



SEPTEMBER 2022

**A RIGHT TO HEAL:  
MENTAL HEALTH IN  
DIVERSE COMMUNITIES**



## Introduction

Across California, Black, Indigenous, and People of Color (BIPOC) gathered together once again to share their perspectives on the communities' mental health needs. This report documents the collective stories, experiences, struggles, and resiliencies that emerged from those discussions with the intention of 1) honoring the voices of those who participated, 2) providing information that can be used by BIPOC communities to advocate and advance the mission to strengthen community mental health, and 3) educating local and state policy makers about BIPOC communities' mental health needs, as well as how to better improve the mental health resources available.

This report documents experiences and impacts of historical and institutional oppression and the associated trauma that are interwoven with BIPOC communities' mental health needs. Much of the information is not new; however, this report centers the voices of California's diverse racial and ethnic communities and provides a glimpse inside how BIPOC communities are leveraging the strength and power from within to take care of their mental health. This report comes at a pivotal moment of a continuing pandemic that disproportionately harmed BIPOC communities combined with protests organizing around ending racialized violence. With this sociopolitical

**“I’m so tired of being tired when will my people get to rest?”**

**Got a huge knot in my throat and on my chest**

**All these killings got me feeling an emotional distress**

**How can I even try to decompress, during unprecedented times of civil unrest. . .**

**My hope is to teach my daughters to be resilient like templos in Teotihuacan**

**Colorful and vibrant like murals on Soto and Chavez...”**

**– Sammy Carrera, ‘Tired’**

backdrop and years of investing in stigma and discrimination reduction within California's BIPOC communities, community members demonstrated a willingness and tenacity to raise their voices about mental health issues, needs, and experiences.

## Invitation to the Reader

Dear readers, co-conspirators, and future allies:

The following content may inspire a variety of reactions and feelings. As you bear witness to these BIPOC community experiences, we invite you, with all of the intersecting identities you bring, to listen and observe your own reactions. The contributors to this report invite you to pause before drawing any conclusions or developing alternate or countering perspectives. Each of us has a deeply complex relationship to racism, and understanding how racism intersects with our personal, interpersonal, and community experiences is a life-long process. This is an invitation to center the issues raised and allow yourself to become curious and consider ways to stand with, empower, and support BIPOC communities' right to strengthen their own mental health and that of their communities. We thank you for your time and attention.



As you read this story of Black, Indigenous, and People of Color’s mental health needs, I acknowledge I am writing to you on the traditional, ancestral, and unceded land of the Chumash and Tongva people, past, present, and future.

I also acknowledge federal, state, and local policies have created significant disparities in mental health for Native Americans – from outlawing traditional and cultural practices to removal from homelands. Today, while American Indians and Alaska Natives are eligible to receive health care services on or near Indian reservations and in urban Indian communities from the Indian Health Service (IHS), California’s delivery system remains deeply fragmented and IHS chronically underfunded.

However, American Indians and Alaska Natives communities have for generations achieved resilience and good health because of their connection to traditional knowledge and medicine. These practices are a fundamental element of Native mental health care that help people achieve wellness and healing and restore emotional balance and one’s relationship with the environment. The approaches are aligned with how Native communities conceptualize culture, which often differs greatly from the Western perspective. For these communities, culture includes the intergenerational transmission of historical and traditional knowledge, positive identity development for youth, strengthening social ties within families, and essentially a cognitive map of how to be a person.

As a non-Native person and settler in this land, I would like to acknowledge what I have learned from leaders in the field of Native mental health including but not limited to Virginia Hendrick, Angel Galvez, Terry Supahan, Montana Weekes, and Paul Massoti.

Please take a moment to reflect on what you can learn about the Native American and American Indian communities’ ability to achieve resilience.

*Carolina Valle, California Pan-Ethnic Health Network*

## CPEHN Founding Partners Overview

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, we are 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 Black, African American, Asian American Pacific Islander, Latino/a/x, and American Indian communities came together in service of their collective vision to create CPEHN, including:



CPEHN and our partner organizations are statewide organizations that 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 our organizing efforts, we strive to gather and deepen 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 elevate their voices more broadly at the state level.

## Project Overview

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. CPEHN’s stated intentions were to 1) equip local advocates and communities to participate in and influence decision-making within the public mental health system 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. Overtime, this project has evolved beyond the initial MHSOAC scope and even what CPEHN and partners envisioned, which was supporting community stakeholders to engage in public mental health system to communicate their mental health needs and preferred solutions and resources. Now, project participants have communicated a vision in which this project transcends attending local meetings and becomes a part of a larger advocacy effort in which BIPOC communities are able to co-create the overall mental health vision and agenda in partnership with the public mental health system and promote a more equitable allocation of services and resources across the continuum using a variety of strategies and approaches, including culturally responsive service delivery.

## Project Methodology

Since our inception, CPEHN’s approach to statewide community engagement is to raise the voices of multiple BIPOC communities by bringing together statewide partners with local partners to enhance 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 to discuss mental health needs from a system perspective. To ensure that we are capturing the regional diversity within the experiences of our BIPOC communities, our statewide partners work with different local partners over time. Each year, CPEHN and each of the four statewide organizations partners with a local organization to plan and host a listening session(s) and/or community event with their respective communities. These sessions took many forms from a series of shorter focus groups to multi-day conferences or educational seminars. Engagement was virtual, in-person, with some videos available afterwards.

**Year 1: 2020- 2021** Last year, statewide partners worked with local organizations across the state to gather 689 community members at in-person and virtual listening sessions in Alameda, Kern, Butte, and Los Angeles counties. The listening sessions/events provided an opportunity to explore how BIPOC communities express their cultural perceptions of mental health and hear about their experiences with the mental health systems.

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

**Year 2: 2021-2022** Across the state, statewide partners worked with local organizations to gather 447 community members at in-person and virtual listening sessions in Del Norte, Humboldt, Orange, Sacramento, San Bernardino, and San Diego counties. The listening sessions/events provided an opportunity for BIPOC communities to discuss issues relevant to their communities' mental health needs and share their perspectives on strengthening mental health service delivery, system partnerships, outreach and engagement, and more.

Statewide Partner	Local Partner	Population of Focus	Location	Event	Total Participants
<b>California Black Health Network</b>	ONTRACK Program Resources	Black/African American/African-Ancestry	Sacramento	Mental Health & Criminal 'Justice' Real Talk & Black Community's Voice Lifted Up	177
<b>California Consortium for Urban Indian Health</b>	True North	American Indian	Del Norte/Humboldt	Mental Health in Del Norte and Humboldt County: Town Hall	98

<b>Latino Coalition for a Healthy California</b>	Vista Community Clinics	Latino and Migrant Indigenous Residents	San Diego	Virtual Community Discussion: Emotional Well Being & Mental Health	32
<b>Southeast Asia Resource Action Center</b>	The Cambodian Family	Southeast Asian	Orange	Community Dialogue on Mental Health and Wellness Forum	90
<b>California Pan Ethnic Health Network</b>	California Black Women's Health Project	Multi-cultural	San Bernardino	Culture, Covid-19, & Community: Mental Health Matters	47

**African American/Black:** ONTRACK Program Resources convened a two day “Real Talk” event in Sacramento focused on the intersection of Black Mental Health and the Criminal Justice System conducted in “Call and Response” ([www.getontrack.org/realtalk](http://www.getontrack.org/realtalk)). The first day focused on lifting up voices from the Sacramento Black community on their experiences specifically involving behavioral health and the criminal “justice” system (“The Call”). This session included a panel presentation of Black community members with lived experience, breakout sessions, large group sharing, and questions & answers. The second day highlighted new Sacramento County and City behavioral health and criminal “justice” related initiatives (“The Response”) to ensure that the Black community is aware of these local initiatives and the opportunities to have meaningful input and roles so that implementation is transparent, responsive, beneficial, equitable, and successful. This session included a panel presentation of officials from the City and County including the Mayor’s Office, Sheriff’s Department, Police Department, Probation Department, Collaborative Courts, Behavioral Health Services, and community activists, breakout sessions, large group sharing, and questions & answers. The event was facilitated by a team of highly skilled Black clinicians who exemplified culturally responsive and trauma informed interactions with both Black community and agency leadership, resulting in unusually robust, respectful and empowered dialogue and participation, with a collective call for collaborative systems change.

**American Indian:** True North hosted a virtual town hall meeting for Del Norte and Humboldt Counties to discuss mental health in the American Indian and other Indigenous communities. Participants were invited to share their experiences with the pandemic, isolation, overall health, hopes, and concerns. Further, they were encouraged to engage with local providers to jointly identify needs and gaps in access to health and behavioral health services. The event was attended by leaders from both Counties, professionals, and community members, including American Indian and the Latinx Indigenous communities. The event opened with music and a personal experience of mental health services, there was a state of mental health address followed by an open dialogue about mental health in small breakout groups. True North and participants noted that this event was a good first step and that their communities wanted more opportunities to connect around these topics and identify resources, as well as support education to continue to mitigate mental health stigma.

**Southeast Asian:** The Cambodian Family convened a three-day community dialogue on mental health and wellness in Orange County. Each day continued to build upon the previous convening and listening sessions which had consecutive culturally relevant interpretation in Khmer (Cambo-

*“If I don’t speak up about my needs,  
the government won’t know.”*

– *The Cambodian Family*

dian). Day 1 was a listening session where participants shared their needs and knowledge about local mental health programs, services, systems, and advocacy opportunities. Building on the needs discovered from day 1, day 2 was an advocacy training where monolingual/limited-English-proficient participants learned some fundamentals around the power of advocacy and how

to communicate their mental health needs to key stakeholders. The final convening introduced community members to Dr. Veronica Kelley, Chief of Mental Health and Recovery Services at the County of Orange Health Health Care Agency and Jenny Hudson, LCSW and MHSA Coordinator who spoke about existing services and programs, the County’s commitment to improving access to mental health services for diverse communities in Orange County, and how to provide feedback as a community member. These events allowed reflection on what the residents have accomplished while reducing mental health stigma and training community members to be active mental health advocates.

**Latino/a and Migrant Indigenous Residents:** Vista Community Clinics held three listening sessions, two in-language and one in English, in the northern part of San Diego County to share perspectives about emotional well-being and mental health. Participants were invited to discuss the meaning of mental health, their experiences with mental health care, and provide feedback on the MHSA Community Planning Process (CPP). The first group started with the experiences and wisdom from promotores due to their knowledge of policy work; the second group focused on promotores and community members, including Lideres from Poder Popular (a longstanding trusted multigenerational community advocacy group aimed at voicing community needs and improving their neighborhoods); and the third focus group included school staff, VCC staff from their health clinics, and community members. The discussions focused on issues related to framing the mental health conversation, the increasing need for mental health services, and how to best support mental health civic engagement. As a result of these sessions, the Poder Popular group has started focusing on mental health policy and advocacy work.

**Muti-ethnic:** The California Black Women’s Health Project hosted a conference entitled, “Culture, Covid-19, & Community: Mental Health Matters” in San Bernardino County. This multi-ethnic event invited community members from Black, Latinx, Asian Pacific Islander, Eastern European, Middle Eastern, and American Indian/Alaskan Native communities. The virtual event featured presentations by Dr. Kendra Flores Carter about mental health across the lifespan and the impacts of stressors related to COVID and Dr. April Clay who discussed the County’s cultural competence advocacy committees and the ways in which each committee was a space for connection and influencing. Following the speakers, participants were invited to join breakout discussions where they discussed themes around how to build community capacity; where care may be available; who needs care and do the needs have to be significant to qualify; how to best get care to the people that need it, particularly in a geographically large County with large suburban centers and multiple outlying small communities; and how to share information with community about the care that is available and how to obtain it.

Please see the local reports for culturally specific findings from the events listed above in the addendum at the back of this report.



## Report Overview

The purpose of this report is multi-faceted. The report serves to document project activities and outcomes and disseminate community defined mental health needs and recommendations. The report also seeks to build capacity and equip community advocates to continue advocacy efforts in support of strengthening BIPOC mental health, as well as provide guidance and feedback to local and state government about reducing mental health inequities. This report provides a collective summary of the experiences and feedback from the local listening sessions, highlights progress accomplished following the events, and discusses policy implications moving forward.

## Community Voices

### Summary of Year 1 Discussions

During the first year, BIPOC communities in Alameda, Butte, Kern, and Los Angeles Counties discussed the state of mental health, mental health inequities, and the mental health system. Conversation highlights from the discussions included:

Mental health stigma is pervasive

Services are difficult to access

Services aren't culturally relevant or responsive

Services aren't useful or helpful

The impacts on BIPOC communities are grave

**Mental Health Stigma:** For many BIPOC communities, the stigmatization of mental illness is so pervasive that it impedes conversation within a community as well as access to care. In the Year 1 report, community members recommended partnering with cultural brokers and culturally specific community-based organizations to tailor public health messaging to be culturally and linguistically appropriate, integrating holistic and traditional approaches to healing that make mental health messaging more culturally accessible, investing in community-based organizations and trusted messengers (i. e. peers and community health workers), and funding (CDEPs) that provide more tangible and inviting mental health programming.

**Service Access:** People of color, their loved ones, and community experience barriers in accessing mental health services that include complex access portals and pathways; lack of culturally responsive outreach and language access barriers; 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.

*“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*

*“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*

**Lack of Cultural Relevance:** In January of 2021, the American Psychiatric Association (APA) issued an apology to Black, Indigenous, and People of Color (BIPOC) for its support of structural racism in psychiatry (American Psychiatric Association [APA], 2021). This apology demonstrates how the mental health system and practitioners are grounded in stereotypes and discriminatory ideas about people of color. Unfortunately, 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. For some BIPOC communities, they are discouraged from accessing services because navigating to find a provider who is clearly culturally and linguistically concordant is too difficult, not a guarantee, time-consuming, and potentially unsafe. BIPOC communities in the listening sessions did 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.

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

– *Mental Health Matters Participant*

**Ineffective Services:** Once care can 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. Structural racism has also resulted in the exclusion of behavioral health inter-

ventions developed and tested by and for BIPOC communities’ health and wellbeing. The lack of consistent funding and support of Community Defined Evidence Practices (CDEPs) as legitimate behavioral health interventions continue to be a challenge. 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.

**Poor Outcomes:** The effects of racism and oppression have dire consequences for communities of color. Not only does racism and racialized violence impact the mental health, wellbeing, and safety of communities of color, but structural racism negatively impacts access, service delivery, and service outcomes. These 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 social determinants of health that disproportionately affect communities of

color, including disproportionate burden of deaths from COVID-19, disproportionate representation within the criminal justice and child welfare systems, as well as issues with housing, food, and economic security that contribute to overall health and mental health outcomes.

## Year 2 Learnings

The learnings from the previous year's listening sessions remain relevant and only increased in urgency or severity during the Year 2 conversations. Many conversations still centered around how hard it is to access services; that the services may not be culturally relevant or responsive even if they are available which reduces the perception of and actual helpfulness of the service; and that while the need remains high, mental health inequity continues to lead to higher rates of depression and suicidality as well as involvement with the criminal justice and foster care systems, which may have grave effects on an individual, their family, and community.

## Continued Themes

**Service Access:** When people who need interpretation call for a mental health appointment, many struggle to get through the voice prompts on the language line to even get to an interpreter. Others shared that they or their loved one are “screened out” because they’re not “severe” enough or are unable to communicate their experiences in a way that would accurately reflect their level of need and distress on a standardized screening tool. Participants also shared that even if they are able to qualify for services, that there may be long waits or there may not even be any resources available. This gap is made worse if the person has limited English proficiency.

**Lack of Cultural Relevance:** Participants continued to report that services are rarely in-language, and that interpretation was not always available. In some instances, family members or a representative from a community-based organization would interpret. One participant described

*“Trying to get in-language mental health services was really challenging and made my mental health worse. I'd rather not reach out than deal with the barriers.”*

*– The Cambodian Family Participant*

*“[my father] was in urgent care the whole day, and there were no Spanish speakers. I had to be on the phone with him all day, trying to figure out what they were telling him... And since there were no neurologists in the area for two weeks, they had to take him down to Napa and fly him out. He was really scared because there were no Spanish speakers at the hospital to actually tell him what's happening, and even the transportation had no Spanish speakers... He didn't have anyone to actually support him. .... if he hadn't had me or my partner help him with those translations to understand the importance of his health as a Spanish speaker, I don't know what path he would have chosen.”*

*– True North Listening Session*

*“We need service providers that are culturally competent and sensitive to Black people ...what are you going to do with those people who have been trained, but refuse to utilize the training? Because culturally competent and culturally sensitive have been buzz words for quite some time so we throw out these trainings to all of our workforce to say that we have satisfied this, and people are walking away not getting it.”*

*– ONTRACK Program Resources Participant*

***“They are not offering any type of help to people coming out of jails or prisons or to the families that are visiting them.... at least to have materials about mental health available to families’ visiting jails and prisons and the inmates coming out of those situations.”***

**– ONTRACK Program Resources Participant**

the myriad of challenges of living in a rural county with limited resources, trying to support a monolingual family member during a health crisis, and the complete absence of translation services and supports.

It was also evident that mental health services rarely operate from a cultural framework, in part because of the lack of bicultural, bilingual providers but also as a result of the limits of a Medi-Cal, western dominated treatment paradigm.

**Poor Outcomes:** Participants also continued to report experiences of depression, hopelessness, and isolation, but this year more spoke about increased severity of needs, like dealing with suicidality. Many continued to report that service access remained problematic, especially in rural communities with limited resources. Additionally, issues related to the criminal justice and foster care systems remained high specifically regarding the issues between the danger that BIPOC and specifically Black communities face from encounters with law enforcement, even when seeking mental health support in a crisis. Participants spoke about the need for formerly incarcerated people to have a more robust support system upon release, equipped with aftercare services, resources, and referrals. Further, the overinvolvement in the justice system at every level, and the over-representation of BIPOC children in the foster care system and being separated from their communities’ remained areas of concern.

## Emerging Themes

The following section contains the new themes that emerged from our community partners this year. Whether it was due to living with heartbreaking losses during the pandemic, navigating increased mental health needs, isolation, financial burdens, or witnessing and experiencing increased racialized violence; in this year’s discussions, it became clear that participants and their respective communities were more open to talk about mental health.

***“We think we have so many services to give but the community doesn’t know [about them] or can’t get there.”***

**– CABWHP Participant**

### **Increased Openness and Increased Need for Mental Health Support:**

During various listening sessions, people discussed feeling less mental health stigma and being more open to seeking support. Many participants disclosed that they had either sought mental health support themselves or knew someone who had. They shared that their needs had become so dire that they could no longer be ignored. It is important to note that many of the partnering community-based organizations have been working on mental health stigma and discrimination reduction campaigns in their communities for over a decade. It is possible that this longstanding work combined with the severity in mental health needs, was a catalyst for community members to have an increased openness around their mental health needs and seek support. Further, while this increased need may be in part as a result of the pandemic, it should be understood from a



***“The pandemic made it more okay to talk about... Things are changing in that people are at least talking about it. Before, stay busy and try to ignore it. Now they understand...it’s okay to talk about it and what things we can do to help ourselves.”***

***– VCC Listening Session Participant***

lens of centuries of oppression and trauma that contributed to mental health issues and other inequities, human suffering, and reduced life expectancy and that the pandemic is a recent example of these inequities and their effects and not the sole cause.

**No Increase in Mental Health Services:**

With this increased need of mental health support and increased willingness to talk about mental health and seek support, it is important to note that the places where mental health support is available did not change, and the resources available to cultural-specific community-based organizations remained relatively the same. As a result, many members of BIPOC communities ended up seeking support from the cultural-specific community-based organizations with whom they already had a trusted relationship.

***“It’s not new that there is a lack of resources. [We] are more willing to talk about it now. [We] are done feeling hopeless about it.”***

***– True North Listening Session Participant***

The statewide and local partners recounted that they had experienced the level of distress and need go up within their communities first-hand and that there was a clear commitment to do their best to respond. However, there was also an acknowledgement that most culturally specific or-

ganizations across the state only receive mental health funding for prevention and early intervention, specifically with outreach and education or stigma and discrimination reduction programs, if they receive any mental health funding at all, and that few receive any type of reimbursement or funding to provide mental health treatment services or mental health crisis support for issues like suicidal ideation, which generally require billing Medi-Cal and are also typically larger contracts.

***“Our waiting room has become a de facto emergency room for people in mental health crisis.”***

***– Vattana Peong, Executive Director, The Cambodian Family***

The implications suggested by the participants and the participating organizations is that people were going to the only place where they could or knew how to get help and that while these organizations did their best to provide support, referrals, and connections to treatment, there were few services available outside of their organizations and the organizations themselves were not funded or equipped to provide clinical services to their communities who were desperately asking for help. This points to the ongoing tension between referring BIPOC communities to a traditional mental health service without a particular cultural framework or provider from that background, as communities continue to request that culture is either integrated into traditional treatment models or that trusted community-based organizations directly provide mental health treatment support, when many CBOs need capacity building, funding, and support to respond to more severe mental health needs.

## Local Accomplishments

Despite the challenges, it is important to uplift local accomplishments and remember the power that each of these communities hold. Since last year, **all** of the statewide partners and Year 1 local grantees have continued the conversations with their communities and the behavioral health departments. There have been gains in the following areas:

- **Community Organizing:** Building capacity and bringing community in to support their sharing their voices directly with decision makers
- **Deepening Partnerships:** Moving from stakeholder to trusted advisor to equal partner
- **Funding:** Acquiring additional funding for the local organization and/or funding added to the County budget that supports the work
- **Emotional Labor/Support:** Planning pragmatically for the toll that it takes on advocates and the support required to advocate within an oppressive system

The following represent key accomplishments that come from these efforts:

**Community Organizing:** All of the participating organizations were able to leverage this opportunity to expand community organizing within the mental health system. In Butte County, Hmong Cultural Center received funding from the Sierra Health Foundation to develop a youth leadership program. As a part of this funding, Hmong youth receive support to attend and participate in Butte City Council and Board of Supervisor Meetings. Recognizing that there is diversity within the Latino community and leveraging their blossoming partnership with Kern County, Visión y Compromiso has been very intentional in bringing more voices to County Behavioral Health meetings, including indigenous Latinx groups. The California Black Women's Health Project continues to train more mental health advocates through the Sisters Mentally Mobilized program, and they developed an MHPA toolkit to support advocates in Los Angeles County and expanded their community advocacy reach to San Bernardino County.

**Deepening Partnerships:** In all of the local communities, there were expanded opportunities for authentic engagement and partnership. Both the Hmong Cultural Center in Butte County and Restorative Justice for Oakland Youth in Alameda County are now training County staff and providers on how to be more culturally responsive and how to implement restorative justice practices, respectively. In Kern County, Visión y Compromiso progressed from presenting at the County's Heritage event last year to co-hosting and planning the event with the County this year. Bakersfield American Indian Health Project is also hosting cultural events that Kern County staff regularly attend, and both partners share their calendar of events for the entire year to maximize mutual participation and engagement. Restorative Justice for Oakland Youth in Alameda County are also strategically partnering with law enforcement as they work on a "safe outside the system" initiative.

**Funding:** Almost every organization received additional funding to support the work, and there were gains with financial resources for all of the Year 1 communities. The state provided funding to Bakersfield American Indian Health Project to expand community health workers, which was supported by Kern County Behavioral Health and Recovery Services and a key recommendation from their local listening session last year. The state also funded Restorative Justice for Oakland Youth in Alameda County to work on their "safe outside the system" initiative. Alameda County is funding Restorative Justice for Oakland Youth in Alameda County for healing circles and provider training in restorative justice and accepted their request for increased funding. The Hmong Cul-

tural Center received funding from Sierra Health for their youth advocacy efforts, and the County added a staff position focused on cultural competency to the local MHSA plan, which was a recommendation from their local listening session last year. Additionally, ONTRACK Program Resources secured a Behavioral Health Justice Intervention Services grant through DHCS to leverage the Real Talk event focused on the intersection of criminal justice and behavioral health of the Black community in Sacramento County, into a systems change effort using the Collective Impact approach.

**Emotional Labor and Support:** Whether it is hearing difficult stories from community members, maneuvering county politics, or dealing with staff burnout/turnover, the Year 1 grantees acknowledged the emotional toll this work can take on them and their communities. To plan for the emotional labor and support staff to stay in this work, Year 1 organizations like Restorative Justice for Oakland Youth in Alameda County started a provider healing circle. To alleviate burden from attending too many meetings, Visión y Compromiso staff share meeting attendance so as not to overburden any one person, and they engage in supportive debriefs whenever possible. The Year 1 organizations also discussed working internally to focus on long-term gains and not react to issues that come up but to be patient with the system and “meet them where they’re at.” They also noted the benefit of providing welcoming and educational experiences which allow the system to experience a cultural lens or framework and to consider additional perspectives and expanded frameworks. They also discussed wanting to offer help and training but being very mindful and checking in with staff about capacity and not compromising good work in the pursuit of new funding.

*“How do we create space where people can do the inner-work? What does it mean to be in relationship in order to hold community in ways that are safe where communities are also able to define for themselves?”*

*– Jodie Geddes, Restorative Justice for Oakland Youth*

## Future Directions

### Advancing Mental Health Equity Conversations

This project is a time-limited project that asks BIPOC communities to engage in a conversation about mental health needs and build capacity to advocate within a system that lacks the cultural framework to meaningfully respond. While CPEHN, along with our statewide and local partners, are grateful for the opportunity to engage with our communities and build our communities’ capacity to advocate on our own behalf, this project should not be a discrete set of activities that end when the contract expires. Meaningful, impactful, and lasting change to strengthen BIPOC mental health outcomes requires ongoing commitment, participation, and financial resources. Specifically, building a community’s capacity to advocate is an important step, but ongoing community organizing requires time and additional resources, specifically to compensate the individuals who give of their time to benefit their communities’ mental health as well as the time required for the organizing itself. The work of strengthening BIPOC mental health cannot be held solely within community. The mental health system, other relevant systems (i. e. , criminal justice, foster care), elected officials, and other policy makers must meaningfully join and stay in the conversation, not as the convener or authority but as a co-participant and listener. What we’ve continued to learn about strategy, partnership, advocacy, and trust building is that it can take years.

## Sacramento Mental Health & Criminal ‘Justice’ Real Talk & Black Community’s Voice Lifted Up

In Sacramento, ONTRACK Program Resources organized an intentional Black-centered 2-day event focused on the intersection of Black Mental Health and the Criminal Justice system. The goal of this event was to go beyond training and education and move towards action that could create structural change. They envisioned an event, which paid homage to the African-American Church tradition of call and response, where the first day was the “call” where participants listened to the voices from the Sacramento Black community on their experiences specifically involving behavioral health and the criminal “justice” system, and the second day was the “response” where representatives from the behavioral health and criminal justice systems could respond and raise awareness about new County and City behavioral health and criminal “justice” related initiatives. Recognizing that to truly affect change within the Black Community, the system must stop criminalizing Black mental health, the organizers carefully designed an event co-facilitated by Black therapists who could support the spaciousness needed to hold raw stories of racism and injustice while moving participants to organize their thoughts in a way that could be used for advocacy in preparation for the second day of ‘the response’. Black mental health providers were available during and after the event at no cost to participants.

Considering the tensions between law enforcement and the Black community heightened in 2020, the goal of bringing the Black community in with law enforcement leadership to have a productive collaborative dialogue required a thoughtful, and deliberate approach. Organizers facilitated planning and preparations calls with day 1 and day 2 panelists together in order to equip panelists to join in the event, understand the collaborative communication approaches, and receive an orientation to the larger advocacy strategy. Day 2 panelists were coached to remain present as a listener during the first day’s discussion and then come back to day 2 able to offer a response. Specifically, they were supported to recognize that there was no magic answer, and that the most beneficial response would be to “sit with it.” Because the sessions were interactive and open discussion was encouraged, panelists were invited to be truly accountable to participants and provide an authentic response. Following the event, ONTRACK organized an additional session to explore the collective impact model as a mechanism for continuing the work together. They subsequently applied and were awarded additional funding from the state in order to fund the ongoing work, including compensating community with lived experience for their subject matter expertise while serving on the steering committee and other key roles ([www.getontrack.org/realtalk](http://www.getontrack.org/realtalk)).

This example highlights how to create an equitable and genuine partnership between the “system(s)” and community as well as describes the level of planning and preparation required, not only for community but for the system, in order for both to come together in a collaborative manner. This example also illustrates the need to fund the work that arises from these listening sessions in order to advance a shared agenda.



## Building Bridges: The Changing Role of the Community Based Organization (CBO)

Community based organizations are a cornerstone of the health, mental health, and wellness in BIPOC communities. They are trusted organizations who bring cultural knowledge and understanding, a safe place to go when help is needed, resources and support. Many culturally specific CBOs provide a range of health, mental health, and wellness services, often times with limited resources. Over the past two years, CBOs are seeing an increase in mental health need and severity and a greater openness to discuss mental health and seek mental health support. However, as discussed previously, there are no additional services available, and CBOs are not properly funded or staffed to provide traditional mental health treatment services or crisis response.

In the following section, CPEHN and the state-wide and local partners discussed these issues in order to develop a menu of approaches or recommendations that would address the needs of BIPOC communities, recognizing that CBOs vary in terms of size, capacity, and mental health expertise.

**Increased Support for Existing Services:** One question explored was how to better support existing services to be more culturally responsive. This could include providing additional training or consultation to existing providers in order to support them in doing the work. Some partners and participants did clarify that culturally responsive training is often not enough, because many workforces have been trained in cultural humility or cultural sensitivity, they suggested ongoing technical training and assistance as well as other measures of accountability to determine if those practices are being utilized.

*“We find ourselves at a pivot point: county behavioral health and public health agencies have been spread thin, and community advocates and community-based organizations have stepped up to fill the gap and play an essential role in our public health and behavioral health infrastructure. For example, CBOs played a critical role in keeping community members connected to each other and health promoting services; advocated on their behalf to policymakers and decisionmakers; and helped sign them up for and provided to them food and financial and rental assistance.”*

*– Prevention Institute*

*“If not us, who would it be?”*

*– The Cambodian Family Participant*

*The Hmong Community Center in Butte County convened an Engagement-focused event in Year 1 of the project that targeted mental health providers serving 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 first part of the event was didactic and led by a psychologist. The second part of the event included breakout discussion groups, similar to a case conference, where providers were given case examples and could also share their own real-life examples. This provided an opportunity to apply the learnings about the Hmong community and culture as well as ask questions that may not have been asked in the larger group. This type of supportive learning environment where providers are encouraged to ask questions that may feel controversial in other settings proved to be successful. Following the event, HCC has continued to provide training and ongoing case consultation to mental health providers to help them better understand and serve their Hmong clients.*

***“The peer to peer and cultural connection is critical, particularly for immigrant and Black communities. If we have bad experiences with the system, the peer to peer/community health worker and cultural connection model is good.***

**– CABWHP Participant**

**New Partnerships:** CBOs recognize the need to continuously build relationships for their stakeholders, including maintaining a robust network of providers or agencies where their communities can be referred when they have a need that exceeds what the CBO can provide. Given the challenges with access and services previously discussed this group discussed creating a network of vetted providers or agencies to whom they can reasonably make referrals. This includes **1)** investing time to vet services and providers to determine if

they are versed in culturally responsive services and are able to operate from a culturally relevant framework, **2)** understanding the eligibility, intake, and treatment requirements and processes in order to support their clients to understand what they’re agreeing to and what the process may be like, and **3)** creating ongoing communication that will allow the CBO to go beyond a warm handoff. CBOs also discussed exploring whether or not there may be ways to enhance their ability to provide more intensive mental health services, including exploring if there are culturally responsive providers who might work directly with the CBO, co-locate their services at the CBO, or formally work with peers or community health workers.

## **Mental Health Structure: CBOs and Medi-Cal**

As CPEHN and the statewide and local partners considered what it would take to support BIPOC communities to gain access to culturally relevant mental health treatment, they discussed the limitations of the public mental health system and explored how CBOs might support the mental health system and BIPOC communities as a treatment provider. Providing mental health treatment through the public mental health system is typically reserved for contract providers who receive MHSA Community Services and Supports and/or Medi-Cal funding. These are generally larger contracts that are given to mainstream contract providers, although there are some examples of larger culturally specific CBOs also being a specialty mental health provider, particularly in some larger jurisdictions such as Alameda and Los Angeles Counties.

**Benefits:** The benefits of a CBO becoming a specialty mental health provider include resolving many of the issues related to access, services and cultural relevance, and mental health outcomes. If CBOs were able to have mental health services within their organizations, it could facilitate ease of access, particularly if they were able to provide an initial authorization for services. There would also be an assumption that the mental health services provided by the CBOs would naturally come from a cultural framework, understand the stigmas and traumas that one may have experienced, and understand how to integrate holistic or other traditional approaches within the mental health services. When taken together, this would likely serve to strengthen and improve the mental health service delivery experience as well as mental health outcomes.

### ***Alameda County Culturally Specific Access Points***

***In Alameda County, there are a limited number of culturally specific organizations that serve as access points for specific communities, such as La Clínica de la Raza for the Latinx community. Latinx clients can go directly to La Clínica for mental health services and bypass the central access line.***

**Risks and Challenges:** However, there are some inherent risks and challenges in an organization becoming a specialty mental health provider, particularly as they are developing their policies and procedures to provide and document specialty mental health services. One of the primary considerations is risk, including financial risk, and the concern that an organization may incur financial liability if they make mistakes as they are learning. There is also concern that becoming a specialty mental health provider would fundamentally change the organization and potentially detract from the core mission and organizational identity. Additionally, becoming a specialty mental health provider carries a substantial administrative burden and documentation that could present challenges, particularly to smaller CBOs. There is also some concern that there are overall shortages of clinical staff, and these shortages are even more pronounced within the BIPOC workforce.

**Contract Structure:** If an organization chose to become a specialty mental health service provider, the contracting arrangement could have some flexibility based on the negotiation between the CBO and the mental health plan. For example, the CBO could contract with the mental health plan directly or could become a subcontractor to an existing specialty mental health provider. The CBO could also go through a fiscal sponsor or fiscal agent for contracting or form a local collaborative.

***In Orange County, there are several networks of community-based providers, two of which the Orange County Asian and Pacific Islander Community Alliance (OCAPICA) and the Multi-Ethnic Collaborative of Community Agencies (MECCA), had a direct Prevention and Early Intervention contract with the county and contracts with local culturally specific CBOs like The Cambodian Family as a way to lend their infrastructure or budget requirements for County procurement, contracting, and compliance.***

**Payment Structure:** One of the organizational challenges of being a specialty mental health provider is cash flow. Many county mental health departments pay in arrears and have significant delays in payment. In some counties, providers may experience a nine-month delay in payment, even though they are incurring the staffing and other costs associated with providing the services. For larger organizations, they may have a reserve or a line of credit that would allow them to manage cash flow. For smaller organizations, including many culturally specific CBOs, this would present an unsurmountable challenge, both during the start-up phase as well as on an ongoing basis. Many counties have some provider contracts that include a 1/12th arrangements with a consistent monthly payment based on the projected budgeted expenses with a mid-year budget revision to adjust the payments and an end of year reconciliation.

This arrangement of being paid 1/12th of the agreed upon contract amount on a monthly basis with an end of year reconciliation eliminates the delays in payment associated with a monthly reconciliation process that generally accompanies the fee for service billing structure. This tends to minimize cash flow implications for smaller organizations and is an existing arrangement that can be negotiated into a contract, particularly if there is a commitment on the part of the mental health plan to engage with the CBO.

**Procurement:** Many if not most counties have procurement rules and processes that require that they engage in a competitive bidding process for contracts that exceed a certain amount. This is generally true for MHSA CSS and Medi-Cal dollars. However, smaller CBOs are at a disadvantage in a procurement process. They don't typically have the same level of treatment or Medi-Cal billing experience, nor do they generally have the infrastructure that includes a grant writer or development department as their competitors may. To this end, it may be helpful to consider whether a set-aside for culturally specific treatment services would help protect funds for CBOs as well as outreach and technical assistance to support organizations to engage in the bidding process.

**Treatment Model:** There was also concern about whether or not culturally responsive approaches, including CDEPs, would be eligible for Medi-Cal reimbursement and if providing mental health treatment would require sacrificing the traditional or holistic approaches to healing that CBOs are currently employing. While this is a valid concern, it may be useful to demystify Medi-Cal, engage in a discussion with DHCS and provide some education about how to operate from a cultural lens within a Medi-Cal framework. For example, most community health workers would qualify as Mental Health Rehabilitation Specialists and be able to provide billable services if 1) the treatment plan being implemented was supervised by a licensed clinician, and 2) they were working towards goals and using interventions that were included in the treatment plan. A number of organizations across the state already engage in this way. Additionally, this approach – even using telehealth to gain access to the appropriate bicultural, bilingual clinician – may provide the coverage needed to allow for billing to occur.

There was some discussion during this project about whether or not a state-wide organization could serve as backbone support to any culturally specific CBO who was interested in becoming or in the process of becoming a specialty mental health provider in order to serve as a fiscal agent as well as provide technical assistance, capacity building, and quality improvement and compliance support to reduce the risks associated with becoming a specialty mental health provider and billing. CBOs may wish to use this report to seek support to fund a feasibility study of becoming a Medi-Cal billable service agency.

### ***Transforming LA Partnership***

***LA DMH launched an initiative a few years ago to provide technical assistance to help smaller organizations become LA DMH contractors and successfully manage the contracts. While this is primarily for PEI projects, it provides an example of how a mental health system can strengthen CBO capacity to engage in mental health contracting.***

### **Advocacy Strategies**

Given the success of the Year 1 grantees in obtaining additional funding, deepening partnerships, building additional capacity and community organizing, it may be useful to consider the key learnings from their success. Their feedback and suggestions included:

**Be consistent & solution-oriented:** All of the participating organizations noted the importance of persistence with the work and encouraged themselves, each other, and other advocates to “just keep showing up.” When decision-makers and other potential partners experience reliability of an organization, they may be more likely to work with them and there can be more space for influence when an organization stays in the conversation. As acknowledged in the previous section, they discussed the toll that this work can take on recommended practicing self-care while continuing to consistently participate in meetings, dialogue, and other opportunities for advocacy. Being consistent and showing up doesn’t just mean attending events, but also inviting systems officials and policymakers to their events to provide them with a cultural experience, truly demonstrating how the cultural experience looks and feels may lead to potential solutions down the road. Some local partners acknowledged that a lot of county systems receive critical feedback, so their approach was to provide community-informed solutions to the issues communities raised, which allows for less defensiveness and more collaboration.



### **Engage, inspire, support, & prepare community advocates to speak to decision-makers:**

Across Year 1 and Year 2 grantees, the sentiment was shared that for long term advocacy success, CBOs needed to invest time and energy into building the capacity of their stakeholders to in turn speak to decision-makers. However, grantees explained that when working with communities, strategy should be spent on understanding what the community faces as real-life issues, so they are truly invested and engaged because the topics are relevant. For example, they suggested spending time hearing from community members about challenges they are experiencing in their neighborhood versus trying to get them onboard with potentially abstract concepts like the importance of the social determinants of health. Many Year 1 and Year 2 partners have invested in providing advocacy and leadership training where they teach community members about relevant issues and policies and prepare them on the most effective ways to speak to decision-makers or influence legislation, including where to submit comments and relevant meetings to attend. Being respectful of their community members time, some CBOs like The Cambodian Family accommodate for language, provide transportation, food, stipends, and childcare whenever possible. The result is that many CBOs now have a base that are trained and can be activated when needed. Over the past year, Hmong Cultural Center, Vista Community Clinics, and the California Black Women's Health Project have provided education training for youth and mental health advocates to meaningfully participate in the public process and provide actionable feedback. Please see some highlights below of this advocacy capacity building from our partners.

## **Project Sunshine, Hmong Cultural Center**

**The Koomtes (Fellowship) Youth Program (KYP) started out as a summer youth program. As KYP participants increased so did requests for services and program activities. KYP was able to educate youth on bridging traditional and cultural differences, empower youth, and help develop leadership skills in areas such as advocacy, mental health, higher education, and community involvement. During the middle of Covid-19 pandemic, HCCBC held a listening session on mental health which brought in an ample amount of youth to share their voices on the lack of knowledge of mental health and the accessibility of mental health services for young people. HCCBC was fortunate to collaborate and partner up with CAYEN, CA Youth Empowerment Network, to establish a Transitional Age Youth (TAY) Team where they developed content and materials for a virtual town hall meeting on transitional age youth and mental health in Butte Community. This TAY team's project is known as Project Sunshine. They create content and social media pieces to break the ice with youth that are undergoing mental health issues and experiences. Project Sunshine works as a virtual mentorship program that helps guide youth to empower themselves using their ideas and voices to educate the community and stakeholders on mental health issues and best practices for youth in the Hmong community. HCCBC was fortunate to be rewarded with funds from Elevate the Youth California to provide a safe space for youth to help reduce substance use and abuse disorder. KYP will form a core group of TAY to help implement program activities and develop skills in advocacy work.**

## Sisters Mentally Mobilized, California Black Women's Health Project

Black women in the United States are disproportionately impacted by disparities in access to high-quality, affordable, and culturally responsive mental health services and supports. The severe lack of access to culturally specific and responsive mental health resources, combined with endemic societal factors that predispose or create higher risk for depressive disorders in the Black community, exacerbates a community mental health crisis that takes a toll on the souls of Black women. Designed and implemented by and for Black women, California Black Women's Health Project developed Sisters Mentally Mobilized as a community defined evidenced practice (CDEP) and mental health prevention and early intervention to address the mental health conditions and resource gaps that predispose Black women to greater risk of depressive disorders. Sisters Mentally Mobilized combined culturally specific mental health awareness and empowerment training and social support networks to build the capacity of Black women to speak to and address mental health conditions and barriers in their lives and communities. These 'sister circles' themselves are a form of emotional wellbeing and culturally responsive support, and participants are encouraged to grow more circles of support and advocacy. The California Black Women's Health Project has recruited and trained over a hundred self-identified Black women to become mental health advocates and community activists from Los Angeles County, Alameda County/Bay Area, Sacramento County, and the Inland Empire (Riverside and San Bernardino Counties).

## Poder Popular, Vista Community Clinics

Poder Popular is a multigenerational group with mixed status families that has been in existence for 10+ years. Vista Community Clinic currently oversees the Poder Popular group in Vista, which includes residents from Vista, Escondido, and Fallbrook. The purpose of the project was to improve health, living and working conditions of agricultural workers by strengthening and engaging grassroots leadership. The goal was to increase local health, develop individual and organizational leadership and increase advocacy capacity to improve long-term health conditions of farmworkers through systems change. During the COVID-19 pandemic, Poder Popular stayed active through virtual weekly meetings. Poder Popular Lideres were great assets to the VCC team because they were voicing the needs of their communities as trusted leaders. They supported the promotion of vaccination equity, testing, educational materials, provided updates through their social media platforms and distributed PPE. They supported VCC with the MHSOAC project by promoting and participating at the community focus groups and sharing their concerns regarding the need for mental health resources that are culturally and linguistically sensitive as well as affordable for low income, immigrant families in North County San Diego. Their values are community centered; they are very perseverant, they are from and for the community, they live in these neighborhoods, they know what is needed for them to live a healthier and safer life and they advocate for it because they want their children to live a better life. Many of them can testify of the ways it has helped & inspired them. As one of the Lideres said, "The love for my community gives me the biggest satisfaction in my life by helping people be happy, getting food, and the help they need."

**Meet people where they're at:** The partners acknowledged that each Counties' mental health systems may be at different levels of capacity to engage with and participate in discussions and efforts to strengthen BIPOC mental health and go beyond the status quo. Visión y Compromiso made sure to emphasize celebrating and appreciating small wins with their teams, especially when trying to meet systems where they are at. They further shared their wisdom of trying to appreciate the efforts that people were making and recognizing that we are all coming from different places. Further, partners emphasized the importance of debriefs and strategy sessions so there is a safe place to express frustrations and help keep them in the work.

**Build and leverage relationships:** Organizational participants noted the importance of paying attention to power dynamics and understanding where there may be levels to affect change in order to determine how to best engage with the system. Some partners suggested creating time to formally or informally connect with leadership, especially when leadership changes. They recommended having an open dialogue about potential opportunities to provide mutual support. They also noted formalizing the relationships where possible in order to be seen as a full-fledged member in order to be treated and funded as such. BAIHP was able to formalize their relationship with Kern County BHRS through a Memorandum of Understanding (MOU) that was endorsed by the Board of Supervisors. This predated the invitation to apply for available state funds that the County had become aware of, to which BAIHP applied and was subsequently awarded. As previously uplifted, other partners like the Hmong Cultural Center have provided culturally relevant trainings for providers and were later sought out for advice given their deep connection to the local community. Similarly, Visión y Compromiso provided feedback to support Kern County to be more inclusive of their stakeholders after their County's Heritage event last year, and this year the County engaged them to plan and co-host with them, they were also invited to participate in the Latinx subcommittee. True North shared that during event planning, they spent significant time speaking with professionals and decision-makers in both Del Norte and Humboldt counties who ultimately decided to join the events and be intentional about listening and providing resources – which True North felt was a step in strengthening their relationship with the counties.

*In San Bernardino County, the California Black Women's Health Project convened an on-line conference with nationally known speaker Dr. Kendra Flores Carter who discussed the impact of stress on mental health across the lifespan and how stress, including the stress from COVID, permeates all aspects of society. The event had a large turnout, in part because of the thoughtful organizing that occurred in advance of the event. The CABWHP leveraged relationships and networks that they had in order to encourage participation in the forum. Specifically, they engaged with a member of the Behavioral Health Commission, Dr. Monica Caffey, as well as twenty-five community leaders from the CBO community. They sent out save-the-dates as well as reminders leading up to the event. They were also able to distribute the invitations on County Department of Behavioral Health (DBH) and local CBO list serves in order to spread the word. CABWHP acknowledged that they engaged in these efforts because they wanted to expand the community of people who were participating in the discussion and advocating for BIPOC mental health. Since this event, they have also trained almost 40 additional advocates in the Sisters Mentally Mobilized training program.*

**Apply for funding where available:** It was noted that funding is what enables the work to happen. The majority of the Year 1 partners and one of the Year 2 partners have received additional funding to do the work. Their advice was to develop a practice of applying for funding and to just keep applying. Another strategy is to leverage collective efforts among CBOs who share similar goals and priority areas to jointly apply for funding and sharing grant writing resources and/or costs. Further, some partners requested an increase in funding for existing contracts – recognizing that a lot of advocacy happens from the free labor of BIPOC communities. This project sets an example of how to compensate advocates for their organizing. Future efforts may need to go beyond this in order to also compensate all advocates.

**Take care of staff and community:** Year 1 and Year 2 partners revealed that sometimes we may forget that our staff are part of the community, and therefore when the community is tired, exhausted, and burnt out- so is our staff. They suggested building wellness support for staff and community partners. SEARAC shared that they shifted to a four-day work week, and specifically asked funders to have flexibility on how their money is used to support staff, which has led to more resources, time, and flexibility for staff to take care of themselves, their loved ones, and their community within their cultural systems. As previously mentioned, RJOY has implemented provider healing spaces and during their event, ONTRACK, created spaces for individuals directly impacted/triggered/activated by the event topic to have opportunities to debrief in smaller intimate spaces with Black mental health providers.



# Policy Briefing

## Policy Recommendations

### Update on Last Year's Recommendations

This section of the report reviews our Year 1 recommendations and provides an update of progress made to date.



### Shifting power to address institutional racial inequities.

This recommendation included adequately resourcing the MHSA Community Program Planning (CPP) process, engaging expert facilitators to develop public processes that solicit and synthesize actionable feedback, committing to genuine transparency and providing adequate information to allow the public to make meaningful contributions to the process.

This recommendation also included co-developing evaluation measures to assess the health of the CPP process and engage in continuous learning and improvement with community residents and considering approaching shared-decision making models that empower communities to make certain decisions. ONTRACK Program Resources has begun this process in Sacramento by utilizing a collective impact model for their work, the intersection of mental health and the criminal justice system in the Black community, and this approach was selected because it requires intentionally working together to share information and solve a complex problem. While they are early on in their process, they have received funding from the state to bring together the Black community and mental health and criminal justice systems to work in partnership to address issues affecting the Black community.

## **Implementing community-defined solutions to address the drivers of mental health.**

This recommendation included forming a Community-Defined Evidence Advisory (CDEP) Committee, requiring the Innovations (INN) components of the Mental Health Services Act (MHSA) to demonstrate how it will address disparities in BIPOC communities, and requiring Prevention and Early Intervention (PEI) reporting to include outcomes that are more important to disparities reduction efforts, such as connection to culture. While there hasn't yet been a CDEP advisory committee, there has been progress at the state and county levels.

There has been openness around figuring out how counties can fund CDEPs, and the MHSOAC has redirected funds to “engage county behavioral health leaders on the opportunities to adapt, extend, and replicate the work of the California Reducing Disparities Project (CRDP). As a part of this process, the MHSOAC contracted with the Prevention Institute to implement Creating Common Ground. The purpose of Creating Common Ground is to build a shared vision for moving mental health further upstream with a focus on community prevention and using a health and racial equity lens. One of the areas that they are exploring is the policy changes related to funding availability and eligibility requirements as a potential lever to expand uptake of CDEPs. DHCS has also formally recognized CDEPs in the children and youth initiative and has formed a workgroup to explore how to incorporate CDEPs. The MHSOAC has also recommended changes to the Innovation regulations that would require that INN projects reduce mental health disparities.

A significant accomplishment in implementing community defined solutions is regarding tribal healing practices. DHCS has included tribal healing practices in the Medicaid application as a part of the Drug Medi-Cal Organized Delivery System Waiver. While not yet approved, the state has demonstrated real commitment to advancing this initiative.

## **Increasing access, cultural and linguistic appropriateness, and integration of mental health services.**

This recommendation includes investing in care teams that include peers, community health workers, traditional healers and patient advocates; increasing capacity of county systems to collect, analyze, and utilize patient-centered outcome data; strengthening the integration of county mental health services, particularly full-service partnerships (FSPs) and hospital-based care, with primary care, substance use disorder treatment, and programs to address social risk factors; rigorously enforcing consumer rights to non-discrimination, language access, timely access, and evidence-based care; and ending 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.

There has been significant progress in this area with legislation that supports peer certification and the expansion of community health workers. Specifically, community health workers are now integrated into Medi-Cal and are reimbursable through the managed care plans. Vista Community Clinic played a critical role in advancing this opportunity. While it does not yet include specialty mental health, it may be useful to look for opportunities to expand community health workers within specialty mental health as a billable service. With peer certification, this provides a wonderful opportunity to get peers certified, and there is still work to be done to add in the billing component, particularly because counties have to opt in to billing for peer support.

There have also been significant setbacks, particularly as it pertains to CARE court. Communities across the state, particularly Black and other communities of color have discussed for a period of years the negative experiences and outcomes that stem from the intersection of mental health and criminal justice. While the additional treatment is needed, there is significant opposition from BIPOC communities to any interventions that include forced treatment and criminal legal system involvement. There is concern that there may be unintended consequences and that this program strays from centering the voices of peers and community in terms of what is most needed.

<b>Recommendations from Lifting Up Black Voices, ONTRACK Program Resources</b>	
<p><b>Practices to Dismantle</b></p> <ul style="list-style-type: none"> <li>• Police response to mental health crises</li> <li>• Any use of the criminal courts as an access point for mental health services</li> <li>• School resource officers as a contributor to the school to prison pipeline</li> <li>• CPS removal of Black children and placing them outside of our community</li> </ul>	<p><b>Programs to Fund</b></p> <ul style="list-style-type: none"> <li>• Investments in Black wellness.</li> <li>• Co-occurring treatment facilities</li> <li>• Trauma-informed approaches to facilitating family contact during criminal justice involvement</li> <li>• Culturally relevant reentry supports</li> </ul>

**Promoting mental health awareness and decreasing stigma.**

This recommendation centers on tailoring public health messaging to be culturally and linguistically appropriate; integrating holistic and traditional approaches; investing in community-based organizations and other trusted messengers like peers; and building an educational integrative cultural mental health campaign and fund CDEPs. While there is not a lot of movement at the state level with stigma and discrimination reduction, the majority of this work is being done at the local level in communities across the state.

# Current Policy Brief

## 2022 Legislative and Policy Agenda

### *Budget Proposals*

This section of the report reviews our Year 1 recommendations and provides an update of progress made to date.

#### **Reducing Race-Based Disparities in Accessing Mild-to-Moderate Mental Health Benefits in Medi-Cal**

One in five people enrolled in Medi-Cal will experience mental health symptoms in any given year. During the COVID-19 pandemic, the prevalence of anxiety, stress, and other mental health symptoms increased exponentially and has continued to severely impact communities of color. With Black, Indigenous, People of Color (BIPOC) facing the brunt of the pandemic –whether it is job loss, food insecurity, housing instability –securing support for mild to moderate mental health challenges is needed now more than ever. CPEHN proposed \$15 million from the General Fund in FY 2022-2023 and \$12 million ongoing thereafter to augment the Department of Managed Health Care’s (DMHC) capacity to support culturally and linguistically appropriate access to mild-to-moderate mental health care services within Medi-Cal in order to reduce race-based access disparities in mental health. The legislature did not adopt the proposal, and administrative advocacy will continue.

#### **Mobile Crisis Response**

Governor Newsom proposed a multi-pronged approach to mobile crisis services by expanding a benefit to families and individuals enrolled in Medi-Cal. Local teams at the county level engaged in a “first responder” model would provide mental health services to community members experiencing a mental health crisis. CPEHN proposed changes to Governor Newsom’s proposal to ensure health and racial equity metrics would be met. Despite CPEHN’s efforts, we did not see the inclusion of racial equity metrics that can ensure successful implementation of this benefit particularly for communities of color. However, the Legislature approved \$1.4B over 5 years to qualified community-based mobile crisis services no later than January 1, 2023. This investment will make mobile crisis intervention services a benefit through Medi-Cal.

#### **C. A. R. E. Court**

A bill signed by Governor Newsom will create a new, involuntary court process that seeks to target interventions for individuals with untreated schizophrenia or other psychotic disorders. CPEHN opposes C. A. R. E. Court given the disproportionate impact it will have on communities of color. However, the legislature approved \$64.5M ongoing in FY 2022-2023 to the Department of Health Care Services, Department of Aging, and the Judicial branch to implement the program.



## *Legislative Proposals*

### **SB 1019 (Gonzalez): Strengthening Mental Health Access for Diverse Communities**

This bill would ensure Medi-Cal managed care plans are required to conduct culturally and linguistically accessible outreach to Californians enrolled in Medi-Cal. The passage of this bill will ensure Black, Indigenous, Communities of Color (BIPOC) have readily available information on their rights to mental health care access and how to find providers that can meet their needs so we may begin to eliminate widespread underutilization of mental health support in Medi-Cal.

### **AB 2697 (Aguiar-Curry): Community Health Workers/ Promotores**

This bill would complement efforts to implement a Community Health Worker/ Promotores benefit under Medi-Cal and ensure outreach and education is conducted to individuals and families that are eligible. The passage of this bill will ensure communities of color receive information about their new CHW/Ps benefit and services they can receive.

### **SB 644 (Leyva): Health Care Coverage Outreach**

This bill would require the Employment Development Department to share contact information of individuals that have applied for unemployment assistance and other related benefits, with Covered California so the Exchange can then conduct outreach and enrollment efforts. The passage of this bill will ensure Californians who experience job loss or reduced-work hours are able to retain access to health care coverage benefits that are affordable and we eliminate gaps in essential coverage.

### **SB 967 (Hertzberg): Health Care Coverage Outreach: Tax Returns**

This bill would require Covered California to annually conduct outreach and enrollment efforts to individuals who indicate interest in no cost or low-cost health care coverage options in their income tax returns. The passage of this bill will provide an avenue for Californians to disclose their interest in receiving information on health care coverage options.

### **AB 2724 (Arambula): Medi-Cal: Alternate Health Care Service Plan**

This bill will allow Kaiser Permanente to enter into provider contracts with the Department of Health Care Services in order to become a statewide Medi-Cal provider. The passage of this bill will ensure thousands of individuals and families, who are enrolled in Medi-Cal, are provided with the option to receive health services through Kaiser and start to eliminate barriers for hard-to-reach regions in the state.

### **SB 929 (Eggman): Community Mental Health Services: Data Collection**

This bill will require robust data collection for individuals who receive mental health treatment through county, or community mental health services. The passage of this bill would provide an opportunity to assess clinical outcomes and demographics of people that receive treatment for severe mental health symptoms.

### **SB 964 (Wiener): Behavioral Health**

This bill would require the California Community Colleges, California State University, and request the University of California, to expand specific accelerated special work degree programs and accreditation standards for individuals who formerly provided community health services as community health workers, peer support specialist, and other similar professions. The passage of this bill would provide community-based health workers with options for accelerated degrees in social work, if they so choose to enroll.

### **SB 1003 (Eggman): Trauma-Informed Care Training Certification Program**

This bill would create the Trauma-Informed Care Training Certification Program, which will provide employees of victim witness programs, sexual assault programs, and other community-based victims of crime programs, with an option to complete trauma-informed care training certifications. The passage of this bill will provide victim support workers with a statewide certification option to complement their existing skillset.

# Local Event Summaries



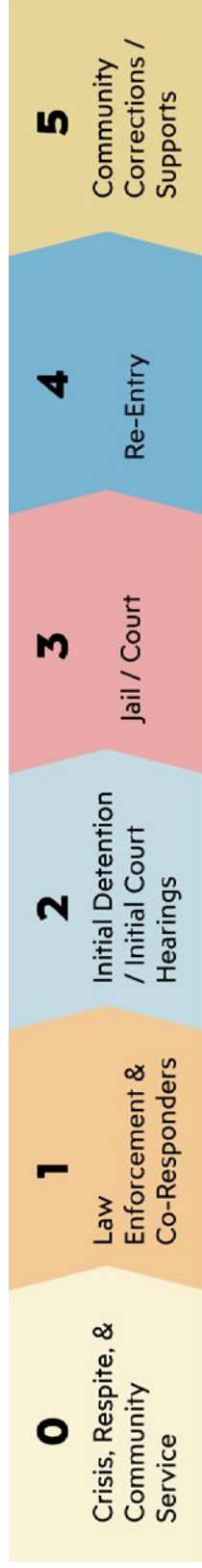
Photo Credit: Vista Community Clinic



# Sacramento's Criminal "Justice" Systems From Real Talk to Hard Data



ONTRACK Program Resources' Community Health and Justice Project (CHJP)'s goal is to transform the way Sacramento's criminal justice, behavioral health and community stakeholders work together to improve collective outcomes for Blacks/African Americans. To help ground the project launch, this document graphically presents different points of contact, aligning with the Sequential Intercept Model<sup>1</sup> in Sacramento's criminal "justice" systems, discussed during the Sacramento Black Community Mental Health + Criminal "Justice" Real Talk event held on November 17 and 18, 2021 and Workshop Exploring the Collective Impact Approach For Improving Criminal Law and Mental Health Outcomes in Black Communities follow-up session on December 2, 2021. Below are a sample of Real Talk issues and questions, along with possible data measures that, when disaggregated by race/ethnicity, can help understand current conditions and identify data-driven strategies and solutions.



## Crisis, Respite, and Community Services

### Real Talk

"The community has long been demanding a **911 police-free alternative, specifically for mental health crisis response**, like the County is doing and the City of Sacramento has done with Department of Community Response. My question is, why are police continuously asking for this money and continuing to expand mental health crisis response and conflict in direct conflict, contrary to what community members have been demanding from police-free mental health crisis response?"

"Having **culturally competent therapists** in our communities to serve as we need them, not just having people with badges come with guns. That's not a good way to do it."

### Possible Data Measures

- # of crisis and support lines in operation (phone and text)
- # of calls within a set time frame; type of caller (family member, law enforcement, self, etc.)
- Type of call or service requested (need related to mental illness, suicidality, substance use, or detoxification); Type of outcome (e.g., referral to emergency service, community provider follow-up scheduled, stabilized with no further follow-up)
- # of CBOs under contract for prevention services; referrals to County services: Mental Health Access Team, Community Support Team, Mental Health Urgent Care Clinic, etc.
- # and % of individuals presenting at ED with a primary or secondary diagnosis related to mental or substance use disorders or impairments (specific diagnosis codes may be needed)
- # of crisis centers, by type (crisis stabilization facility, 23-hour mental health observation unit, respite center, etc.); # of chairs, beds, or spaces per center; # of individuals presenting with mental or substance use disorders or impairments; % admitted; % of people with prior justice involvement

## Law Enforcement & Co-Responders

### Real Talk

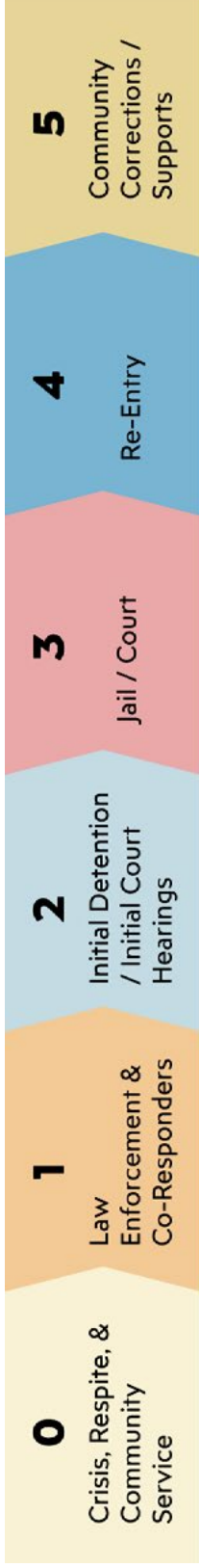
"How many times does a person have to be arrested for the agency to realize that there is a mental health issue? Are there policies and procedures in place for this? **Are there alternatives, other than jail?**"

"**Officers building that rapport with undeserved communities** is a start. Getting to know the people in the neighborhoods they patrol so they can better understand what's truly happening when they get a call."

### Possible Data Measures<sup>ii</sup>

- # of dispatchers that are trained in cultural competency, by agency
- # of calls with primary concern related to mental illness or substance use, with disposition
- # and % of officers that are trained in culturally competency, by agency
- # of cases (including calls to law enforcement and encounters in the field by law enforcement) where mental health or substance use is or becomes primary concern





## Initial Detention/Initial Court Hearings

### Real Talk

"With almost 2/3 of the people in our jails in need of mental health support, **why is the process at the time of law enforcement response to arrest instead of offering support in that moment?** What is law enforcement doing to transition the labor force away from punitive functions and toward roles of intervention, care, and restoration?"

"I'm a person that has been arrested in a full-blown mental health crisis in complete psychosis by Sac PD. And then I had the **sheriff's department release me at 3am, still in full blown psychosis**. And so, **these are the types of behaviors that we need to see change differently**. That's fully within the Sheriff Department's control to not release somebody into the dark at 3am. Thank God my friends were there."

### Possible Data Measures

- # of cases (including calls to law enforcement and encounters in the field by law enforcement) where mental health or substance use is or becomes primary concern
- # and % of dispositions, by type (arrest, by type of charge; transportation to services by law enforcement; referral to EMS; stabilized in community, etc.)
- Average # of intakes and bookings per day; average # of releases per day
- Type of BH screening conducted (if applicable, specify name of screening tool) and at what point in the intake or booking process
- # of individuals screened for mental or substance use problems upon intake; % screening positive
- # of individuals provided more in-depth assessment for mental or substance use disorders
- # of individuals flagged for follow-up; % provided follow-up mental health / substance use related services

## Jails/Court

### Real Talk

"How does one get selected to participate in the Collaborative Court program and **how there is assurance of racial equity**, or at least equality?"

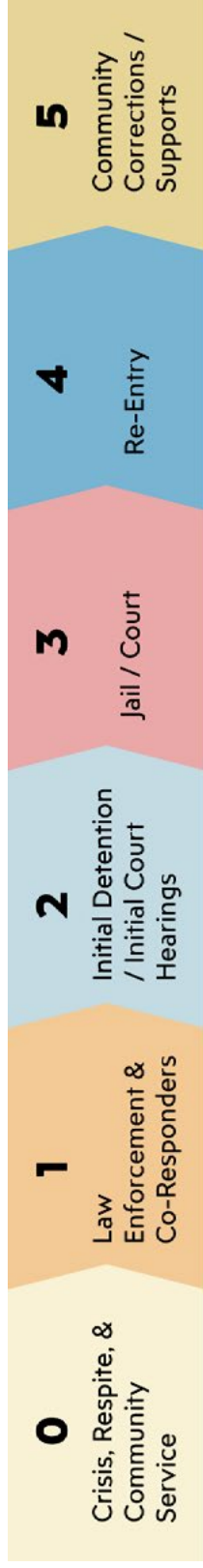
"**How do we increase the number of cases that are eligible for Mental Health Court?**"

"When a person, whether they're on parole, or whether they have a history of breaking the law, when they come into the county jail **have something in place to be able to receive them in such a way that they are receiving the mental health the treatment that they need**, instead of being pushed aside and thrown into the jail system that doesn't have the capacity to care and to identify care for them and identify their needs. And I didn't see that in the Sacramento County Jail."

"In my opinion **quality treatment should begin in jail** instead of waiting more than a year in jail to go to a state hospital before receiving appropriate treatment."

### Possible Data Measures

- # of initial hearings annually for people identified as having a mental or substance use disorder
- Rate of referrals to community-based services, including pretrial services, at initial hearings for this population, by agency initiating or requesting the referral (e.g., public defenders' office, prosecutor's office, judge)
- Rate of diversion to community-based services at initial hearings, as indicated by active engagement with service provider, by agency initiating or requesting the diversion (e.g., public defenders' office, prosecutor's office, judge)
- Type of pretrial services available and capacity of specialized mental health or substance use pretrial caseloads
- # of referrals to each treatment court; % of referrals accepted.
- Current capacity of each court
- # and % of individuals with a history of or currently experiencing a mental or substance use disorder (either self-reported or confirmed through health records)
- Average length of incarceration among people with mental illness versus the general population
- # of individuals connected to supportive services and programming (faith-based groups, employment training, education, etc.)
- # and % of individuals receiving facility-based behavioral health treatment services
- # of individuals placed or continued on medication-assisted treatment



## Re-Entry

### Real Talk

"We're talking about people go in and coming out of prison worse than when they came in in terms of their mental health. **We're talking about Post Traumatic Stress Disorder.**"

4

"We need to recognize that **community-based treatment and community-based supports**, like the public defender's pre-trial program, and other community-based reentry and support programs are **far more effective.**"

### Possible Data Measures

- # and % of persons receiving assessment(s) to shape reentry plan
- # and % of persons with mental or substance use disorders released annually
- # and % of persons released with psychotropic medications
- # of days of psychotropic medication or prescription coverage in possession upon release
- # of persons released with health insurance coverage (reactivated Medicaid, private insurance, etc.)
- Rate of linkage to reentry services

## Community Corrections/Community Supports

### Real Talk

"Instead of punitive punishment in parole leading the way, **it needs to have a hard shift to "How do I keep you home, healthy connected to support systems and making good decisions?** Violating for an 8-day period completely disrupts healing and restoration for someone returning home."

5

"Engagement is a huge thing. If you don't engage somebody that no matter what you're trying to give them a lot of times it's not impactful, because there's no engagement. They're the ones that have been through it, are the ones that can engage the community that needs to be served, so **utilizing individuals with lived experience [with] a lot the community-based organizations to help get those services and those resources across.**"

### Possible Data Measures

- # and % of persons being served by community corrections with identified mental or substance use disorders
- # of hours of mental health and substance use training of community corrections officers (both with and without specialized caseloads)
- # of CBO partners funded to provide community supports
- # and % of persons being served by CBO partners with identified mental or substance use disorders
- # of CBO staff (clinical & non-clinical) with specialized culturally competent training
- # of hours of culturally competent mental health training of CBO staff
- # and % of persons served by CBOs with improved mental health/reduced risk

<sup>i</sup> Adapted from the Sequential Intercept Model (SIM). <https://www.samhsa.gov/criminal-juvenile-justice/sim-overview>. See also <https://dce.saccounty.gov/Public-Safety-and-Justice/CriminalJusticeCabinet/Documents/SacramentoAdultSIM-WorkingDraft.pdf>

<sup>ii</sup> Source: SAMHSA (2019) Data Collection Across the Sequential Intercept Model (SIM): Essential Measures. Retrieved May 12, 2022. <https://store.samhsa.gov/sites/default/files/d7/priv/pep19-sim-data.pdf>  
Graphic inspired by Policy Research Associates, Inc.'s Sequential Intercept Model





Bakersfield American  
**B·A·I·H·P**  
Indian Health Project

**Community Health Assessment:**  
Octavio Escobido and  
Jackie Lopez,  
both Tejon Indian  
Tribal Members; honoring of  
Octavio at the  
Native American Heritage  
event on November 2021.



Darrel Garcia (Tubatulabal  
Indian Tribe-RIP) teaching  
Youth and Young Adults  
about traditional tobacco  
and safe practices at our  
**Native American Spring  
Gathering** event.



**Eagle Heart Drummers  
&  
Basket Weavers** teach  
preserving culture in our  
communities.





# The Cambodian Family



## Khmer During Pol Pot (English Translated Version)

I miss the past, that is a fact without saying.  
History of the Khmer kingdom, the sorrow that was deep in the heart.

Pol Pot era, cruelty occurred over expectancy, millions of  
Cambodians faced crisis, lord had no mercy for the citizens.

Working non-stop, morning ot night to no end.  
Children and adults were not able to complain.

We were overworked, then got sick from the lack of nutrients. Truth  
was, there was no food, no sympathy or mercy.

The sick received no care, left like animals to suffer alone;  
Some were severely ill and passed away, one after another.

When wind blew and rain stormed, still shivering with thin clothes,  
we couldnot beat the cold air.

When work was not satisfied, they punished us until we died.  
They called it “fixing” and took us away, though no one ever did  
return.

Lived like animals, depressed and in pain, every individual.  
Some lose consciousness or became crazy because the pain was  
too tremenous.

And their families, separated in despair, isolated every day from  
each other. They left their loved ones behind like everyone else.

Starting today, to all Cambodian citizens: please learn and  
participate in politics and the news in all provinces and unite as one.

– N. Srouy







## Hmong Cultural Center of Butte County (HCCBC)

has been working collaboratively with the Butte County Office of Education to expose Hmong Youth to Mental Health and Advocacy. HCCBC has been able to recruit and retain 14 active youth to participate and learn leadership skills to empower themselves and their peers. These 14 youths are learning to voice their opinions and suggestions. Share about their mental health needs and learn how to speak openly in front of an audience. The goals of empowering these youths are to help them break cultural barriers and shine light on other Hmong Youths to become leaders and change the model minority stereotype in their community. These youths will be the foundation to help survey the other Hmong Youth to survey the mental health needs in the Hmong Community.



# Vista Community Clinic



Photo Credit: Vista Community Clinic



# Sacramento

Statewide Partner	Local Partner	Population of Focus	Location	Event	Total Participants
California Black Health Network	ONTRACK Program Resources	Black/African American/African-Ancestry	Sacramento	Mental Health & Criminal 'Justice' Real Talk & Black Community's Voice Lifted Up	177

**Summary:** ONTRACK Program Resources convened a two day “Call and Response” session in Sacramento focused on the intersection of Black Mental Health and the Criminal Justice System. The first day focused on lifting up voices from the Sacramento Black community on their experiences specifically involving behavioral health and the criminal “justice” system (“The Call”). This session included a panel presentation of Black community members with lived experience, breakout sessions, large group sharing, and questions & answers. Day 1 panelists included Ryan McClinton, public health advocate; Raphael Calix, former lifer at San Quentin, Donetta Johnson who shared her described the differences between her experience at Sacramento and Butte County jails, Tamara Lacey, a family member who shared her lived experience supporting her grandson navigate his mental illness and incarceration, and wisdom from community activist Stevante Clark, Tifanei Ressler-Moyer, JD, co-founder of Decarcerate Sacramento, and ONTRACK Soul Space Empowerment Advocate, Keke Brown ([www.getontrack.org/realtalk](http://www.getontrack.org/realtalk))

***“One of my worst experiences was not having to serve thee (3) plus decades inside of the most violent state prisons in California or the nation. For me the worst experience of late, was when the Sacramento parole program created for me an impossible way to successfully continue on a path of not only recovery, but to be free from a system that was not trying to help me survive.” – Raphael Calix***

The second day highlighted new Sacramento County and City behavioral health and criminal “justice” related initiatives (“The Response”) to ensure that the Black community is aware of these local initiatives and the opportunities to have meaningful input and roles so that implementation is transparent, responsive, beneficial, equitable, and successful. This session included large group discussions, breakout sessions, questions and answers, and panel presentations from officials from the Sacramento City and County, including Alondra Thompson, LCSW, County Behavioral Health Services, Geoff Twitchell, PhD, Forensic Behavioral Health Division Manager, Chief Deputy Jim Barnes, County Sheriff Department, Chief Marlon Yarber, County Probation, Chief Daniel Hahn, City Police Department, Chief Deputy, Kathy Lester, City Police Department, Kelly Rivas, City Mayor’s Office, Tiffanie Synnott, Principal Criminal Attorney County Public Defender’s Office, and Special Guest: the Honorable Lawrence G. Brown, Collaborative Courts, Sacramento Superior Court, and final remarks by Ryan McClinton. Participants shared their experiences of incarceration, reentry, and foster care and talked about the specific types of reforms that would support moving people out of the justice system and into community services that would support their mental health.

The overarching theme from these discussions was how to center justice as a mechanism for reforming Black mental health and an underlying assertion that the way to promote Black mental health is to deconstruct its criminalization. Overall, Black people's behavioral health issues, clearly related to trauma, have been handled egregiously by the criminal "justice" systems, resulting in retraumatization to those incarcerated, their loved ones and the Black community at large. The four major Real Talk Focal Points/Themes included:

*"They are not offering any type of help to people coming out of jails or prisons or to the families that are visiting them.... at least to have materials about mental health available to families' visiting jails and prisons and the inmates coming out of those situations."*

*- ONTRACK Program Resources Participant*

### **Focus/Theme 1: Need for Black Community-Based Services, Resources, and Interventions**

Panelists and participants from the Black community overwhelmingly focused their remarks on the need for alternative effective, culturally responsive, trauma informed community-based services, resources, and interventions, including peer supports.

### **Focus/Theme 2: End Jail Atrocities.**

While somewhat less in volume, panelist and participant comments related to the need to end the atrociously inhumane conditions in the County Jail were some of the most powerful and compelling during the two-day sessions.

### **Focus/Theme 3: Funding Justice/Reform.**

Another topic that was raised powerfully by panelists and participants was the issue of funding and the need to look at this issue, especially as a source of revenue for community based services and resources.

### **Focus/Theme 4: New Levels of Collaboration, Inclusion and Empowerment of the Black Community.**

In terms of frequency, the need for a new level of collaboration was mentioned almost as much as the need for community-based services.

**Future Directions:** The good news from the Real Talk event is that there appears to be unprecedented willingness from key stakeholders within Sacramento's systems and Black community to work collaboratively on these issues. Since the event, ONTRACK Program Resources hosted a meeting with Junious Williams, Jr. to learn about and explore how collective impact could serve as a model to advance the collaborative efforts from the event. ONTRACK also applied for and received funding from the Department of Health Care Services (DHCS) from the Behavioral Health Justice Intervention Services grant program to launch the Community Health and Justice Project (CHJP). CHJP intends to transform the way Sacramento's criminal justice, behavioral health and community stakeholders work together in order to map a strategy to reduce Black/African Americans (Black) disproportionality and disparities using collective impact. CHJP will collaboratively develop a system change plan (Blueprint) to improve outcomes for Black people involved in the Sacramento criminal justice and behavioral health systems.



# Del Norte/Humboldt

Statewide Partner	Local Partner	Population of Focus	Location	Event	Total Participants
California Consortium for Urban Indian Health	True North	American Indian	Del Norte/Humboldt	Mental Health in Del Norte and Humboldt County: Town Hall	98

**American Indian:** True North hosted a virtual town hall meeting for Del Norte and Humboldt Counties to discuss mental health in the American Indian and other Indigenous communities. Participants were invited to share their experiences with the pandemic, isolation, overall health, hopes, and concerns. Further, they were encouraged to engage with local providers to jointly identify needs and gaps in access to health and behavioral health services. The event was attended by leaders from both Counties, professionals, and community members, including American Indian and the Latinx Indigenous communities. The event opened with music and a personal experience of mental health services, there was a state of mental health address followed by an open dialogue about mental health in small breakout groups. True North and participants noted that this event was a good first step and that their communities wanted more opportunities to connect around these topics and identify resources, as well as support education to continue to mitigate mental health stigma.

*“When we walk together, it’s amazing how far we can go.”*

*-True North Participant*

*“It can be difficult to find therapists who have similar values and cultural knowledge to share.”*

*- True North Participant*

Throughout the discussion, there was general agreement that there were problems with access and gaps in mental health services. While it is not new that there is a lack of resources, people appeared more willing to talk about it now and wanted to move beyond feeling hopeless about it. Many participants commented on the challenges of being in a rural environment where there is a lot of racism and discrimination. They spoke of the pow-

erlessness and fear that can come from asking for help, specifically from a system that may not value you. One participant noted that it was easier to become invisible than try to get help. However, even when a person attempts to access services, there was a note about service gaps and being overly reliant on a small group of providers or services. For example, there is only one place in Del Norte that will fill a particular injectable medication for mental health. However, a group of mental health consumers who have been prescribed that medication have been “banned” from the one pharmacy that will fill that medication because they have exhibited challenging or disruptive behavior at the pharmacy. A lot of the discussion centered around the challenges in finding a counselor or service provider who was a cultural match, could provide in-language services, and could come from a cultural framework. People shared stories of going through a crisis without appropriate interpretation services and family members not knowing what services were available or being provided as a result. Several participants discussed experiencing first-hand the youth

mental health crisis from interactions with their children or students. One school-based employee explained, ‘we have had to 5150 more students than ever in the last year and that is concerning.’ In Del Norte and Humboldt counties, school is one of the few areas where a considerable amount of community members assembles. Participants suggested increasing School-based mental health services with a cultural lens to impact stigma and provide more community healing. Participants also discussed the types of changes that would help their communities, including:

- Utilizing a cultural and holistic approach that includes getting back to the land for nurturing and connecting with roots.
- Looking into alternative mental health care with non-licensed providers like coaches, pastors, counselors, and traditional healers
- Identifying specific funding to support providers working and living in rural areas, specifically bilingual providers and reducing barriers for providers to work in rural communities (i. e. , fast tracking graduate requirements and placement)
- Strengthening the referral processes and connection to services
- Integrating and teaching healthy coping methods at schools.

There was a tremendous spirit of opportunity, and participants appeared to really want more time and more discussion to talk about these issues and explore what suggestions they have. True North acknowledges that this was the first of this type of event in their community and is committed to working with their communities to continue the conversation in the coming months and look for opportunities to move forward. Following the True North listening session, Del Norte County received significant funding from the Mental Health Services Student act grant which will establish mental health/crisis centers with five (5) full time employees (FTEs) at 1 junior high, 1 high school, and the alternative school. This secured funding will also establish a Behavioral Health Director for the school district.

# San Diego

Statewide Partner	Local Partner	Population of Focus	Location	Event	Total Participants
Latino Coalition for a Healthy California	Vista Community Clinics	Latino and Migrant Indigenous Residents	San Diego	Virtual Community Discussion: Emotional Well Being & Mental Health	32

## Latino/a and Migrant Indigenous Residents:

Vista Community Clinics held three listening sessions, two in-language and one in English in the northern part of San Diego County to share perspectives about emotional well-being and mental health. Participants were invited to discuss the meaning of mental health, their experiences with mental health care, and provide feedback on the MHS Community Planning Process (CPP). The first group started with the experiences and wisdom from promotores due to their knowledge of policy work; the second group focused on promotores and community members, including Lideres from Poder Popular (a longstanding trusted multigenerational community advocacy group aimed at voicing community needs and improving their neighborhoods.); and the third focus group included school staff, VCC staff from their FQHCs, and community members. The discussions focused on issues related to framing the mental health conversation, the increasing needs for mental health services, and how to best support mental health civic engagement.

***“We are making progress because at least people are already admitting that mental health EXISTS...but we are starting, especially in our Latino community.”***

***– VCC Listening Session***

There was an acknowledgement that it can be hard to even frame the conversation about mental health, how important it is to ease people into the conversation, and how even in a trusted space, it can be challenging. The mental health discussions were heavy, and people shared the sadness, loss, and experiences of depression following the events of the past couple of years. There was some sense that even though it was difficult to talk about, that it was becoming more acceptable

to talk about mental health and substance use, and there was a sentiment that everyone was either struggling or had an experience of mental health or knew someone who had. Before, people would stay busy and ignore feelings of sadness, depression, or anxiety. Now, there is more of an understanding that it’s okay to talk about it. While there is this change in openness to mental health,

***“The pandemic has left me with a deep and profound sadness, and feelings of isolation. It has taken away my family.”***

***– VCC Listening Session Participant***

there are still deeply ingrained beliefs that lead to this being a slow change over time. One participant exemplified this by sharing, ‘as a male and being first generation, you are taught to be strong and not show emotions, there is a social pressure.’ It is also important to acknowledge that because VCC is well known and trusted in their community and participants were familiar with staff,

more people were open to sharing their personal experiences and challenges. There was a lot of discussion around access. Participants discussed issues related to long wait times and not being able to get help when they asked for it or needed it. There were also insurance and documentation barriers as well as an acknowledgement that it is just hard to access mental health services, in terms of literal access as well as the courage to ask for help.

***“The provider didn’t understand me.”***

***– VCC Listening Session Participant***

There was also discussion about the cultural disconnect in that most providers are not reflective of the Latino/a/x community and are not able to operate from a cultural framework. This included discussion about how community members might not understand the mental health process and how services progress. Questions such as, “What exactly is expected in this visit? What is the process? What is going to be provided?” were typical concerns. While there is a general structure to mental health services and how they are supposed to unfold and support recovery, this may not be known to those accessing services, which limits a person’s ability to prepare for and fully participate in services.

Participants had three main suggestions for continuing the conversation. The first was with using civic engagement strategies through their Poder Popular leadership group that recently started focusing on mental health policy and advocacy. The second was to create healthier spaces where people can congregate and build community using non-traditional approaches to mental health and wellness, such as community gardens, where people can get together and talk about mental health.

The third was to provide services through more of an on-going workshop or class format rather than individual appointments. They also recommended that schools could be a hub for community resources and provide parent workshops to offer information about local resources.

***“I didn’t know what to expect from the appointment, and I didn’t know how to prepare.”***

***– VCC Listening Session Participant***

### **Future Directions**

Vista Community Clinics is moving towards providing more integrated behavioral health services within their

Federally Qualified Health Clinics (FQHCs). They are planning to start in-house and build their own clinical capacity to directly provide behavioral health services in order to embed integrated care within their clinic operations. They are also hoping to connect with other behavioral health providers to provide integrated care. In addition, and as a result of these sessions, the Poder Popular group has started focusing on mental health policy and advocacy work. Since the event, VCC hosted their first Mental Health Fair: Sowing the Seeds for Healthy Minds / Sembrando semillas para mentes sanas on May 14th, 2022. This public event included health screenings, community resources booths, activities for all ages, and an opportunity drawing. The event was open to the public. The event was held on Saturday, May 14th at VCC: Vale Terrace location from 9am-1pm.



# Orange

Statewide Partner	Local Partner	Population of Focus	Location	Event	Total Participants
Southeast Asia Resource Action Center	The Cambodian Family	Southeast Asian	Orange	Community Dialogue on Mental Health and Wellness Forum	90

**Southeast Asian:** The Cambodian Family convened a three-day community dialogue on mental health and wellness in Orange County. Each day continued to build upon the previous convening and listening sessions had consecutive culturally relevant interpretation in Khmer (Cambodian). Day 1 was a listening session where participants shared their needs and knowledge about local mental health programs, services, systems, and advocacy opportunities. Building on the needs discovered from day 1, day 2 was an advocacy training where participants learned some fundamentals around the power of advocacy and how to communicate their mental health needs to key stakeholders. The final convening introduced community members to Dr. Veronica Kelley, Chief of Mental Health and Recovery Services at County at Orange Health Care Agency and Jenny Hudson, LCSW and MHA Coordinator who spoke about existing services and programs, County’s commitment to improving access to mental health services for diverse communities in Orange County, and how to provide feedback as a community member. These events allowed reflection on what the community has accomplished while reducing mental health stigma and training community members to be active mental health advocates. The Cambodian Family acknowledged that one of the key facilitators of success for their events is using interpreters who understand the language of advocacy and complex jargon in health systems, and to translate the context into something digestible for their community members.

**“Our Cambodian population in Orange County is very small compared to other ethnic groups. If we don’t share and advocate for our community, others will never know about our struggles and cultural stigma surrounding mental health.”**

**– The Cambodian Family Forum Participant**

There was discussion about how with trauma, symptoms may come unexpectedly, and that it is important to be able to access support quickly and without delay. Complicated access lines, wait times, geographic and linguistic isolation, and initial interactions that primarily focus on screening

and assessment information take away from a person getting the support that they need when they most need it, particularly if they have waited to ask for help until they couldn’t ignore it any longer. One staff shared that they had a mother come into their waiting room with her son who was suicidal. They had nowhere else to go and couldn’t find any help. The staff also tried to look for referrals and linkages, but all they

**“Our waiting room has become a de facto emergency room for people in mental health crisis.”**

**– Vattana Peong, Executive Director, The Cambodian Family**

***“We do not feel comfortable sharing with a therapist because of the language barrier and the difference in culture. Because most therapists are not from my culture, I don’t feel connected to the point where I can be comfortable and open up my personal feelings. Instead, I am more comfortable just treating myself.”***

***The Cambodian Family Participant***

could find was the Emergency Department, which is not what either the mother or son wanted, but there was nothing else for them. Other participants both shared feeling more comfortable talking about their mental health and expressed having more mental health need but not having services in language, in culture, or accessible.

Other participants noted that the barriers they experienced in trying to access mental health services actually made their mental health worse and that they were unlikely to reach out again in order to avoid the negative experiences they had while seeking services. Often times, the inability to access support re-traumatizes or further exacerbates the mental health issues they sought help

for in the first place. Part of the discussion focused on cultural competency with some discussion about whether or not county services could ever really become culturally competent or whether it made more sense to invest in culturally specific organizations that not only can provide culturally specific services but also culturally specific access portals. There was also a recognition that people were already going to the places where they are comfortable and feel safe to get help, such as The Cambodian Family, regardless of whether they provide mental health services.

***“Once, when I was in need of mental health services, I got a referral to see the therapist from the Family doctor. However, the address was too far for me, and the therapist could only speak English.”***

***– The Cambodian Family Forum Participant***

Consistent with the overarching themes of this report, participants continued to suggest:

- Hiring and training bilingual and bicultural mental health providers to provide mental health services for monolingual community members.
- Providing transportation and/or providing mental health services at local, accessible community organizations like The Cambodian Family
- Developing more opportunities for group support and community-based healing, so community members (especially elders) aren’t so isolated and can connect.
- Build a workforce that reflects the community in need of the mental health services, including creating a high-school-college-MSW/MFT pipeline for ethnic communities.

The event also focused on building advocacy within the participants. TCF staff explained that understanding cultural context is key when training community members on advocacy, especially in communities that have gone through a genocidal regime where they could be persecuted by their government for speaking up. This makes the role of the community-based organization even more important as they may serve as a bridge between community and the government. Many participants spoke about how they have learned to use their voice to advocate and have gained confidence because of the trainings. However, one person noted that it is hard to get into advocacy as it is basically unpaid labor. The event intended to help build a shared consciousness that, ‘our community needs are dire, funding is limited, and that the community can advocate for our

needs.’ The latter half of the event focused on building the tools and courage for advocacy as well as showing what has been accomplished in recent years as a result of advocacy. Additionally, there was a sentiment shared that advocacy builds resiliency and that it served not only to improve the system but also strengthen and empower the advocate.

# San Bernardino

Statewide Partner	Local Partner	Population of Focus	Location	Event	Total Participants
California Pan Ethnic Health Network	California Black Women's Health Project	Multi-cultural	San Bernardino	Culture, Covid-19, & Community: Mental Health Matters	47

**Muti-ethnic:** The California Black Women's Health Project hosted a conference entitled, "Culture, Covid-19, & Community: Mental Health Matters" in San Bernardino County. This multi-ethnic event invited community members from Black, Latinx, Asian Pacific Islander, Eastern European, Middle Eastern, and American Indian/Alaskan Native communities. The virtual event featured poetry by Sammy Carrera about invoking the power of ancestors, and a presentation by Dr. April Clay who discussed the County's cultural competence advocacy committees. Dr. Clay explained that the cultural committees meet regularly, provide a space of connection, and are powerful vehicles to strengthen community and county relationships. While she acknowledged that some subcommittees are poorly attended, she championed their ability to provide counsel and influence the county behavioral health department. The event also featured a presentation by Dr. Kendra Flores-Carter about mental health across the lifespan and the cultural and societal impacts and stressors related to COVID. The event even included a recorded message from Assembly Majority Leader Eloise Gómez Reyes who spoke about the policies she is championing to expand culturally and linguistically relevant services and encouraged stakeholders to share their mental health needs so she could advocate on their behalf at the State Capitol.

*"You don't know what's available unless you live in an area where services are available."*  
**- CABWHP Mental Health Matters Participant**

Following the presentation by Dr. Flores-Carter who works on a Perinatal Mental Health Initiative aimed at addressing disparities for childbirth and the maternal mental health system, participants were invited to join breakout discussions. Some participants started to reflect on their own journeys of how race factored into their treatment. Black and Latinx community members described how racism was a negative factor in their birthing experience. One participant described that when he and his wife were unable to have a doula and home-birth that when they arrived at the hospital, they were met with unwelcoming medical staff who did not listen to their cultural birth plan and dismissed their ideas and needs. He

*"We do not feel comfortable sharing with a therapist because of the language barrier and the difference in culture. Because most therapists are not from my culture, I don't feel connected to the point where I can be comfortable and open up my personal feelings. Instead, I am more comfortable just treating myself."*  
**- The Cambodian Family Participant**

One participant described that when he and his wife were unable to have a doula and home-birth that when they arrived at the hospital, they were met with unwelcoming medical staff who did not listen to their cultural birth plan and dismissed their ideas and needs. He



said, “There is a resistance to a holistic approach and mental health in general.” Other participants explained that due to negative experiences in other health departments, systems, and institutions that families are even less likely to want to receive mental health support. During the event, there were some familiar overarching themes, such as a sense that people had tried and tried to get the care that they needed but were unable to. Similarly, there were participants who were very well versed in available services compared to those participants coming from geographic areas in the County with limited resources. This highlights a challenge seen across California when there is an expansive geography with resources centralized in one or two areas in that the system thinks that there are so many services available, but the community doesn’t know about them or can’t get to them. As in previous years, participants continued to discuss the barriers of stigma in various cultural communities, and the need to for mental health educational campaigns that normalize the need for services. One participant described the stigma she faced from her Latinx family she started receiving services for mental health. Stakeholders suggested combatting mental health stigma by providing welcoming mental health messaging in places where people frequent like barbershops and grocery stores.

Participants uplifted the important work of peers and Promotores and underscored the need to build community capacity in addition to having more culturally competent providers and modalities teaching frameworks on cultural competence and cultural humility in health care.

***“My family mentioned to me when I was going to therapy for the first time that I was “weak-minded” because of that. That they never needed therapy and survived so why should I use those services, etc. Really sad that we have many who think like this.”***

***– CABWHP Mental Health Matters Participant***

Participants recommended:

- “Building energy” around data collection for Black and Latinx women’s experience with racism and with the maternal mental health system.
- Listening to the voices of immigrant families, who are often left out of the conversation.
- Partnering with trusted community members like Promotores, community health workers, faith-based leaders, teachers, and church communities as first line mental health responders.
- Creating mental health campaigns, literature, and educational opportunities in the community that address de-stigmatizing mental health help. This campaign could include video clips featuring the voices of trusted community members who have received mental health support and can share about the benefits.

Following the CABWHP event, Majority Leader Reyes secured \$10 million in the Budget Act of 2022 (AB 178) for the Golden State Social Opportunities Program to provide grants of \$20,000 per year for up to two years to students pursuing mental health careers who are enrolled in an in-state postgraduate program if they commit to working in a California-based nonprofit and the first priority is for current or former foster youth and homeless youth and second priority is intended to be given to individuals currently employed at a California-based nonprofit.

***“The peer to peer and cultural connection is critical, particularly for immigrant and Black communities. If we have bad experiences with the system, the peer to peer/community health worker and cultural connection model is good.***

***– CABWHP Mental Health Matters Participant***

# Project Partners

## Statewide Partners

---

### California Pan Ethnic Health Network (CPEHN)

CPEHN advocates for federal, state and local policies that advance health equity. We bring together the expertise, lived experience and concerns of California's diverse communities and we develop and advocate for a common health care policy agenda. We bring together and mobilize communities of color to advocate for public policies that advance health equity and improve health outcomes in our communities. We center racial justice, build courageous coalitions and boldly champion policies that will make the biggest difference in the health of communities of color.

---

### California Black Health Network (CBHN)

CBHN is the voice and trusted resource for Black Health Equity in California and the only Black-led, statewide organization dedicated to advancing health equity for all African Americans and Black Immigrants. CBHN conducts outreach, education, and advocacy to achieve health equity for Black Californians through the lens of understanding critical issues that lie at the intersection of racial justice, social justice, and environmental justice.

---

### California Consortium for Urban Indian Health (CCUIH)

Established in 2006, CCUIH is a nonprofit 501(c)(3) statewide alliance of Urban Indian Health Programs and substance abuse treatment facilities collectively referred to as UIHPs. By blending the leadership and experience of our consortium members with shared resource development, and by combining applied research with educational and policy advocacy efforts, CCUIH offers innovative strategies to support the health and wellness needs of the Urban Indian community in California.

---

### Latino Coalition for a Healthy California (LCHC)

Founded in 1992, the Latino Coalition for a Healthy California (LCHC) is the only Latinx-led statewide policy and advocacy organization protecting and advancing Latinx health equity. We are a cross-sector coalition of community leaders, advocates, policy advisors, administrators and providers united by our common belief in protecting Latinx health and advancing health equity for all. Our work consists of community-centered programming, policy and advocacy development, and strategic communications.

---

### Southeast Asia Resource Action Center (SEARAC)

SEARAC is a national civil rights organization that builds power with diverse communities from Cambodia, Laos, and Vietnam to create a socially just and equitable society. As representatives of the largest refugee community ever resettled in the United States, SEARAC stands together with other refugee communities, communities of color, and social justice movements in pursuit of social equity. Our work in California focuses on amplifying the voices of the largest Southeast Asian

American (SEAA) population in the United States, building community engagement and coalitions, strengthening the capacity of stakeholders, and producing key legislation to promote equity among SEAA communities on issues of health, education, and immigration.

## Local Partners

---

### **Bakersfield American Indian Health Project (BAIHP)**

Originally established in 1997, The Bakersfield American Indian Health Project (BAIHP) is an Urban Indian health program funded by the Indian Health Service as an outreach and referral center. It is the only Indian health care facility in Kern County. BAIHP serves a client population representative of over 220 tribes across the nation, whom currently reside in Kern County. BAIHP is a Public Health Case Management and Referral Program that focuses on improving the access and utilization of quality health care services for the urban American Indian population of Bakersfield, California. Our Team is committed to this purpose.

---

### **California Black Women's Health Project (CABWHP)**

California Black Women's Health Project (CABWHP) is the only statewide, non-profit organization that is solely committed to improving the health of California's 1.2 million Black women and girls through advocacy, education, outreach and policy. We focus on empowering Black women to take personal responsibility for our own health and to advocate for changes in policies that negatively affect Black women's health status.

---

### **Hmong Cultural Center (HCC)**

Hmong Cultural Center of Butte County was founded in 2000 as a non-profit 501(c)(3) organization in Butte County, California. The mission of Hmong Cultural Center of Butte County (HCCBC) is to improve the lives of individuals and families through culturally sensitive education, advocacy, support, and services. Our vision of Hmong Cultural Center of Butte County is to empower individuals to overcome challenges. HCCBC provides resources, community based family support and empowerment through the promotion of health, education, cultural integration, and social services to strengthen Hmong families and communities throughout Butte County.

---

### **ONTRACK Program Resources (ONTRACK)**

Since 1997, ONTRACK Program Resources (ONTRACK) has been a leader in the provision of training, consulting, and technical assistance services aimed at reducing disparities, and improving services for diverse communities. ONTRACK has built a reputation for providing culturally responsive, strengths-based, applicable expertise to hundreds of organizations across a wide range of private and public sector agencies, including behavioral health, health care, human services, educational, and social justice issues. ONTRACK works with public and private organizations to improve leadership and workforce skills, programs, and systems in order to better serve increasingly diverse communities and positively impact your bottom line.

### **Restorative Justice for Oakland Youth (RJOY)**

RJOY was founded in 2005. RJOY works from an anti-racist, anti-bias lens to promote institutional shifts toward restorative approaches. We provide education, training, and technical assistance and collaboratively launch demonstration programs with our school, community, juvenile justice, and research partners.

---

### **True North Organizing Network (True North)**

In 2014, True North leaders and staff participated in a “season of listening,” facilitating over 1000 conversations in North Coast communities. At the end, 220 people came together to set the course of the organization. United by shared values, community members identified five campaign issues for research and action: Water and the Environment, Immigrant Rights, Police Accountability, Mental Health and Homelessness, and Public Education. True North Organizing Network supports families, elders and youth of diverse faith traditions, races, cultures, and economic capacities—using the power of relationships and a disciplined community organizing model—to courageously challenge social, economic and environmental injustice in our region.

---

### **The Cambodian Family (TCF)**

The mission of The Cambodian Family is to promote social health by providing refugee and immigrant families the opportunities to develop the knowledge, skills, and desires for creating health and well-being in their lives. Our vision is to see refugee and immigrant families that are healthy, happy, self-reliant, and contributing members of society. The families we serve have good physical and mental health, satisfying jobs with good wages, kids who thrive in school, a sense of belonging to the larger community, and a comfortable community center of their own in which they take pride and feel strong support.

---

### **Visión y Compromiso (VyC)**

Visión y Compromiso is committed to community wellbeing by supporting promotores and community health workers through advocacy, leadership, networking, and training. We elevate the voice of California’s promotores by ensuring that promotores are heard, their work is valued and the environment supports healthy communities for Latino families. We provide promotores and community health workers opportunities to exchange information, share best practices, and build skills needed to understand and interpret the theory and methodology associated with their community work.

---

### **Vista Community Clinics**

Vista Community Clinic is a non-profit community health center dedicated to providing high-quality, comprehensive, compassionate and community-engaged health and wellness services to all those in need. Almost 50 years ago, volunteers opened Vista Community Clinic (VCC) in the basement of a city animal shelter to provide healthcare to poor people. In 2002, VCC was certified as a Federally Qualified Health Center and a Migrant Health Center. VCC remains committed to delivering high quality care to patients, regardless of insurance or residency status. VCC has



since expanded to operate nine (9) clinics, four (4) mobile units, and a Health Promotion Center in Southern California. The federal Health Resources & Services Administration named VCC a National Quality Leader in 2017 and a Health Center Quality Leader in 2020. The Center implements about 40 grant-funded projects a year, making more than 150,000 community contacts annually.”