Complete Testimony for the Little Hoover Commission Public Hearing on the Mental Health Services Act Tuesday, September 23, 2014 - 9:30 a.m. State Capitol – Room 437

(Revised 9-19-14)

First, REMHDCO would like to thank the Little Hoover Commission for inviting us to testify at this hearing. Since forming in late 2007, this is our first time being asked our opinion regarding the MHSA and reducing disparities in such detail. We are honored to provide this information to the Commission as you have had a record over many years of producing in-depth and comprehensive reports.

Here are written answers to the questions provided to us.

1. What is REMHDCO and how does the organization work to reduce mental health disparities?

REMHDCO stands for the ***Racial and Ethnic Mental Health Disparities Coalition***. REMHDCO's mission is: ***To work towards the reduction of mental health disparities among racial & ethnically diverse communities through advocacy and policy change***. REMHDCO is a voluntary coalition of individuals and organizations that focuses on being "agents for change" primarily at the state level which includes the Mental Health Services Act (MHSA).

Please see the Attachment 1 that lists REMHDCO's officers that also contains our Founding Members, as well as a partial list of the organizations that are represented by our members. REMHDCO is currently a program of the Mental Health Association of California, which serves as our fiscal sponsor until we incorporate as our own 501(c)3 organization.

<u>Activities</u>

- REMHDCO staff and members have provided public comment on disparities at all Mental Health Services Oversight and Accountability Commission (MHSOAC) meetings since 2007 and currently

participate at all MHSOAC Committee meetings either as a committee member or as a public attendee.

- REMHDCO staff and members also regularly attend and make public comment at:

    - The California Mental Health Services Administration (CalMHSA) Board of Directors meetings and CalMHSA Advisory Committee meetings.
    - The Cultural Competence, Equity, and Social Justice Committee of the California Behavioral Health Directors Association.
    - The Advisory Committee for the Center for Multicultural Development of the California Institute for Behavioral Health Solutions.

- REMHDCO facilitates the "MHSA Partners Forum" – an informal monthly meeting of government and community representatives where any issues regarding the MHSA are discussed.

- REMHDCO has been on the planning committee and attends the semi-annual Mental Health Policy Forum where attendees include the County Mental/Behavioral Health Directors and Executive Directors of the major private non-profit providers.

- REMHDCO meets with State Departments including the California Department of Public Health (Office of Health Equity), the California Department of Health Care Services, and the California Office of Statewide Planning and Development in regards to MHSA issues.

Accomplishments

- REMHDCO's most significant program accomplishment is being awarded the contract for administration of the California MHSA Multicultural Coalition (CMMC) which is a key component of the California Reducing Disparities Project (CRDP), a ground-breaking statewide project funded by the MHSA since 2010.

  Please see Attachments 2 and 3 regarding the CMMC and the CRDP.

- REMHDCO's most significant policy accomplishments include advocacy that contributed to:

    - Keeping the administration of the CRDP with the Office of Health Equity (under the State Department of Public Health) instead of allowing any control of this project to go to counties. If this had gone to any other entity, REMHDCO believes there would not have been the *collaboration* with the racial, ethnic, and cultural communities to carry it out successfully.

    - Preserving the funds ($60 million) for the Phase 2 of the CRDP under the Office of Health Equity thereby allowing a governmental entity with knowledgeable and experienced staff, *trusted by communities* to continue work on the Project.

    - Ensuring that the requirements for the County Cultural Competence Plan were retained when the State Department of Mental Health was "reorganized" by the Governor's Administration in 2012. REMHDCO has also been key in making sure that the State Department of Health Care Services did not change them dramatically or weaken them.

    - Preventing the staff and the functions of the Office of Multicultural Services under the State Department of Mental Health from being dissolved when that department was reorganized. This result protected the invaluable knowledge and experience that had been developed by that Office over many years of hard work and research.

What are "mental health disparities" and "culturally competent services"?

The Institute of Medicine (IOM) has defined a health service disparity between population groups to be **the difference in treatment or access not justified by the differences in health status or preferences of the groups.** Mental health disparities have been noted as far back as 2001 in the Surgeon General's report, *Mental Health: Culture, Race and Ethnicity*, stated with the increasing diversity of our population, it was in the best interests of the nation to make sure that all of our populations are as healthy as they can be.

Both the Institute of Medicine and the National Institutes of Health (NIH) have prioritized disparities in mental health on their research agendas, and The President's New Freedom Commission on Mental Health included elimination of disparities as one of six goals for transforming the mental health system.

Culturally competent services have also been discussed as far back as the late 1980's. Generally, people in mental health are comfortable utilizing the definition developed by Terry Cross and others at Georgetown University that reads:

"Cultural competence is defined as a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals and enables that system, agency, or those professionals to work effectively in cross-cultural situations."

How the mental health needs of racial and ethnic communities might differ from other communities.

The mental health issues of racial and ethnic communities may not be that different from other communities. However, different approaches are needed to reduce the barriers to accessing mental health services that incorporate culturally appropriate help seeking behaviors such as creating natural settings for racial and ethnic communities to gather so trust can be established with a services provider. There is no short answer to this question, but one could start by accessing the comprehensive and relevant information included in the Phase I reports (there are five of them so far) of the California Reducing Disparities Project that can be accessed at:

http://www.cdph.ca.gov/programs/Pages/OHECaliforniaReducingDisparitiesProjectPhaseI.aspx

2. Has statewide capacity to provide mental health services and supports to racial and ethnic communities improved since passage of the MHSA?

The MHSA has undoubtedly increased ***the potential*** for more culturally competent services to be provided to racial and ethnic communities and for disparities to be reduced across the state. This promise is primarily evident in several aspects of the MHSA:

- The emphasis for government entities, including counties, to work collaboratively, in partnership with stakeholders, which should include representatives of racial and ethnic underserved communities.

- The **Prevention and Early Intervention (PEI) component** of the MHSA that allows prevention services that are based on ***community-defined practices or promising practices*** (as opposed to only *evidenced based practices*) and also allows programs to serve people before they are formally diagnosed with a severe mental illness.

  Other components and aspects of the MHSA may also increase culturally competent services to underserved communities but the PEI component is clearly the one with the most potential.

- The **California Reducing Disparities Project (CRDP)** is the most significant statewide effort to address this topic funded by the MHSA. [See Attachment 3.] This ground-breaking project is funded through the State Administration portion of the MHSA and is administered by the Office of Health Equity under the Department of Public Health.

  Development of the CRDP demonstrated some of the most robust stakeholder process by a government entity since the passage of the MHSA. This project will primarily focus on *promising practices* or *community defined practices*, although some policy changes will also be recommended through the Special Population Reports and the CRDP Strategic Plan. Phase 2 of this project has not yet begun.

<u>If so, what evidence do we have?</u>

Unfortunately, while the passage of the MHSA in 2004 gave hope to the vast array of multicultural communities in California, **we have very little evidence in the way of formal studies or evaluations regarding whether the MHSA has reduced disparities or increased culturally competent**

services. The state seems to be at this stage starting to address this area with more clarity but there is more work to be done.

There was a small study done by Dr. Ann Arneil-Py, then Executive Director of the California Mental Health Planning Council (CMHPC), several years ago that looked at penetration rates for some of the counties in California since the passage of the MHSA. Sadly, this study actually showed that the penetration rates for the four major racial/ethnic communities (African American; Asian/Pacific Islander; Latino; Native American) actually ***decreased*** since the passage of the Act.

Although the Act is almost ten years old, the MHSOAC has only recently completed its first evaluation of the Act regarding the reduction of disparities. [There was a small study in 2011 that utilized Geographic Information Systems (GIS) to Understand Mental Health Needs, Utilization and Access within a Social Context in California and in Three Selected Counties.] Several reports completed for this current evaluation have been posted on their website but none of these reports have been presented to any of the MHSOAC committees, nor to the Commission itself. **It is doubtful that any significant conclusions can be drawn from these reports,** so any recommendations must also be considered within very narrow contexts.

Although the MHSOAC has a Cultural and Linguistic Competence Committee (CLCC), this Committee's current responsibilities do not include assisting either the staff or the Commission in measuring the reduction of disparities. The CLCC does assist the Commission with outreach for its Community Forums and provide occasional cultural competence training for the Commission. Up until 2014, the cultural competence training for the Commissioners consisted of only a single one-hour training per year.

The MHSOAC Evaluation Committee has approved many evaluations regarding the Community Services and Supports component or *Full-Service Partnerships*. Since the majority of MHSA funds go to this component, REMHDCO has consistently requested for years that there be simple demographic studies on Full-Service Partnerships to determine whether racial and ethnic communities are being served in proportion to their numbers of members qualifying for these services. To date, no such information has been gathered and analyzed for such a study.

The California Reducing Disparities Project is not the type of project to measure or address the question of whether the MHSA has reduced disparities. Of course, it is hoped that valuable information on promising practices and policy recommendations will eventually lead to an increase in culturally competent services and the reducing of disparities, but it is too early in the project to make any claims yet.

County Cultural Competence Plans

There is great potential to evaluate and measure both cultural competence and the reduction of mental health disparities at the county level through the County Cultural Competence Plans that have been required in the past. **Collectively, these Plans can provide data that can be analyzed on a statewide level.** These are comprehensive reporting requirements that were developed by the former Office of Multicultural Services under the State Department of Mental Health, with input from the Ethnic Services/Cultural Competence Mangers from the counties. Through their contracts with the state, the counties have been required in the past to submit these plan reports on a regular basis.

Although given a 5-year reprieve from producing these reports when the MHSA was passed, there were County Cultural Competence Plans due to the State in 2010. The 2010 reports were to have included additional criterion to cover the county MHSA programs. These 2010 reports were to be scored and the results actually published on the State Department of Mental Health's website.

See Attachment 4 – The Reviewer Instructions which contains the Domains and the Criterion required in the 2010 County Cultural Plan

Tragically, when the State Department of Mental Health was reorganized in 2012, the responsibility for administration and oversight of these County Cultural Competence Plans was transferred to the Department of Health Care Services (DHCS). As feared by REMHDCO, the scoring of the plans was never completed and even our requests to have the plans themselves posted by the Department were never granted. Although REMHDCO and the California Pan-Ethnic Health Network (CPEHN) have met with DHCS periodically to let them know of our concerns regarding the Plans, neither of our organizations was invited to participate on the Department's Advisory

Committee on the development of a "new and improved" set of cultural competence plans.

Although the MHSOAC's evaluation on reducing disparities included a report consisting of a review of these 2010 County Cultural Competence Plans, as mentioned previously, it is doubtful that many conclusions or recommendations from this report will be strongly promoted.

Describe any challenges of which we are aware.

It is REMHDCO's belief that there are two primary challenges in developing evidence regarding whether cultural competence has increased and whether disparities are being reduced since the passage of the MHSA:

- **One is the current lack of even basic demographic data collected in a consistent manner by the counties so that disparities can be measured.**

- **The other is the need to have active and increased support by government entities collecting that data, and evaluating the data with the goal of reducing disparities.**

The race issue

It is impossible to discuss the topic of mental health disparities without mentioning that many in the mental health community prefer not to talk about *race* or *ethnicity* when discussing mental health disparities. So often, when the topic of mental health disparities comes up, many immediately preface their comments with statements such as, "There are many other disparities besides race and ethnicity in the mental health community such as……" (transition age youth, the LGBT community, those in rural communities, etc.)

This can also be examined by comparing the current definition in regulations of "Underserved" and the definition proposed by REMHDCO which was not submitted in time for consideration. (See Attachment 5) Notice that *race and ethnicity* are not mentioned until far into the current definition, but that the REMHDCO definition mentions these first, while still including all the other underserved communities.

3. What strategies, if any, would you recommend to help improve the oversight and evaluation of MHSA funds?

With regards to oversight and evaluation of MHSA funds in terms of increasing cultural competence and reducing disparities, there are many strategies that must be implemented in order to make a difference. Implementing a single strategy is unlikely to be successful as this is a "systems" issue.

In addition, REMHDCO believes that oversight and evaluation of the MHSA funds must include *administration* of the funds in terms of ***adherence to the values and principles of the MHSA***. Merely focusing on what monies are spent on certain programs will not provide the complete picture on the success of the MHSA at either the state or local levels. For example, genuine community stakeholder involvement and making sure "stakeholders" include representatives from underserved racial and ethnic communities must be measured because they have been faltering.

Lastly, one of the biggest obstacles to oversight and evaluation of the MHSA is recognition that there is currently no significant oversight and evaluation over the county mental/behavioral health departments by any state entity. The two primary entities, the MHSOAC and the Department of Health Care Services bear the primary responsibility but neither seems willing or able to do anything without the approval of the California Behavioral Health Directors Association (CBHDA).

Strategies regarding adherence to the values and principles of the MHSA

I. Increase and ensure representation or seats at decision-making tables and advisory committees for knowledgeable individuals whose priority is reducing disparities for underserved racial and ethnic communities. This must go beyond having a "diverse group".

- It is generally accepted that the MHSA and standard practice call for community stakeholders to include mental health clients/consumers and family members. Some even go as far as to differentiate between

family members of adults and parents or care-givers of children, providing separate seats for each. Others may also differentiate between different age groups within the client population such as seniors and transition age youth.

However, when it comes to representation of individuals knowledgeable about and committed to reducing disparities, very often, it is assumed that ***any person of color*** will suffice. This is not true! ***Diversity*** does not guarantee ***cultural competence***! While a person of color is likely to have an individual experience that should be valued, there is no guarantee that the person is willing or able to utilize this personal experience to provide information on working with that community.

Diversity may be an important component of cultural competence but just because a person is African American, or Asian, or Latino, or Native American does not mean that this person will be knowledgeable about how to reduce disparities or how to outreach to racial/ethnic communities, and most certainly will not guarantee that the person will prioritize and speak out about this issue. Conversely, there may be people who are white who may be experts in reducing disparities and are willing to advocate for this. (Kimberly Knifong of the Office of Health Equity is such an individual.)

- While there are Commissioners on the MHSOAC who support reducing disparities, there is no Commissioner who champions this issue and regularly speaks out about ensuring culturally competent services to racial and ethnic communities. An additional seat for such a Commissioner could go a long way to ensuring these issues are addressed.

II. Provide equitable MHSA funding and resources for organizations representing racial and ethnic communities.

There are three statewide organizations that represent consumer and family organizations that have received significant sole-source contracts for years from the State Department of Mental Health and more recently the MHSOAC. Although these are reputable and well-known organizations, they do not – from the viewpoint of leading racial and ethnic mental health

organizations – adequately represent and serve communities of color. Several years ago, another sole-source contract was given to a program for Transition Age Youth. Even though the majority of this age group in this state is made up of youth from racial and ethnic communities, there were no requirements in the contract to reach out specifically to them or ensure that they were served. REMHDCO has repeatedly requested that the MHSOAC provide a similar contract for a statewide organization that represents racial and ethnic communities so that consumers and family members from these communities can be represented, but the MHSOAC has consistently declined to do this.

There was recently an extremely important MHSOAC evaluation on the statewide and local stakeholder process. This evaluation was designed at a *Stakeholder Summit* of representatives of consumer and family groups, but did not include a single representative of an ethnic community based organization (ECBO) or organization representing racial and ethnic communities. When REMHDCO made inquiries about who was on this Steering Committee, we were not given any names but were assured that "there were people of color" on it. Again, just because there are people of color on a committee, does not mean that issues of cultural competence and reducing disparities will be adequately addressed, if discussed at all. We recently found out that there will be a follow-up project to provide technical assistance to counties on improving their local stakeholder process, based on the results of this study. How will the issue of inadequate stakeholder representation of racial and ethnic communities be addressed when the basis of this follow-up project are based on an evaluation that did not adequately involve or reach these communities?

Similarly, the California Institute for Behavioral Health Services (CIBHS) has managed a project called "Working Well Together" funded through MHSA funds to provide support to counties in working with and hiring consumers and family members. To our knowledge, this project had very limited interaction with experts in reducing racial and ethnic disparities, or organizations that specialized in serving particular racial or ethnic communities.

III. Government entities should develop independent and strong Community Advisory Committees, including a Cultural Competence or Reducing Disparities Committee, and be more

open to listening to them and following their recommendations.

In regards to oversight and evaluation of the MHSA funds, it is more efficient and desirable to ensure that the funds are spent correctly and in accordance with the values of the MHSA in the first place. This is especially important in the case of reducing disparities.

- The Office of Health Equity (OHE) under the California Department of Public Health is a leader among Government entities with the knowledge and experience of working in partnership with racial and ethnic communities. The staff of OHE were formerly with the outstanding Office of Multicultural Services under the California Department of Mental Health who developed and continue to administer the California Reducing Disparities Project.

  Other Government entities should look to OHE for how to work more collaboratively with community partners. OHE could certainly provide technical assistance in how to put together a strong and independent Cultural Competence or other Advisory Committee, although they should be not be expected to provide this assistance without being compensated.

  Now under the leadership of Jahmal Miller, the OHE is by far, the most trusted Government entity by representatives of community agencies serving racial and ethnic communities.

  Although other state entities may have some kind "cultural competence committees", they are neither as ***independent***, nor as ***strong*** as they could be. Sometimes, these committees have little connection with the upper management staff or the larger commission or governing body.

- The MHSOAC has a Cultural and Linguistic Competency Committee (CLCC). The CLCC are required to design their activities by a charter that is developed and approved by the MHSOAC with limited input from the CLCC. [More information on the CLCC was given above on page 6 of this report.]

- The California Mental Health Planning Council (CMHPC) has reputation for representing community stakeholders well but several years ago, disbanded their Cultural Competence Committee.

- The State Department of Health Care Services (DHCS) currently does not have a Cultural Competence or Reducing Disparities Advisory Committee, although there have been some indications that DHCS may form such a committee in the future. Currently, they are utilizing some members of the Office of Health Equity Advisory Committee to advise them on the development of the new County Cultural Competence Plan requirements. [See page 7 of this report for more information on CCPs.] However, these meetings to develop the County Cultural Competence Plan requirements are not open to the public, and members of the public are not even allowed to listen in to the meetings or conference calls.

- The California Behavioral Health Directors Association had a committee made up of all the County Ethnic Services/Cultural Competence Managers. These Ethnic Services Managers (ESMs) are very knowledgeable and committed to reducing disparities at the local level. However, they are usually not asked for input into CBHDA policy positions.

  A recent example is CBHDA's position on the draft Prevention and Early Intervention regulations being developed by the MHSOAC. Although as mentioned before in this report, Prevention and Early Intervention is crucial to reducing disparities and better serving racial and ethnic communities, CBHDA has a position opposed to collecting disaggregated data for communities such as the Asian/Pacific Islander, Latino and other communities. This position was developed without the input of the Ethnic Services Managers.

  Several years ago, CBHDA created a "Social Justice Advisory Committee" which had representatives from the community. Two years ago, CBHDA made the decision to combine this committee with the Ethnic Services Managers Committee. Neither Committee was asked for their input before the committees were combined. This combined "Cultural Competence, Equity, and Social Justice Committee" is now co-chaired by two County Behavioral Health Directors.

- The California Mental Health Services Authority (CalMHSA) does not have a Cultural Competence Committee, although it does have an "Advisory Committee". Their Advisory Committee has an equal number of County Behavioral/Mental Health Directors and community representatives.

Strategies for providing more oversight and evaluation of the County Mental/Behavioral Health Departments

What needs to take place in order for this to happen is ***culture change*** more than anything else we can recommend. At this time, particularly at both the MHSOAC and the State Department of Health Care Services, there is culture of accommodating and supporting the counties, even when community stakeholders are advocating for stronger oversight and accountability in terms of administration of the MHSA.

While REMHDCO is in no way suggesting that there be an adversarial relationship between the oversight bodies and the Counties, neither should there should be a relationship that values more what the Counties (through CBHDA) want more than what community stakeholders advocate for. When we say community stakeholders, we mean consumers, family members, and community providers, in addition to representatives of underserved racial, ethnic, and cultural communities.

There needs to be another culture change that involves more communication and collaboration between Government and Community partners. Just as the values of the MHSA direct the programs to be consumer and family driven, with transparency and collaboration throughout the process *at the individual level*, this also applies to developing increased transparency, collaboration, and partnership between the government and communities at *the administrative level*.

Currently, most MHSA Government Partners send representatives to the MHSA Partners Forum on a regular basis. This group of government and community representatives meets monthly to discuss policy issues related to the MHSA. This discussion takes place informally with all representatives present, in a manner that community partners prefer to giving 2-3 minute

public comments at various government hearings. Representatives have expressed the desire to have CBHDA representation at these Forums, as the County Behavioral Health Departments are the major providers of MHSA services. REMHDCO did meet with CBHDA in an effort to encourage them to participate more frequently than twice a year.

Also, earlier this year, despite a letter requesting that Community Partners be included at the table if the MHSOAC had negotiations with the CBHDA regarding the draft PEI regulations, our request was not honored. [See Attachment 6.] Not only was there no response to this letter, the MHSOAC met privately with CBHDA to discuss CBHDA's concerns with the draft PEI regulations. While REMHDCO acknowledges, as the attorney for the MHSOAC kept repeating that "No laws were broken", this was certainly a disappointing development in regards to the MHSA Government and community partnership.

Lastly, there has to be a culture change that recognizes the value of the recommendations and concerns of community stakeholders including but not limited by any means to REMHDCO. The nation and even other countries are watching to see how California increases access to mental health services and life expectancy of all its residents from every racial, ethnic, and cultural community within its borders. We are extremely grateful for the passage of Proposition 63 and remain optimistic that it can serve to transform the system as hoped by so many. REMHDCO welcomes the opportunity in the future to work in partnership with government entities towards that end. Once again, we sincerely thank the Little Hoover Commission for inviting us to provide testimony today as we believe this in itself, may be a turning point in our efforts to reduce disparities.

List of Attachments for REMHDCO Written Testimony For the September 23, 2014 Little Hoover Commission Hearing On the Mental Health Service Act

Attachment 1: List of REMHDCO's Officers, Founding Members, and Partial List of Members

Attachment 2: Purposes of the California MHSA Multicultural Coalition (CMMC) – a component of the California Reducing Disparities Project (CRDP)

Attachment 3: Fact Sheet on the California Reducing Disparities Project (CRDP)

Attachment 4: The Reviewer Instructions which contains the Domains and the Criterion required in the 2010 County Cultural Plans

Attachment 5: Current definition of "underserved" in the MHSA regulations compared with language proposed by REMHDCO

Attachment 6: Letter from MHSA Community Partners (including REMHDCO) to the MHSOAC requesting that if the MHSOAC met with CBHDA to discuss the draft Prevention and Early Intervention regulations, that the Community Partners be included in these negotiations.

[No response to this letter was received and the MHSOAC negotiated privately with CBHDA on the regulations.]

REMHDCO

Racial and Ethnic Mental Health Disparities Coalition

FOUNDING AGENCIES

California Disability Rights
California Family Resource Association
California Primary Care Association
Community Health for Asian Americans (CHAA)
Family Alliance for Counseling Tools and Resolution
Hmong Collaborative/Southeast Asia Resource Action Center
Latino Coalition for a Healthy CA
Mental Health Association in CA
Native American Health Center
Tessie Cleveland Community Services Corp.

MEMBERS

African American Health Institute of San Bernardino County
Asian Pacific Policy and Planning Council
Asian Americans for Community Involvement
Asian Pacific Community Counseling
CA Black Women's Health Project
CA Elder Mental Health & Aging Coalition
CA Federation of Independent Living Centers
Capitol Unity Council
Chamberlain's Mental Health Services
ECCAC Latino Community
Ethiopian Community Outreach Family
Harmonium Inc.
Hmong Women's Heritage Assn.
La Familia Community Counseling
Muslim American Society - Social Services
Magna Systems
Multi Ethnic Collaborative of Community Agencies (MECCA)
NAMI en Espaniol
Pacific Clinics
Slavic Assistance Center
Southeast Asia Resource Action Center
Southeast Asian Assistance Center
Special Services for Groups
Survivors of Torture
Union of Pan Asian Communities
The Village Project

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CMMC

CALIFORNIA MHSA MULTICULTURAL COALITION

What is the Purpose of the CMMC?

- The CMMC's primary goal will be to work toward the integration of racial, ethnic, cultural, and linguistic competence into the public mental health system.

- The CMMMC will provide a new platform for racial, ethnic, and cultural communities to come together to address historical system and community barriers and work collaboratively to seek solutions to eliminate barriers and mental health disparities.

- The CMMC will be a new structure to bring forward diverse multicultural perspectives that have not been adequately represented in the mental health system or in previous efforts to obtain consumer and family member input to improve outcomes in programs and services.

- The CMMC will be pivotal in providing critical insights and assessments of systems (i.e. policies, procedures, and service plans) in moving toward a more culturally and linguistically competent system.

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Fact Sheet

CALIFORNIA DEPARTMENT OF PUBLIC HEALTH OFFICE OF HEALTH EQUITY

CALIFORNIA REDUCING DISPARITIES PROJECT (CRDP)

Background and Purpose

In response to former U.S. Surgeon General David Satcher's call for national action to reduce mental health disparities, the former Department of Mental Health (DMH), with support from the Mental Health Services Oversight and Accountability Commission (MHSOAC), the California Mental Health Directors Association (CMHDA) and the California Mental Health Planning Council (CMHPC), created a statewide policy initiative to identify solutions for historically unserved, underserved, and inappropriately served communities. In 2009, the former DMH launched a statewide Prevention and Early Intervention effort, the California Reducing Disparities Project (CRDP), which focuses on five populations:

- African Americans
- Asians and Pacific Islanders (API)
- Latinos
- Lesbian, Gay, Bisexual, Transgender, Queer, and Questioning (LGBTQ)
- Native Americans

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

Phase I

Strategic Planning Workgroups (SPW)

Beginning in 2010, the CRDP funded the following five organizations to develop population-specific Strategic Planning Workgroups (SPWs):

- African American: The African American Health Institute of San Bernardino County
- Asian/Pacific Islander: Pacific Clinics
- Latino: The Regents of the University of California, Davis, Center for Reducing Health Disparities
- LGBTQ: Equality California Institute/Mental Health Association of Northern California
- Native American: The Native American Health Center

Each SPW is comprised of a broad representation of the diversity within their respective population group including, but not limited to, community leaders, mental health providers, consumer and family members, individuals with lived experience, and academia. The five SPWs worked to identify new service delivery approaches defined by multicultural communities *for* multicultural communities using community-defined evidence to improve outcomes and reduce disparities. Community-defined evidence is "a set of practices that communities have used and determined to yield positive results as determined by community consensus over time and which may or may not have been measured empirically but have reached a level of acceptance by the community."[1]

Each of the five SPWs developed a Population Report that included recommendations for reducing

[1] National Latina/o Psychological Association, Fall/Winter 2008, National Network to Eliminate Disparities in Behavioral Health, SAMHSA, and CMHS, Larke Nahme Huang, Ph.D

disparities and removing barriers to accessing programs and services, along with an inventory of community-defined promising practices that could support efforts to reduce disparities. The Population Reports are available on the CRDP website.

California MHSA Multicultural Coalition

Another component of the CRDP is the California MHSA Multicultural Coalition (CMMC). The CMMC addresses a variety of mental health issues and provides state-level recommendations on all of the MHSA components and related activities. The CMMC's primary goal is to integrate cultural and linguistic competence into the public mental health system. The CMMC provides a new platform for racial, ethnic, cultural, and LGBTQ communities to come together to address historical system and community barriers and collaboratively seek solutions that will eliminate barriers and mental health disparities.

By creating and funding this coalition, the CRDP developed a new structure to bring forward diverse multicultural perspectives that have not been adequately represented in the mental health system or in previous efforts to obtain input from consumer and family member and individuals with lived experience. Individuals who have expertise in areas concerning multicultural communities, community members interested in improving the public mental health system, and service providers who work with racial, ethnic, cultural, and LGBTQ groups form the membership of the CMMC. The coalition includes representatives from each of the five CRDP SPWs and also represents the broader unserved, underserved, inappropriately served diverse communities in California.

The CMMC provided input and support to the SPWs in the development of the CRDP Population Reports for each of the target populations and the CRDP Facilitator/Writer of the comprehensive statewide Strategic Plan to reduce disparities.

CRDP Strategic Plan

The California Pan-Ethnic Health Network (CPEHN) collaborated with the SPWs to compile the five Population Reports into one comprehensive Strategic Plan. Still under development, the Strategic Plan will identify culturally appropriate strategies to improve access to services, quality of care, and mental health outcomes for the five CRDP target populations. When completed in 2014, the CRDP Strategic Plan will provide the public mental health system with community-identified strategies and interventions that will result in relevant and meaningful culturally and linguistically competent services and programs that meet the unique needs of the CRDP-targeted populations.

Phase II

Phase II of the CRDP, to begin in 2014, will provide four years of funding to implement the practices and strategies identified in the CRDP Strategic Plan. The focus of Phase II will be on demonstrating the effectiveness of community-defined evidence in reducing mental health disparities. Through a multi-component program, the CDPH plans to fund selected approaches across the five CRDP-targeted populations with strong evaluation, technical assistance, and infrastructure support components.

After successful completion of this multiyear investment in community-defined evidence, California will be in a position to better serve these communities and to provide the state, and the nation, a model to replicate the new strategies, approaches, and knowledge.

For updates and more information about the California Reducing Disparities Project, please visit the CDPH Office of Health Equity web site at: http://www.cdph.ca.gov/programs/Pages/CaliforniaReducingDisparitiesProject(CRDP).aspx

2010 Cultural Competence Plan Requirements (CCPR)

DMH Information Notice No.: 10-02

Reviewer Instructions

CA Department of Mental Health
Office of Multicultural Services
Marina Castillo-Augusto, M.S, Acting Chief
January 2011

POST RATING PROCEDURES

A. OMS will input reviewers' scores into a spreadsheet and tally the scores, according to a predetermined formula[2], to determine the final score for the County's CCPR.

B. Utilizing written comments from the review team as evidentiary support, OMS will draft a summary letter to the County indicating the CCPR initial score, identified strengths, and areas for improvement and technical assistance.

C. The County will be given a 30-day period to provide a written response to the CCPR score and summary report. The County's response may include clarifying information regarding specific concerns from the review teams. Counties are not required to provide a written response, it is optional.

D. OMS will evaluate the supplemental information received to determine if the score will be adjusted.

E. If necessary, OMS will reconvene the review team to evaluate the supplemental information that may be provided in response to the summary report and score.

F. The final CCPR score for each County will be posted on the DMH website. The County's CCPR, OMS' Summary Report, and the County's written response will be posted along with the final score.

[2] OMS will use the average scores of the review team to determine a final score for the County's CCPR. The formula for the final CCPR score is based upon a predetermined weighted percentage for each criterion and the overall score. For more information about the formula, please contact the Office of Multicultural Services, (916) 651-9524 or via email at OMS@dmh.ca.gov.

Comparison of Language for "Underserved"

The current language in the MHSA emergency regulations:

Section 3200.300. Underserved.

"Underserved" means clients of any age who have been diagnosed with a serious mental illness and/or serious emotional disturbance and are receiving some services, but are not provided the necessary or appropriate opportunities to support their recovery, wellness and/or resilience. When appropriate, it includes clients whose family members are not receiving sufficient services to support the client's recovery, wellness and/or resilience. These clients include, but are not limited to, those who are so poorly served that they are at risk of homelessness, institutionalization, incarceration, out-of home placement or other serious consequences; members of ethnic/racial, cultural, and linguistic populations that do not have access to mental health programs due to barriers such as poor identification of their mental health needs, poor engagement and outreach, limited language access, and lack of culturally competent services; and those in rural areas, Native American rancherias and/or reservations who are not receiving sufficient services.

NOTE: Authority cited: Section 5898, Welfare and Institutions Code. Reference: Sections 5814(a)(1), 5814(d), 5814.5, 5830, 5840 and 5848, Welfare and Institutions Code.

Language proposed by REMHDCO:

"Underserved" means people from racial, ethnic, or limited/non-English speaking communities that have a demonstrated history of disparities in access to and utilization of appropriate, voluntary mental health services. Underserved may also include people from the lesbian/gay/bisexual/ transgender/intersex (LGBTI) community, rural communities, people who are homeless, transition-age youth, older adults/seniors, and other groups that demonstrate a disparity in access to community mental health services.

REMHDCO

December 4, 2013

Richard Van Horn – Chairman
David Pating, MD – Vice Chair
Mental Health Services Oversight and Accountability Commission
1300 - 17th Street, Suite 1000
Sacramento, CA 95814

Mental Health Association in California

Dear Mr. Van Horn and Dr. Pating:

The Community Partners who have signed this letter respectfully request that we and other community stakeholders be included in any future meetings to address the concerns raised by the California Mental Health Directors Association (CMHDA) regarding proposed changes to the Prevention and Early Intervention (PEI) regulations being developed by the Mental Health Services Oversight and Accountability Commission (MHSOAC).

CPEHN

The CMHDA letter dated November 20, 2013 that proposed significant changes to the draft PEI regulations was not available for review by any community partners prior to the MHSOAC meeting on November 21, 2013. We realize that there is a tight timeline to finalize the PEI regulations, but this meeting was the second time that major proposed amendments to the draft regulations were shared with Community Partners without any prior notice.

NAMI CALIFORNIA
The State's Voice on Mental Illness

We appreciate that the MHSOAC conducted an open and inclusive process to initially develop the draft PEI and Innovations regulations. We hope that in the spirit of the MHSA – promoting collaboration between government and community partners, transparency, and "doing business differently" – that the MHSOAC will include representatives of major community stakeholders as well as

Camhpro

CMHDA in any future discussions before adopting any of the changes proposed in their letter.

Sincerely,

Beatrice Lee

Beatrice Lee
President of the Racial &Ethnic Mental Health Disparities Coalition

Rusty Selix
Executive Director of Mental Health America of California

Ruben Cantu
Program Director of California Pan Ethnic Health Network

Caliph Assagai
Legislation and Public Policy Director of NAMI California

Sally Zinman
California Association of Mental Health Peer Run Organizations

cc: Robert Oakes
Executive Director of the California Mental Health Directors Association