted a change in action, not just in planning.

Post Event

Since the event, Visión y Compromiso and LCHC met with Kern County BHRS to review their findings from the events. Kern BHRS staff have been extremely receptive to collaborating with Visión y Compromiso and LCHC and have admitted there is an opportunity to engage with residents and CBOs more meaningfully. As a result, Nataly Santamaria and Norma Benitez from Visión y Compromiso are now on the Latino Subcommittee of the Cultural Competency Resource Committee (CCRC). Both are helping co-plan an event for Latino Heritage month in September focused on substance abuse and suicide prevention in the Latino community. Nataly Santamaria will support by being one of the panelists. It is worth noting that this blossoming relationship between Visión y Compromiso and Kern BHRS is a step in the right direction for repairing the longstanding history of mistrust and skepticism between the Spanish-speaking community and the mental health department.

Recommendations

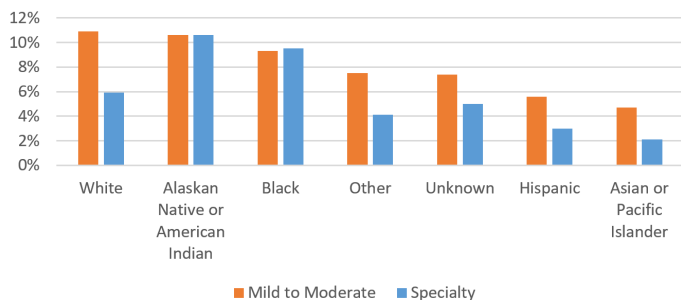
1. Kern BHRS should work towards more accessible meetings. This includes better publicizing of MHSA meetings to ensure that they are truly public meetings. Meetings should be announced through diverse outlets, and community members should be invited and encouraged to attend. MHSA meetings should have interpretation available for Spanish-speaking participants to promote accessibility for all, and they should not be solely held in the middle of the day, to include working-class community members. BHRS should also consider providing incentives and childcare so that community members can participate.
2. Kern BHRS may wish to invest in restructuring the MHSA and Cultural Competency Committee meetings to normalize community participation and promote more substantive discussion and consideration of the issues at hand. They should consider developing an MHSA 101 training for new stakeholders so that they can meaningfully participate in the process. Many counties offer this type of orientation in the 30 minutes prior to an MHSA meeting.

3. Kern BHRS may wish to more intentionally include *Visión y Compromiso* and other community-based organizations in the process, especially those that are representative of unserved, underserved, and inappropriately served communities.
4. Having a dedicated outreach staff with cultural competence training may help enhance all the preceding recommendations.
5. Finally, there is a desire to promote accountability and re-align the County's MHSA efforts with the original spirit and intention of the Act, which was to leverage community participation in order to design, plan, implement, and evaluate efforts that transform mental health services into a wellness and resiliency focused, consumer and family driven, culturally responsive, integrated mental health system of care.

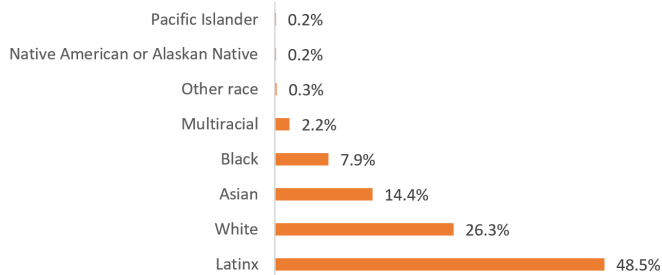
Los Angeles County Profile

Los Angeles County is the largest county in California and the nation with a population of 10,000,000. LA County is home to more than one-quarter of California residents, is one of the most diverse counties in the nation, and includes approximately forty percent of California's safety net population (i.e. Medi-Cal, foster care, etc).

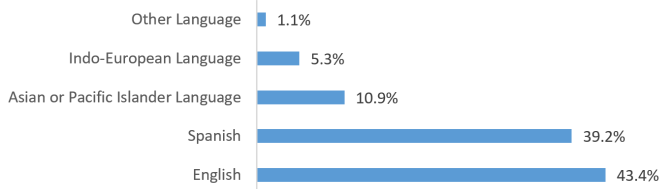
Los Angeles County Medi-Cal Mental Health Utilization by System - FY 2019-2020



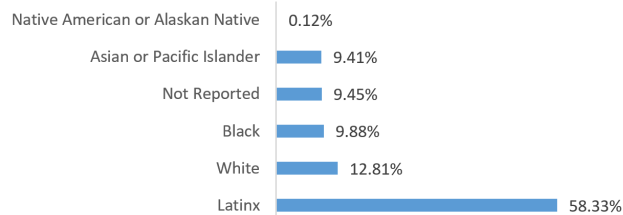
Los Angeles County - Population by Race and Ethnicity



Los Angeles County - Language Spoken at Home



Los Angeles County - Medi-Cal Enrollment by Race and Ethnicity



Los Angeles County Department of Mental Health (DMH) is responsible for public mental health services in the County, including serving as the Specialty Mental Health Plan and administering the MHSA. According to the most recent EQRO , the following issues related to access, penetration, quality, and outcomes were noted:

- Consistent with statewide trends, Latino and API consumers are underserved by LA DMH. The penetration rate for the Latino community has improved slightly from 2017-2019 and continues to be above the state average.
- Stakeholders have requested that the department implement more support groups specifically for TAY, consumers, and family members to strengthen connections and support networks. Stakeholders have also requested better access to group therapy particularly to counter the isolation effects of the pandemic.
- Timeliness of services – urgent, non-urgent, and in-language – continues to be an area of focus, although some improvement has been seen.
- Nearly one in three adults who are discharged from psychiatric hospital services are readmitted. This rate is alarming and points to a need for much better coordination of outpatient services.

According to the most recent MHSA Program and Expenditure Plan, LA County has established Underserved Cultural Communities (UsCC) subcommittees which meet to advise the department and address the needs of specific populations. These include: Access for All (Deaf, Hard of Hearing, Blind, and Physical Disabilities), American Indian/Alaskan Native, Asian Pacific Islander, Black and African Heritage, Eastern European/Middle Eastern, Latino, and Lesbian, Gay, Bisexual, Transgender, Queer, Questioning, Intersex, Asexual, Two-Spirit (LGBTQIA2-S). Due to its size, LA County also has 8 Service Area Leadership Teams (SALT), composed of consumers, providers, and community members, which provide the department with information and recommendations related to the services and needs in their region. LA County combines leaders from the UsCC and the SALT into the Community Leadership Team (CLT). The CLT synthesizes and prioritizes stakeholder recommendations. This informs the 3-year plan. The Cultural Competency Committee meets monthly, also to advise the department and increase cultural awareness, sensitivity, and responsiveness.

Los Angeles County Listening Session: Mental Health Matters: Culture as a Social Determinant

Statewide Partner: California Pan-Ethnic Health Network (CPEHN)

Local Partner: California Black Women's Health Project (CABWHP)

Region: Los Angeles

Population of Focus: Multi-cultural

Dates:

October 29, 2020: Kickoff Convening

May 6, 2021: Community Listening Session

October No. of Participants: 60 May No. of Participants: 80

¹⁷<https://www.caleqro.com/data/MH/Reports%20and%20Summaries/Fiscal%20Year%202020-2021%20Reports/MHP%20Reports/Los%20Angeles%20MHP%20EQRO%20Final%20FY20-21%2012.29.20.pdf>

¹⁸http://file.lacounty.gov/SDSInter/dmh/1109575_LACDMH_3YrPlan_Final2021-24.pdf

Overview of Event: The California Black Women’s Health Project (CABWHP), in partnership with the California Pan-Ethnic Health Network (CPEHN), hosted a kick-off event and a restorative community listening session focused on Culture as a Social Determinant of Mental Health for the multi-cultural communities in Los Angeles County. All events were facilitated virtually.

To demonstrate the theme of culture as a social determinant of mental health, CABWHP used a healing-centered framework to create a set of events that both invited community dialogue and insight, while infusing inclusive cultural healing practices of breathwork, connection to ancestry, and music. Events were designed to be multi-cultural with outreach and representation across the diversity of LA County, including to Black, American Indian, Latino, Indigenous, Korean American, Cambodian, and other Southeast Asian and Asian/Pacific Islander groups. There was a deep acknowledgment of the diversity across and within each of these communities, which only served to add richness to the conversation and strengthen cross-cultural ties. Participants included consumers, families, providers, community leaders, and other interested stakeholders.

The purpose of the kickoff event was to: 1) Bring awareness of the challenges and issues facing diverse racial and ethnic communities through advocacy, outreach, and engagement at the local level; and 2) Discuss/explore the possibility that LACDMH is working to increase services and access to the services that are needed in our diverse racial and ethnic communities. As attendees entered the virtual event they were greeted by music. Sonya Aadam Young, CEO of CABWHP, opened the kickoff event with an invitation to breathe deeply, connect with the body, and unite with one another around the topic of mental health. The kickoff event included a Land Acknowledgement and reflection of the impact of settler colonialism; an orientation to the MHSA; a Q&A session with Theion Perkins from the Los Angeles County Department of Mental Health (LACDMH); a discussion on local advocacy opportunities with the Underserved Cultural Communities (UsCC) subcommittees with Sylvia Gonzalez-Youngblood from the American Indian/Alaska Native UsCC; a presentation from Dr. Luis Guzman from the Asian Pacific Islander and Latino UsCC; and a keynote address from Dr. Jamila Young about the impact of culture on mental health. The spirit of uplifting cultural practices for healing was exemplified by the performance of the Wildhorse Singers Native American drumming and singing group.

“My anxiety sits on my shoulder while I write/ And instead of shrugging her off/ I learn to ask her what she wants to say/ Most days she wants to be written free/ To dissolve into bliss.”

– Danyeli Rodriguez Del Orbe

The purpose of the Community Listening Session was to: 1) Bring awareness of the challenges and issues facing the diverse racial and ethnic communities through advocacy, training and education, and outreach and engagement at the local levels; and 2) Give community members a platform to discuss their personal, unique experiences accessing mental health services in LA County’s diverse racial and ethnic communities. The event was planned to bring together multiple cultures, and the organizers ensured that all were represented in the promotional materials. They also offered small incentives to trusted community members to support their community’s ability to attend. For group cohesion and cross-cultural community building, the entirety of the event was held as a large group, which required time and patience, but was important for everyone to be heard and hear everyone else. The event itself was designed to have a communal vibe that would welcome many different choices and deeply integrate culture and the ways in which Black and other marginalized cultures experience mental health challenges and pursue mental health wellness. The event was infused with cultural healing experiences and included guided meditation by Brenda Azul (Mexican American healer), spoken word from poet Danyeli Rodriguez Del Orbe (Afro-Dominican), and a musical selection from Daniel Richardson, an award-winning African American composer and musician. Each of the performers were intentionally selected to contribute to this cross-cultural collective space.

Key Highlights

Mental Health System: One of the themes that emerged from the discussion was the importance of finding a therapist who “looks like you” and understands your culture and language. However, participants also noted that providers of color are often overwhelmed because there aren’t enough multilingual, multicultural providers available. Further, BIPOC providers are also at higher risk of vicarious trauma given the high rates of severe and chronic trauma as a result of being marginalized due to their race or ethnicity. People also discussed that culturally specific organizations are routinely underfunded, which only makes things harder. As a result, these same organizations rely heavily upon interns who are still in training to provide clinical services; many of these internships are 1- or 2-year placements, which makes it challenging to establish a long-term healing relationship and exposes individuals to therapist turnover and having to re-establish therapeutic relationships again and again.

Conversation Highlights:

- Even when multicultural communities found culturally reflective providers, they experienced racism and discrimination by front office staff or other gatekeepers.
- Culturally specific organizations receive less funding and overly rely on clinical interns who have less experience and turnover quickly, making it difficult to build trust.
- Barriers due to navigating a complex and confusing system, lack of language proficiency, unattractive and unwelcoming physical environments, and lack of understanding cultural perspectives on healing make it difficult to engage in mental health support.

They also noted that the physical spaces available within these underrepresented communities are often bleak, dingy, in disrepair, and not warm or welcoming and noticeably different than other clinics and healing spaces in more affluent communities.

“I was trying to find a new psychiatrist, and I wanted a woman of color. Well, the only one I could find, I couldn’t believe how her front office was treating me as a new patient coming in. First time, you’re late so you have to come back. Second time, you don’t have the paperwork so you can’t have the appointment today. You have to come back. But they never sent me the paperwork. The third attempt, they said you’re late, and I said you told me a certain amount of time that you could be late, and you changed the time. And then they said, if you don’t make this next appointment, we are not giving you another appointment, ever. I was frustrated and feeling low emotionally, and my tone of voice changed. When I was told I couldn’t have the appointment, I was labeled ‘the angry Black woman’.”

Some participants shared that even when they can find a provider who is a cultural match, that the “gatekeepers” may not be culturally responsive. There were stories of experiencing micro-aggressions in the front office as well as the insurmountable hurdles faced to even obtain that first appointment. Community members spoke about the significance that these initial interactions have on their trust and comfort level and how often they go wrong. One social services provider mentioned that she had been working with someone for quite some time, and that this woman had finally agreed to seek mental health services. However, the mental health provider wouldn’t let this trusted ally serve as the interpreter

despite the client's request. Whether or not there was a reason for this, it did not serve to build a trusted relationship with the client or between organizations. Similarly, participants noted that providers refused to engage with family members, which for some seeking services, chosen family member involvement is a key component in their mental health recovery. Other participants shared that finding mental health providers that speak their language and are culturally responsive is extremely difficult.

“[Communities] need somebody that speaks the language as well as [understands] the cultural norms.”

People also discussed how complicated the system is and that it is so hard to navigate, not only for people seeking services but also for providers, especially if those providers are new to the system or in an internship. They also discussed that the language used by therapists and psychiatrists is overly technical and difficult to understand.

Towards the end of the discussion, one participant mentioned that the consequences of mental health stigma, inaccessible services, and culturally inappropriate services have dire consequences for our communities, including suicide, incarceration, abuse, among others. In her closing keynote, Dr. Jamila Young talked about how people of color have traditions that include speaking with their ancestors, and how the mental health system, without an appropriate cultural framework, may diagnose this as a psychiatric symptom, when in reality, it is a cultural experience that should be viewed from within a cultural framework, not a diagnostic lens. Because anti-blackness and racism is institutionalized, this is an example of how the system weaponizes culture in order to diagnose people of color with a serious mental illness that is totally inappropriate from a cultural perspective. This point appeared to resonate across all participants.

Specific suggestions that emerged from the discussion around increased cultural responsiveness included using more healing groups or safe spaces, incorporating the whole person (i.e., mind, body, and spirit), using trusted messengers and incorporating more storytelling. One person suggested that the system focus more on the “gentler, more relational relationship side of it.”

Mental Health Services Act, Community Program Planning: There was a diversity of experience with the CPP process amongst participants, and an acknowledgment that LACDMH has a bifurcated system whereby the “treatment system” and the cultural specific groups are separate, which makes organizing more difficult.

Participants wanted to bring more and different voices to the table and needed more community-friendly outreach to refresh the CPP stakeholder groups. However, community members expressed a sense of discouragement that if and when people go to a town hall and provide feedback, it wouldn't be incorporated into the plan. Also, there was feedback that the CPP process moves so quickly and with minimal transparency into how decisions are made that it's challenging to participate, especially for someone who's new to the process. Some reflected that the County does not provide information about concrete results or outcomes of the programs they fund through the CPP process which makes it harder for stakeholders to participate.

Post Event

Following the event, CPEHN and the CABWHP developed and disseminated the Mental Health Toolkit. The toolkit intends to increase awareness of the challenges and issues facing diverse racial and ethnic communities through advocacy, training and education, and outreach and engagement in LA County. The toolkit contains 1) Demographics of LA County, 2) Mental Health Disparities in LA County, 3) The MHSA: How You can Get Involved, 4) Community Program Planning: Your Opportunity to Make Your Voice Heard, 5) Key Contacts for Continued Advocacy Efforts, and 6) Local Mental Health Resources.

Recommendations

1. The LACDMH website is confusing and hard to navigate; it appears bureaucratic and not intended for the community to use. LACDMH could invest in making their website more inclusive (e.g., gender identities) more easily accessible, and easier to navigate.
2. When someone calls the LACDMH Helpline, a 1-800 number, there should be an option for someone to select the language of the voice prompts so that they can listen in their own language.
3. LACDMH should engage in more intentional collaboration with the communities it serves, including inviting more diverse communities to MHSA and other committee meetings, providing training to newer stakeholders to support their participation, and openly considering community feedback when making decisions.
4. LACDMH should invest in culturally specific organizations and stop the practice of underfunding. In order to accomplish this, they should also make the application and contracting process more accessible and consider what technical assistance and payment schedules might be needed to better support these organizations.

Appendix I: 2021 Legislative and Policy Agenda

As this pandemic demonstrates, California's communities of color continue to bear the brunt of the health, economic, and mental toll of the virus. With the advent of a new federal administration, we have the opportunity to once again lead the way in expanding mental health access and quality so that all may live and thrive in our diverse state. Below is a summary of the policy and budget priorities from this last year that will have an impact on the mental health of communities of color. 2021 saw some critical investments in behavioral health equity, though more must still be done to ensure quality implementation, access, and the reduction of disparities in BIPOC communities across the lifespan.

Budget Proposals

Behavioral Health Children and Youth Initiative: One-time \$4 billion investment towards a new behavioral health initiative that will support behavioral health services for children and young adults. This will support broader access to services for many youth of color. Importantly, as a compliment to evidence-based practices, California will provide grants to qualified entities for scaling up both evidence-based and community-defined practices. Enacted via the 2021 Final State Budget in SB/AB 133 (Committee on Budget), as proposed by the Governor and State Legislature, with modifications.

Health Plan Quality and Equity Performance Reviews: Establishment and enforcement of health equity and quality standards for all DMHC licensed full-Requires DMHC to convene a Health Equity and Quality Committee comprised of diverse individuals and entities to establish standard measures and annual benchmarks for equity and quality. Clarifies 5-year regulatory timeline. Requires DMHC to consider evolving equity measurements such as surveys assess consumer experience and satisfaction that take into account cultural competence, health literacy, exposure to discrimination, and social and cultural connectedness such as connection to community identity, traditions, and spirituality. Enacted via the 2021 Final State Budget in SB/AB 133 (Committee on Budget), as proposed by the Governor and State Legislature, with modifications.

California Reducing Disparities Project: One-time \$63 million investment to continue the success of the California Reducing Disparities Project which seeks to reduce disparities in mental health in BIPOC communities. Research from the Office of Health Equity and the California Reducing Disparities Project suggests community-defined evidence practices improve the behavioral health of children and youth from Black, Indigenous, People of Color (BIPOC) and Lesbian, Gay, Bisexual, Transgender, Queer and Plus (LGBTQ+) communities as opposed to traditionally funded services. Enacted via the 2021 Final State Budget in AB 129 (Ting) and SB 129 (Skinner), as adopted by the State Legislature.

988 Suicide Prevention Hotline: On September 2, the Department of Health Care Services announced the use of \$20M to help establish and support the 9-8-8 suicide and mental health crisis hotline. Inspired from AB 988 (Bauer-Kahan), the proposal implements the national 988 system in California so that community members experiencing a mental health crisis are able to call and receive life-saving care. Call centers will be able to deploy crisis services – such as mobile crisis teams and crisis stabilization services for all individuals. Enacted via the 2021 Final State Budget in AB 129 (Ting) and SB 129 (Skinner), as adopted by the Governor and State Legislature, with modifications.

Policy Proposals

SB 316 (Eggman): Medi-Cal: Federally Qualified Health Centers and Rural Health Clinics. SB 316 would allow health centers to be reimbursed for 2 visits if an individual needs behavioral and physical health services in the same 24 hour period. Currently, Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs) may bill for a behavioral health visit or a physical health visit in a 24 hour period, but will not be reimbursed for both. This means that patients with

a medically necessary behavioral health condition must wait 24 hours before they can be seen for a visit if they already obtained a physical health visit on that same day. This restriction creates significant access barriers because patients don't always have the time, transportation or opportunity to leave work again for a second visit with a behaviorist. We also know that patients, especially those who are Black, Indigenous or people of color are battling cultural norms and stigma that leads some to believe that behavioral health visits are less important and not needed, making it unlikely that the patient will return for their behavioral health visit. This proposal is now a two-year bill meaning that the State Legislature can resume moving SB 316 through the legislative process beginning in 2022.

AB 118 (Kamalger): Emergency Services: Community Response: Grant Program. The C.R.I.S.E.S. Act pilot grant program will provide stability, safety, and culturally informed and appropriate responses to immediate emergency situations such as a mental health crisis, people experiencing homelessness, intimate partner violence, and natural disasters. These organizations will also aid in the follow-up to those emergencies by involving community organizations with a deeper knowledge and training in responding to those situations. This proposal was voted out of the State Legislature on September 8, 2021 and is now pending a signature from the Governor.

AB 638 (Quirk-Silva) Existing law, the Mental Health Services Act (MHSA), an initiative measure enacted by Proposition 63 in 2004, establishes the continuously appropriated Mental Health Services Fund to fund various county mental health programs. The MHSA also requires counties to establish a program designed to prevent mental illnesses from becoming severe and disabling; designates funds for prevention and early intervention to broaden the provision of those community-based mental health services. Referred to Assembly Concurrence in preparation for a Floor Vote on July 15, 2021.

SB 682 (Rubio): Childhood Chronic Health Condition and Health Disparities: SB 682 will require the California Health and Human Services Agency to establish and submit a plan to the Legislature and the public that outlines the steps the state will take to eliminate racial disparities by the year 2030, in chronic conditions affecting children – which includes youth depression. Referred to Assembly Appropriations Committee on July 13, 2021.

AB 937 (Carrillo): VISION Act: AB 937, the Voiding Inequality and Seeking Inclusion for Our Immigrant Neighbors (VISION) Act, would protect refugee and immigrant community members who have already been deemed eligible for release from being funneled by local jails and our state prison system to immigration detention. Prohibiting transfers to ICE would protect Californians from being subjected to inhumane and unsanitary conditions in immigration detention, close the main pipeline filling immigration detention beds, and reunite refugee and immigrant families and communities. Additionally, AB 937 ensures local and state entities do not use immigration status as a reason for denying participation in a diversion, rehabilitation, or mental health program. This preserves access to mental health care services for formerly incarcerated undocumented individuals during and/or following completion of their sentence. This proposal is now a two-year bill meaning that the State Legislature can resume moving AB 937 through the legislative process beginning in 2022.”

SB 221 (Wiener): Health Care Coverage: Timely Access to Care: SB 221 will establish clear timely access standards for health plans who operate under Department of Managed Health Care (DMHC) and health insurers who fall under the jurisdiction of the California Department of Insurance (CDI), requiring them to provide follow-up appointments and other forms of care within ten business days, unless a provider believes a longer gap is appropriate. SB 221 can help BIPOC patients retain mental health services at a frequency that is therapeutic and not disruptive. This proposal was voted out of the State Legislature on September 9, 2021, and is now pending a signature from the Governor.

SB 293 (Limon): Medi-Cal Specialty Mental Health Needs: SB 293 will standardize and streamline the documentation process for an EPSDT evaluation. Standardizing and streamlining the documentation process for an EPSDT evaluation would save time during a visit for a patient and provider. Often, time loss is a factor that has physicians reconsidering doing an EPSDT evaluation because there are so many other things to screen and address. This proposal is now a two-year bill meaning that the State Legislature can resume moving SB 293 through the legislative process beginning in 2022.

Medi-Cal Policy Changes

California has a number of proposals to innovate in behavioral health, including through the California Advancing and Innovating Medi-Cal (CalAIM) initiative, which could have important implications for improving access to care and reducing disparities in BIPOC communities (who make up the majority of Medi-Cal consumers). If these proposals are to be successful, they must include specific language regarding the need to address racial, ethnic, linguistic behavioral health disparities.

Behavioral Health Payment Reform: DHCS is proposing to reform behavioral health payment methodologies for counties. Under the current CPE methodology, counties are not able to retain revenue when implementing cost-reduction efforts, thereby limiting the ability to fully invest in the delivery system to improve access and quality. These reforms will allow not only for more timely review and final payment, but will enable the county behavioral health system, for the first time, to participate in and design true outcomes and value-based reimbursement structures that reward better overall results and quality of life for Medi-Cal beneficiaries, who are primary from communities of color.

Changes to Medical Necessity: In CalAIM, DHCS proposes to update and clarify medical necessity criteria for specialty mental health services for both adults and children, including allowing reimbursement of treatment before diagnosis and clarifying that treatment in the presence of a co-occurring SUD is appropriate and reimbursable when medical necessity is met.

A No Wrong Door Approach: DHCS proposes to implement a “no wrong door” policy to ensure beneficiaries receive medically necessary treatment regardless of the delivery system where they seek care. This policy would allow beneficiaries who directly access a treatment provider to receive an assessment and mental health services, and to have that provider reimbursed for those services, even if the beneficiary is ultimately transferred to the other delivery system due to their level of impairment and mental health needs.

Expansion of Peers Legislation passed last year (SB 805) directed DHCS to allow counties to certify peer support specialists and pay for their services for individuals receiving specialty mental health or SUD services. Peer support is an important component of mental health and substance use disorder services.

Expansion of Community Health Workers. California recently added community health workers as a class of health workers who are able to provide benefits and services to Medi-Cal beneficiaries, effective January 2022.

Proposal (though not yet approved) to reimburse for traditional healers. These changes are requested to ensure American Indians and Alaska Natives have access to culturally appropriate and evidence-based substance use disorder treatment. It is pending approval with the federal Centers for Medicare and Medicaid Services, but could serve as a model for integration of CDEPs.