











"WE AIN'T CRAZY!
Just Coping With a Crazy System"

Pathways into the Black Population for Eliminating Mental Health Disparities

love ity family courage peace togetherness culture faith love

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“NOTHING COULD BE MORE TRAGIC THAN FOR MEN TO LIVE IN THESE REVOLUTIONARY TIMES AND FAIL TO ACHIEVE THE NEW ATTITUDES AND THE NEW MENTAL OUTLOOKS THAT THE NEW SITUATION DEMANDS.”

MARTIN LUTHER KING, JR 1967

"We need more African American providers. The system must respond to that. We need someone who understands where I am coming from culturally. I need someone comfortable enough to sit and talk with use from my culture to understand what we need in our family. Right now, we do not get the help we need. This system has failed, and continues to do so."
37 year old Black single mother, daughter with schizoid-affective disorder
Solano County Client Family Member (Bay Area Region)

"It's amazing to me that Black people are not in an insane asylum. Some of the types of things in my 79 years, I have had to put up with just to survive, is amazing to me. As I think back over it. I should have been in counseling a long time ago. I think, if counseling was available to me, I would have been in counseling a long time ago. I wish I had access to talk to somebody about what I feel. If I can talk I can get this up. If I had access, I would have taken advantage of it. We need help from ethnically qualified counselors."
Helen B. Rucker, 79 year old Black community activist
Monterey County (Coastal Area)

"Major mental health problems for Blacks are depression, stress, and anxiety. We need safe communities and free and open health services."
25 year old African American, Latino, Caucasian single male
San Diego County (Southern Region)

"Proper diagnosis... I have two daughters; you know going through stuff...It's very frustrating.... I took them in for mental health services... But I think because one presented well, bright kid, it was like, 'Why are you here? You alright, you come from a good family." And I'm, I'm very upset about that. I feel like she didn't get the help she needed, because there's some things that we're talking about now that, that I think could have been caught when she was 16. She did not have a proper assessment."
57 year old African American female, client family member
Fresno County (Central Valley Region)

"I have a 17 year old son with ADHD. He does not like to take his medication. The medicine makes him mellow. He doesn't like that... I came from a family where my mother didn't take anything stronger than an aspirin, and she did not believe in pills and all of that...."
Glenn, 46 year old same gender loving gay male client family member
Sacramento County (Northern Region)

"I hate my family. They didn't treat me right. I was abused. I did not get the help I needed. Nobody helped me. That's why I am like this today. That's sad... I can't take care of myself. I have to have a care giver with me all the time."
Sharonda Capers, 38 year old Black female diagnosed bipolar
member Black Los Angeles County Client Coalition (BLACCC) (Los Angeles Region)

"I see mental illness as a dysfunction in a relationship, or something traumatic has happened to you..."
22 year old Black female, diagnosed with childhood depression
Riverside County (Inland Empire Region)

The African American CRDP is to be commended on the effort and quality of this first report on the rationale and the approaches to eliminating mental health disparities in the African American population in California. Although the report focuses on mental health of the African American population in California, it is clear from the Surgeon General's Report that the insidious elements of racial disparities are disturbingly nationwide.

The states of Ohio and Virginia have developed similar committees, studies, and reports that parallel the CRDP's findings and set of recommendations. In each of these state reports, there should not be any doubt about the importance of the charge, its complexity, or reality. Racial disparities are real phenomena and have devastating results in communities already suffering from poverty, addiction, and unemployment. There are multiple factors that make the work of the CRDP and their methodology difficult and illusive. One of these factors is the long history of mental disorders in the African American community and the contradictory policies and approaches that have been instituted in California and the rest of the United States.

These policies were initiated as early as 1765 in Virginia with the unscientific belief that Africans were immune from mental illness made its way into public policies. The resulting policies created a system of mental health care that left Africans without a means of accessing clinical services outside of the rubric of the Black church. Their reliance on the church is a second complicating factor since there are few linkages between the church and the more formal mental health system as was noted in New Orleans following hurricane Katrina.

Numerous reports over the decades have identified key factors within the formal mental health system that act as impediments to access by African Americans and their families. In its relationship to the African American population, the formal mental health system has offered inaccurate diagnoses, disproportionate findings of severe illness, greater usage of involuntary commitments, and a woeful inadequacy of service integration. Another impediment has been the tendency of African Americans to delay seeking help, sometimes for decades following the onset of mental illness. The complexity of these factors has created an intense stigma in the African American community that disparages mental illness as crazy – a condition and a status that is viewed as personally caused and difficult to resolve.

The California story, as shown in this report from the African American CRDP parallels these same issues and the need for new approaches to address the remnants of disparities. The African American CRDP Population Report offers a number of new thoughts and ideas about how to address a series of old and interrelated issues that need to be considered in this new decade. The African American Strategic Planning Workgroup has outlined a path that if followed and supported offers a vision for change and improvement.

King Davis, Ph.D., Professor and Robert Lee Sutherland Endowed Chair
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The African American Health Institute (AAHI) of San Bernardino County took on the enormous task of implementing the California Reducing Disparities Project (CRDP) for African Americans. The task required gathering information, identifying issues, and taking the time to understand and report community-defined practices from the perspective of the population that support indicators of mental health disparities for Black Californians. The CRDP African American Strategic Planning Workgroup (SPW), in addition, identified disparities in mental health access, availability, quality and outcomes of care regarding mental health issues.

This project, CRDP, services to continue the process of enlightening the general public about the on-going lack of appropriate preventive or early intervention of mental health services as well as services to initiate programs that address the disparities among Black Californians. Without a doubt, issues of depression, anxiety, alcohol, substance abuse, eating disorders, sleep disorders, sexual disorders, schizophrenia, bi-polar, dementias, stress, death and dying, suicide, domestic violence and a host of other physical causes of mental suffering, can be understood and treated. Therefore, a focus on early interventions that includes an educational approach regarding mental illness can lead to greater understanding, and awareness of treatment methods that eliminate incidents of disparities among Black Californians.

Mental health researchers and practitioners have collaborated to create treatment plans for groups, individuals and families as well as extended family members that address the most common mental difficulties and disorders that affect adults, children, and adolescents. The AAHI project identified barriers that especially prevent African American individuals and families from receiving services, and offered recommendations as well as plans that address the mental health needs of African American people.

I believe the CRDP African American Population Report serves as a bridge that will connect the dots for early treatment and appropriate intervention for people of African descent. In addition, I believe the project's goal is to end continued documentations of disparities and, implement programs that actively administer services throughout California that address the mental health needs of the African Americans. This project also addresses the need to establish funds to fight against system wide racial discrimination directed toward the African American population.

Efforts to address the issues of cultural populations that are presently "unserved, underserved, or inappropriately served" in the mental health system is overdue. I support the efforts of AAHI and the recommendation in this African American Population Report. We must change our system here in California to establish early intervention programs for Blacks and other cultural and ethnic groups.

Dee Bridges, M.F.T., B.C.P.C., President
African American Mental Health Providers of Sacramento

ACKNOWLEDGEMENTS

The California Reducing Disparities Project (CRDP): African American Strategic Planning Workgroup (SPW) Population Report is the product of a collaborative effort of different people of African ancestry including clients & client family members, consumers, traditional and non-traditional mental health providers such as, psychologists, social workers, prevention specialists, anthropologists, marriage and family therapists, academicians, researchers, nurses, psychiatrists, community-based and faith-based organizations, and many others. **Thank you** to every person that took time to participate in a focus group, or small group meeting, or public forum, or one-on-one interview, or complete a survey. Thank you for taking the time to share your thoughts, opinions, ideas, practices and recommendations. Without your extraordinary support, invaluable contributions, and responds to frequent queries and helpful research on current issues, practices, and statistics, this report would not have been possible. Again, thank you!

Special thanks to:

AAHI-SBC Staff: V. Diane Woods, Linda Williams, Nacole Smith, and Denise R. Hinds

AAHI-SBC Consultants: Daramöla Cabral, Stephanie T. Edwards, Valerie Edwards, Reverend James C. Gilmer, Suzanne Midori Hanna, Richard Kotomori, Walter Lam, Edward T. Lewis, Temetry Lindsey, Erylene Piper-Mandy, Carolyn Murray, and Wilma L. Shepard

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SPW Special Advisors: Nancy Carter, Cheryl T. Grills, Hanna Head, Robbin Huff-Musgrove, Nicelma King, Tondra L. Lolin, Gislene Mariette, Wade Nobles, Thomas Parham, Sharon Yates, Marye Thomas, and Gwen Wilson

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Videographers: Michael Blaze and the Skid Row Photography Club, William Brooks, Ken McCoy, David Moragne, Mariama Nance, The Blue Pyramid, and Kauzo Yamata

Graphic Design and Printing: Foran Concepts; San Bernardino City Unified School District Printing Shop; University of California Davis, Department of Human and Community Development

Volunteers: Davie Acosta, Abena Dakwa, Ezra Torru Dinwanbor, Patricia Douglas, Nelson Graves, Sherrice Mitchell-Williams, Vaurlon Smith, Armand Theus-Box, Simone Theus, Wafer Theus, Thelma Thomas

Student Interns & Research Assistants: Emerald Bradley, Jalisa Budd, Najela Cobb, Jaqueline Jones, Nia Rachelle Deese, Melissa Duncan, Magnolia Gonzales, Monisha Lewis, Banchamlak Shita, Camille Weldon, Robin D. Joseph, Rosy Uzuh, Aida Fall, Crystal Stubbs, Dominique A. Brown, Marissa Lang, Darion Jamar Rose

DEFINITIONS OF COMMONLY USED TERMS

African Ancestry/Descent: People having origins coming from Africa
African American: A person of African origin born in America (American citizen)
African: A person born on the continent of Africa
Afro-Caribbean: People of African ancestry born in the Caribbean
Afro-Latino: People of African ancestry born in Latin America

Community: Any group having interest in common; working together for mutual benefit

Community Defined Evidence (CDE): A set of practices that communities have used and found to yield positive results as determined by community consensus over time. These practices may or may not have been measured empirically (by a scientific process) but, have reached a level of acceptance by the community. CDE takes a number of factors into consideration, including a population's worldview and historical and social contexts that are culturally rooted. It is not limited to clinical treatments or interventions. CDE is a complement to Evidence Based Practices and Treatments, which emphasize empirical testing of practices and do not often, consider cultural appropriateness in their development or application. DHHS SAMHSA, 2009 / *Community Defined Evidence Project*

Client: A person with a mental health diagnosis

Client and Services Information (CSI) System: The California central repository for data pertaining to individuals who are the recipients of mental health services provided at the county level. CSI contains both Medi-Cal and non-Medi-Cal recipients of mental health services provided by County/City/Mental Health Plan program providers (CSI, 2011)

Consumer: One who uses mental health services for personal use

Client Family Member: Family member of a person with a mental health diagnosis

Culture: "The vast structure of behaviors, ideas, attitudes, values, habits, beliefs, customs, language, rituals, ceremonies, and practices peculiar to a particular group of people and which provides them with a general design for living and patterns for interpreting reality." Wade Nobles, 1986 *African Psychology: Toward its Reclamation, Reascension and Revitalization*

Cultural Competence: Having knowledge to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities (DHHS, 2011).

Culturally Congruent: *"Cultural consistency (congruency) means that the phenomena (prevention programs, training activities, and so on) can be judged as congruent with the particular cultural precepts that provide people with a 'general design for living and patterns for interpreting reality' (i.e., giving meaning to) their reality."* That is the program emerges and is predictable from the cultural substance of the group being served. Cultural congruent refers to the need for services and programming to be in agreement and consistent with the cultural reality of the community being served. Wade Nobles and Lawford Goddard, 1993 / *Toward an African-centered Model of Prevention for African-American Youth at High-risk*

Culturally Proficient: A level of knowledge and skills used to successfully demonstrate interacting effectively in a variety of cultural environments; consistently demonstrate what you know about a given culture; performance *(Parham, 2004)*.

Culturally Relevant: Reacting to others cultural suggestions or appeals

Culturally Sensitive: Highly aware of personal beliefs about other cultures and assumptions, and exploring the reality by asking others to give information that verify personal assumptions.

Health: Total person well-being, be it physical, mental, social, spiritual, or psychological

Health Disparity: United States Public Law (P.L.) 106-525, Minority Health and Health Disparities Research and Education Act of 2000 (page 2498): "A population is a health disparity population if there is a significant disparity [difference] in the overall rate of disease incidence, prevalence, morbidity, mortality, or survival rates in the population as compared to the health status of the general population." Health disparities are the persistent gaps between the health status of minorities and non-minorities in the United States. DHHS, 2010 / *The National Plan for Action to End Health Disparities*

Institutionalized Racism: Refers to a systemic and systematic set of attitudes, beliefs, and behaviors within social systems that reinforces concepts and actions of racial inferiority or superiority

Internalized Racism: Self perpetuated oppression

LGBTQI: An acronym that refers to people who identify themselves as lesbian, gay, bi-sexual, transgender, queer, questioning, or intersex; a group of people who embrace same gender loving (SGL) sexual orientation

Prevention and Early Intervention (PEI): Prevention and early intervention means the component of the Three-Year Program and Expenditure Plan that consists of programs to (1) prevent serious mental illness/emotional disturbance by promoting mental health, reducing mental health risk factors and/or building the resilience of individuals, and/or (2) intervene to address a mental health problem early in its emergence. California Code of Regulations, Title 9, June 2010

Penetration Rate: California DMH penetration rate in the CSI database referred to as "Comparison of Total Clients to Holzer Targets" and "Percent Difference from Target." The penetration rate was calculated by using census data combined with estimates that were calculated by applying prediction weights (CSI, 2011). The rate is determined by dividing the number of unduplicated clients by the number of average monthly eligible individuals, and then multiplying that number by 100. California Department of Mental Health, 2011

Prevalence: California DMH prevalence data in the CSI database shows the number of youth who have serious emotional disturbances (SED) and the number of adults who have serious mental illnesses (SMI). [Prevalence is defined as the total number of cases of a disease in a population at a specific time *(Webster's Dictionary, 2009)].*
California Department of Mental Health, 2011

Race: A socially determined or generated designation to a group based on genetic traits

Racism: Racism refers to more than attitudes and behaviors of individuals, but includes concepts of power, stratification, and oppression. It is the institutionalization of the attitude of race prejudice through the exercise of power against a racial group defined as inferior. Carolyn B. Murray, 1998 / *Racism and Mental Health*, p 345

Social Determinants of Health: The complex, integrated, and overlapping social structures and economic systems that include the social environment, physical environment, health services, and structural and societal factors. Social determinants of health are shaped by the distribution of money, power, and resources throughout local communities, nations, and the world. Scientists generally recognize five determinants of health in a population (CDC, 2011):

- Biology and genetics: such as, gender and age
- Individual behavior: such as, alcohol use, smoking, overeating, injection drug use
- Social environment: such as, discrimination, income
- Physical environment: such as, where a person lives, and crowded conditions
- Health services: such as, having or not having insurance, or access to quality care

Stakeholders: A person or organization with an invested interest

Strategic Planning: A disciplined effort to produce fundamental decisions and actions that shape and guide what organizations and communities will do, and why. The process requires the use of the best available information to make decisions now while considering future impact. Strategic planning requires broad scale information gathering, identification and exploration of alternatives, and an emphasis on future implications of present decisions. Strategic planning emphasizes assessment of the environment outside and inside the organization or community. R. Kaleba, (2006) / *Strategic Planning; Healthcare Financial Management,* 60(11):74-78

White Privilege: *"In critical race theory, 'White privilege' is a way of conceptualizing racial inequalities that focuses as much on the advantages that White people accrue from society as on the disadvantages that people of color experience."* Wikipedia Encyclopedia, 2011

LIST OF ACRONYMS:

CDE	Community Defined Evidence
CDMH	California Department of Mental Health
CRDP	California Reducing Disparities Project
CSI	Client and Services Information
DHHS	Department of Health and Human Services
GIS	Geographic Information System
LGBTQI	Lesbian, Gay, Bisexual, Transgender, Questioning, Intersex
MHSA	Mental Health Services Act
MHSOAC	Mental Health Services Oversight and Accountability Commission
NAMI	National Alliance on Mental Illness
PEI	Prevention and Early Intervention
PTSD	Post Traumatic Stress Disorder
RFP	Request for Proposal
SAMHSA	Substance Abuse and Mental Health Services Administration
SMI	Severe Mental Illness
SPW	Strategic Planning Workgroup

DISCLAIMER:

Throughout this document the words Blacks and African Americans are used interchangeably. They refer to people of African ancestry irrespective of nationality. The terms are used interchangeably because many people continue to refer to themselves in this manner and reports, statistics, and other resources use the terms in this manner.

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EXECUTIVE SUMMARY

The African American Health Institute of San Bernardino County, a non-profit 501c3 grassroots community-based organization, was awarded a $411,052 contract (#09-79055-006) to conduct the California Reducing Disparities Project (CRDP) for the African American population. Funds were made possible by the Mental Health Services Act (MHSA) 2004. Contract period was for two years, from March 1, 2010 to February 29, 2012. The primary deliverable of the contract was the development of a Reducing Disparities Population Report that would include an inventory of community-defined strength based promising practices, models, and/or other resources and approaches to help better address mental health needs. In addition, the Population Report will form the foundation for the final California Reducing Disparities Strategic Plan.

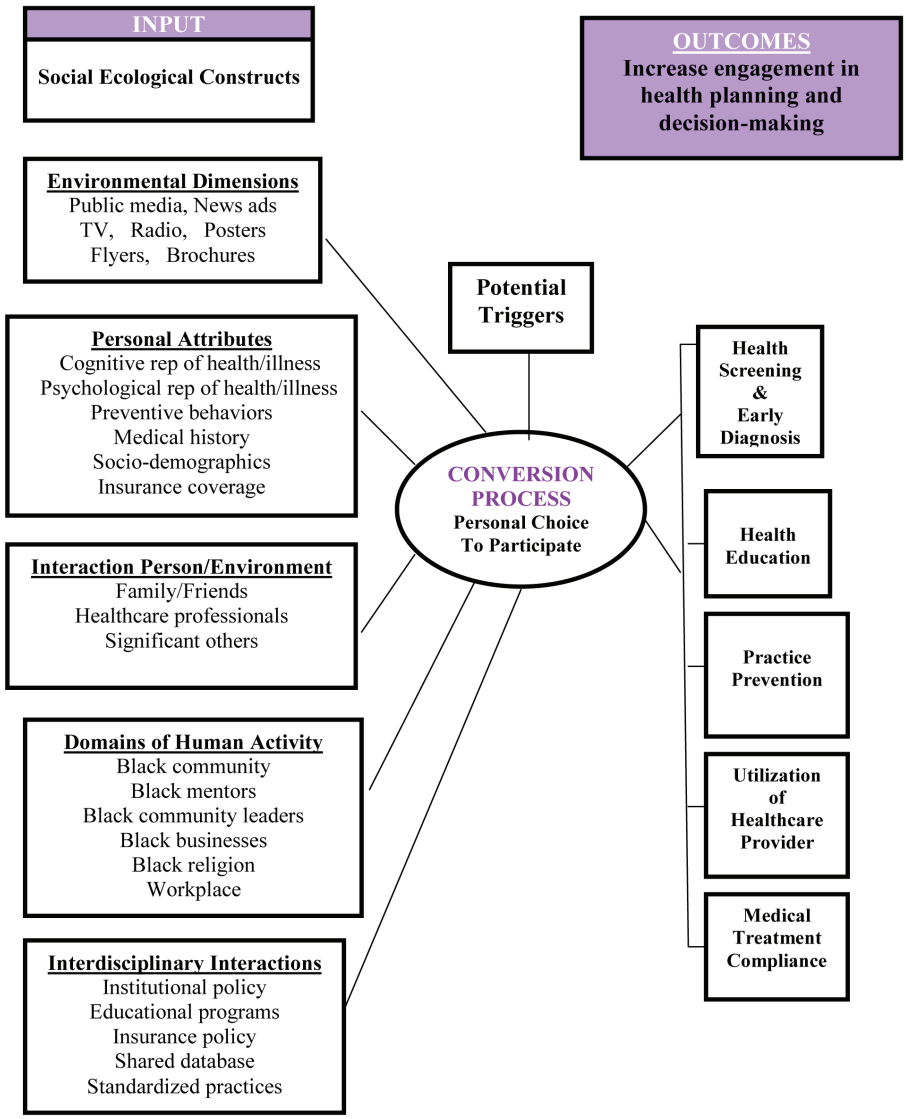
"We Ain't Crazy! Just Coping with a Crazy System" Pathways into the Black Population for Eliminating Mental Health Disparities is the population report created by the African American Strategic Planning Workgroup (SPW) during this contract period. It contains the most current disparity data and related information about mental and behavioral health prevention and early intervention (PEI) affecting the target population. Information in this report is about people of African ancestry living in California, including American citizens, Africans, Afro-Caribbean, Afro-Latino, Afro-Native American, Afro-Asian, Afro-Filipino, and African any other nationality.

"We Ain't Crazy! Just Coping with a Crazy System" is a descriptive investigative discovery of mental health issues and recommended community practices. Recommendations are based on meaningful practices as identified by the population.

DESIGN

The AAHI-SBC project design was framed according to a community grassroots engagement approach successfully implemented in the past by Dr. Woods while working with the Black population; see *Figure 1* our community engagement logic model (Woods et al.,2004a, Woods et al., 2004b; Woods, 2004c; Woods et al., 2006; Woods et al., 2008; Woods, 2009). Community-based participatory research (CBPR) methods were employed to implement a large scale population-based approach to engage Black people for project input from the beginning of the process unto the end.

A community grassroots ecological design was necessary based on the expressed needs of the population. According to their reported lived experiences Black people throughout California repeatedly expressed that their local DMH system has failed them and continue to do so. The population wanted assurance that participating in the CRDP and producing a population report was not going to be "business as usual." Participating in the CRDP was an affirmation that the population believed that the truth was going to be told. The Black population expressed they would **no longer be ignored, used, abused, or threatened, neither would they any longer tolerate inhumane, insensitive interactions from the local DMH system.** The CRDP design was to ensure that Black people had the freedom to comfortably share their perspectives without fear of retaliation or harm to client family members. This CRDP African American Population Report is the reality of Black people living in California and their experiences using the local DMH system for mental issues, as well as what they believe is needed for PEI.



A Social Ecological Logic Model Operationalize for the African American Health Initiative Planning Project in San Bernardino County, California (Woods, 2004c & 2009).

Figure 1: *A Community Engagement Logic Model*

NO EXCUSES. This report is not an excuse document. Our CRDP Population Report has been developed based on a fact finding approach. We have taken time to collect extensive data and present factual information based on the data collected. A strategic broad scale community-based approach was utilized to identify what Blacks in the State of California need for prevention and early intervention (PEI) of mental health issues.

We triangulated our fact finding approach to obtain a better insight into the issues and forthcoming recommendations. Therefore, a diverse Black population was engaged to include those affected by mental health issues, those who provide mental health services, as well as interested others. This approach involved **broad scale information gathering, identification and exploration of alternatives,** with emphasis on immediate actions and future implications. Special efforts were undertaken to identify expressed meaningful community-defined mental health practices and to make recommendations that would significantly change the way Blacks are treated and how they are provided mental health services in the State of California.

During the CRDP SPW efforts to create an African American Population Report to honor the request of the population for the truth to be told and that we must tell the "entire story" was the community driving force behind the process. We present the final CRDP results in a collection of several documents. Document #1 is the complete comprehensive report, *"We Ain't Crazy! Just Coping with a Crazy System" Pathways into the Black Population for Eliminating Mental Health Disparities.* It includes disparity data, a discussion on various barriers, a historical context, an overview of the California MHSA and how care is received and perceived by the population, presentation of various meaningful community practices as identified during statewide data collection with Blacks; policy, system, community and individual recommendations and resources. The *"We Ain't Crazy! Just Coping with a Crazy System" Executive Summary* (document #2) provides a snapshot of the CRDP community process used to develop the report, and highlights major project findings. A *"We Ain't Crazy! Just Coping with a Crazy System" Community Public Policy Brief* (document #3) is two pages and contains facts and major recommendations for the population. Finally, the collection of resources are separate published documents that include, a *Directory of California African American Mental Health Providers,* a compendium of *Black Mental Health Scholars and Scholarly Work,* a report on the *African American Practitioner Education and Training Curriculums in California,* in addition to specific county reports such as the *Los Angeles County African and African American Mapping Project* and the *Alameda County African American Utilization Study.*

STRATEGIC PLANNING PROCESS

The project was implemented in three stages: Phase 1, Phase 2, and Phase 3. A detailed discussion is included in Section D (page 123) of this report. The goal for Phase 1 was to establish the Strategic Planning Workgroup (SPW), and develop the background sections of the report. Utilizing the African American Health Institute of San Bernardino County's extensive statewide and national partnership network, diverse people of African heritage were contacted and invited to participate base on their availability to work on the project. Final SPW members, advisors and consultants totaled 58 individuals. A complete list of SPW members and their affiliation are included in *Appendix L*. Selected SPW members volunteered for a specific team assignment and agreed to work with the team based on a specific predetermined timeline for written project deliverables. The following individuals participated in key informant interviews and project pre-planning:

NAME	AFFILIATION	RESIDENT COUNTY & REGION
Valerie Edwards, LCSW	Clinical Social Worker	Alameda County, Northern & Bay Area
Richard Kotomori, MD	Psychiatric Medicine	Riverside County, Inland Empire
Walter Lam	African Immigrant Health, Consumer	San Diego County, Southern
Rev. James Gilmer, MA	Minister, Consumer	Ventura County, Los Angeles
Phyllis Jackson	Community Leader, Client Family Member, LGBTQI	San Diego County, Southern
Gloria Morrow, PhD	Clinical Psychologist	San Bernardino County, Inland Empire
Terri Davis, PhD	Counseling Psychology	Contra Costa County, Northern & Bay Area
Edward T. Lewis, MSW	California Black Social Workers Association	Sacramento County, Northern
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Stephanie Edwards, MPA	Resource Development, Client Family Member, LGBTQI	San Diego County, Southern
Suzanne Hanna, PhD	Marriage & Family Therapist	Riverside County, Inland Empire
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Erylene Piper-Mandy, PhD	Psychological Anthropologist	Los Angeles County, Los Angeles
Wilma Shepard, LCSW	Clinical Social Worker	Riverside County, Inland Empire
Carolyn Murray, PhD	Psychology	Riverside County, Inland Empire

Sequentially, an extensive literature review and archival resources were gathered on mental health in the Black population with emphasis on prevention and early intervention and published African American scholarly work. Over 200 articles were reviewed. This information was used to provide background data to guide the strategic planning process.

Phase 2 involved collecting information and data from the Black population. **Phase 3** was the final stage that included analyzing all data, writing the report, conducing validation meetings, finalizing the report, and collaboration in the development of the State Reducing Disparities Strategic Plan.

METHODS

We used a mixed methods approach framed in an ecological design to engage statewide community participation. Community-based participatory research methods used to engage the diverse Black population were regional focus groups, small group meetings, one-on-one interviews, public forums, and surveys using standardized processes, procedures and protocols. General information obtained from the population centered on good mental health and how to prevent mental issues, and how to intervene early when mental issues happen.

Participant recruitment targeted 19 different categories, such as: African American citizens, African immigrants, Africans (born in Africa), clients & family members, consumers, faith community, grassroots organizations, homeless, forensics, LGBTQI, substance abusers, foster care, older adults, musicians, artist, youth (students), government officials, mental health providers, social workers, Black mental health workers, educators, teachers, and academics. Each regional consultant was responsible for recruiting for project participation and for making sure regional input was maintained in the project. After initial data and information was collected and compiled in a draft population report, public forums were conducted in each region to validate report content and to obtain additional information from the population.

A total of **35** focus groups, **43** one-on-on interviews and **9** public forums were conducted; **635** surveys administered; and 6 small group meetings attended to collect data. See the summary participant demographics below across all target populations and methods of data collection.

A Matrix of the African American CRDP Participants across All Methods of Participation

	SPW, Advisors & Consultants	Phone & Email Surveys	Focus Group Participants	In-depth 1-on-1 Interviews	Small Group Attendees	Consumers, Clients, Client Family Member Surveys	Public Forum Attendees
TOTALS	**58**	**70**	**260**	**43**	**98**	**305**	**188**
Female	72%	70%	53%	46%	59%	68%	68%
Male	28%	30%	47%	54%	41%	32%	32%
LGBTQI[1]	1%	NA	9%	2%	13%	5%	3%
Age Range	28 - 73	NA	17 - 81	29 - 81	NA	18 - 82	18 - 82
Average Age	54	NA	46	56	NA	51	52
Consumer, Client & Client Family Member	57%	NA	69%	42%	65%	47%	35%

[1] LGBTQI = Lesbian, Gay, Bisexual, Transgender, Questioning/Queer, Intersex

MAJOR FINDINGS

A total of **1,195 "unduplicated" individuals** statewide participated in the African American CRDP, including SPW members, consultants, advisors, contractors, volunteers, as well as participants in focus groups, surveys, individual interviews and public forums.

Using the best available data, the African American population revealed alarming statistics related to mental health, such as high rates of serious psychological distress, depression, suicidal attempts, dual diagnoses, and many other mental issues. Co-occurring conditions with physical health problems such as high rates of heart disease, cancer, stroke, infant mortality, violence, substance abuse, and intergenerational unresolved trauma provides a complexity of issues that places the population in a **CRISIS** state. In the report we present the most recent California mental health data available to provide a visual picture of the population's condition.

In relationship to the Black population, the mental health system has offered inaccurate diagnoses, disproportionate findings of severe illness, greater usage of involuntary commitments, and a woeful inadequacy of service integration. The complexity of these factors has created an intense stigma in the Black community that disparages mental illness as "crazy" – a condition and a status that is viewed as personally caused and difficult to resolve. The Black population has rejected the label "crazy" and continues to work within their communities using strategies and interventions they know works to help their people overcome physical, social, emotional and psychological limitations and challenges.

But, data is missing that would clarify how "persons" use the mental health system, and the actual level of care received which is critical in determining how to prevent mental illness in the population. Findings in the CRDP are based on actual lived experiences of the Black population in California and documentation about the population and current mentail health system

RECOMMENDATIONS

As a result of reviewing the most current data available and information collected from the people, we provide several new thoughts and ideas about how to address a series of old, unresolved, interrelated issues that perpetuate disparities.

Participants were clear in articulating 274 PEI practices that are helpful at the individual, community and systems levels. If practices are implemented in counties, they could help to improve and enhance the existing mental health system, as well as assist in re-designing the system to align with culturally congruent practices for PEI in people of African heritage. Our CRDP African American Strategic Planning Workgroup has outlined a pathway into the Black population to eliminate mental health disparities as recommended by the people affected by mental health issues. If followed and supported offers a vision for permanent change.

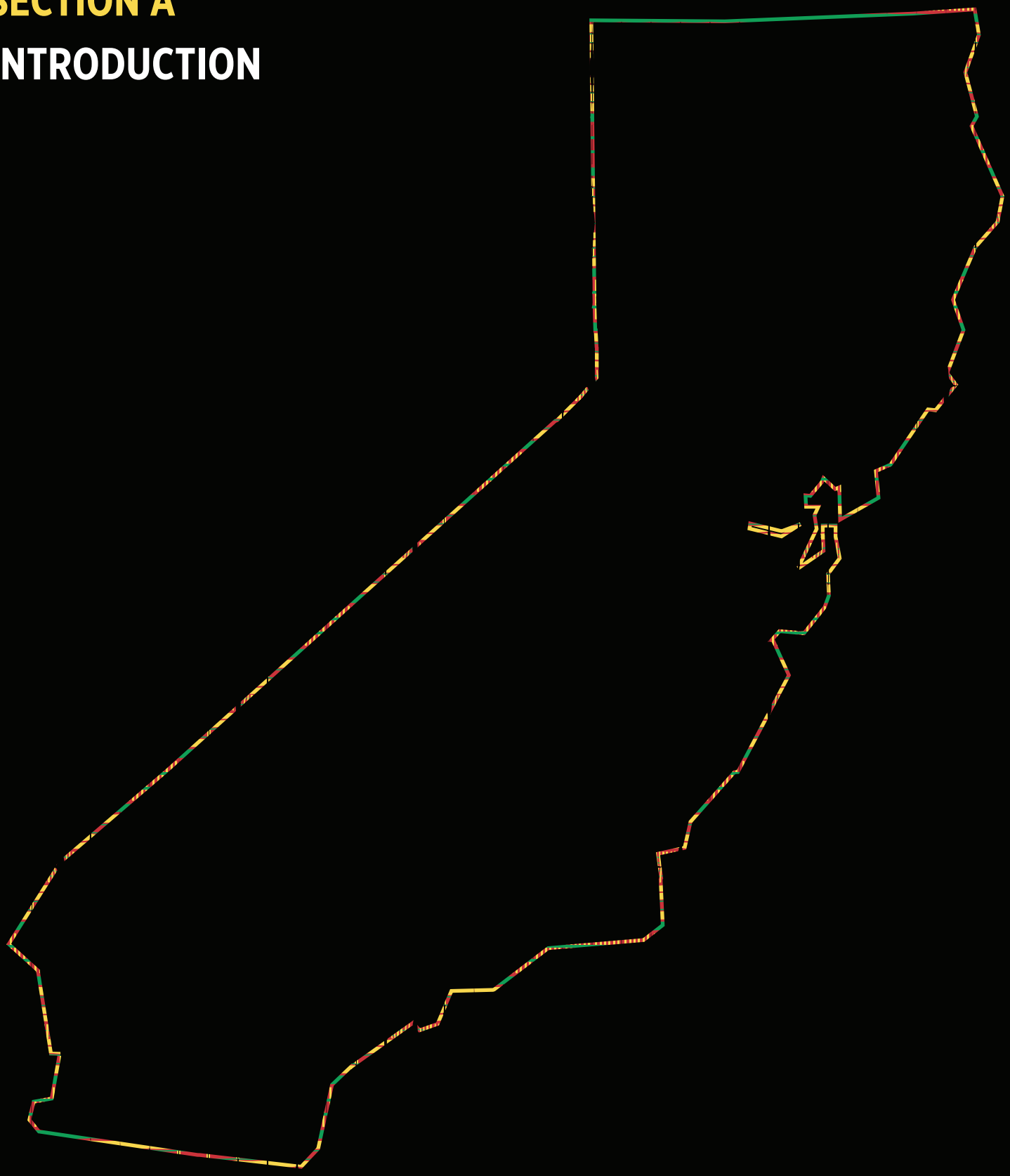
However, complex, aggressive, and urgent actions are needed. Immediate responses are demanded by Black people based on what the population identifies as their need for help. NOT what the system wants to do that is easy or convenient for the system. The recommendations from the population need to be accepted to bring health and healing to people of African ancestry living in California.

“WE ARE THE CHANGE.”



nityrespecthopecompassiondignityfamilycouragepeacetogethernessculturefaithloveu

SECTION A
INTRODUCTION



INTRODUCTION



This is the 21st Century. Our world has drastically changed. We are a global community. The past has shaped our present and is critical to our future survival. The California Reducing Disparities Project (CRDP) African American Population Report is about defining community-based evidence for mental health of people living in California (a western regional state of the United States of America). This is a NO EXCUSES report. The specific aim of the report is to document mental health disparities and to present the perspective of the Black population on what practices they believe are meaningful for prevention and early intervention of mental health issues. The report provides tools for individuals, communities, consumers, policy makers, providers, and funders to improve mental health.

After the introduction there are four sections of the report; the Statement of Problem, Service Delivery to Blacks, Data Collection and Analysis, and Final Recommendations. Section B, the Statement of the Problem describes the complexity of various dimensions of challenges faced by African Americans in the mental health system. Section C, Service Delivery is a brief overview of how mental health services are currently delivered to the Black population. Section D, Data Collection provides details of the CRDP including how information was obtained from the population, the data collection methods and analysis. Section E, Final Recommendations identifies meaningful community practices, strategic recommendations for local, community and statewide implementation, as well as examples of current projects, programs and initiatives conducted by Blacks.

The terms Blacks and African Americans are used interchangeably in this document because people continue to refer to themselves in this manner, and scientific reports and statistics use the terms to represent people of African ancestry irrespective of nationality. We acknowledge that African people in America are different relative to their country of origin. We also acknowledge that Black people living in California (irrespective of country of origin), all use the mental health system and are included in this report. All Black people in America have African ancestry.

BACKGROUND

Promotion of human rights, more than ever before, remains in the forefront of international efforts. On December 21, 1965, under resolution 2106 A (XX) the United Nations (UN) adopted the International Convention on the Elimination of All Forms of Racial Discrimination (United Nations, 2010). About 45 years later on December 10, 2010, the UN General Assembly declared the year 2011 to be the International Year for People of African Descent. To launch this special initiative a UN Working Group of Experts on People of African Descent developed an agenda to fight against issues of structural racial discrimination, xenophobia, racism, and other related prejudices directed toward people of African descent irrespective of nationality. Our Population Report is dedicated to the 2011 *International Year for People of African Descent.*

The U.S. Department of Health and Human Services (DHHS) continues to document disparities in access, availability, quality, and outcomes of care. Mental health disparities among racial/ethnic population groups have been declared a national problem, as reported in Mental Health: Culture, Race, and Ethnicity: A Supplement to Mental Health: A Report of the Surgeon General (DHHS, 2001) and The President's New Freedom Commission on Mental Health's Report Achieving the Promise: Transforming Mental Health Care in America (DHHS, July 2003).

According to the mental health report by the DHHS (2003), across the nation's racial, ethnic and cultural populations are unserved, underserved or inappropriately served in the mental health system. These disparities have been attributed to a limited ability of publicly funded mental health systems to understand and value the need to adapt service delivery processes to the histories, traditions, beliefs, languages and values of diverse groups (DHHS, 2001). This inability results in misdiagnosis, mistrust, and poor utilization of services by ethnically/racially diverse populations (Snowden, 1998; Takeuchi, Sue, & Yeh, 1995).

In America, The Patient Protection and Affordable Care Act, March 23, 2010 and the Health Care and Education Reconciliation Act, March 30, 2010, collectively known as "The Affordable Care Act" have become law. The Affordable Care Act (ACA) recognizes that prevention and early intervention, as well as treatment of mental and substance use disorders are an integral part of improving and maintaining overall health (DHHS, 2011 www.HealthCare.gov). During the height of the U.S. health reform debate, the California Department of Mental Health (CDMH) is to be commended for its leadership in launching a significant landmark initiative to re-design the state public mental health system to address disparities based on expressed population needs.

The CDMH brought forth a carefully crafted statewide initiative to engage ethnic, racial and cultural groups to identify appropriate programs, interventions, resources and systems that will meet their needs for mental and behavioral health issues. In 2009, the CDMH released a request for proposal (RFP 09-79055-000) entitled, California Reducing Disparities Project Prevention and Early Intervention Mental Health Services Act Strategic Planning Workgroups. The RFP was developed in response to the glaring disparities that exist in mental health care for diverse populations.

The purpose of the California RFP was to:

> *"... reduce ... disparities by bringing forward community-defined solutions and recommendations developed by workgroups comprised of community representatives (from five populations: African Americans; Asian/Pacific Islanders; Latinos; Lesbian, Gay, Bi-sexual, Transgender, and Questioning [LGBTQ]; and Native Americans) ... to develop Strategic Planning Workgroups (SPW). These [SPWs]... would identify population-focused, culturally competent recommendations for reducing disparities in mental health services, and seek to improve outcomes by identifying community-defined, strength-based solutions and strategies to eliminate barriers in the mental health systems. This RFP will seek to engage these communities to support the California Department of Mental Health (DMH) in implementing the California Reducing Disparities Project (CRDP) for the Prevention and Early Intervention (PEI) component of the Mental Health Services Act (MHSA). The principal deliverable of this project will be the development of the comprehensive California Reducing Disparities (CRD) Strategic Plan, with a focus on PEI, which will include the Reducing Disparities (RD) Population Reports for each of the five populations. This CRD Strategic Plan will provide the public mental health system, with information of community-identified tools to integrate relevant and meaningful culturally competent PEI services and approaches to meet the unique needs of the racial, ethnic, and cultural communities in California"* (California DMH 2009 RFP 09-79055-000, page 1).

Each of the five awarded population groups was to produce a specific Reducing Disparities (RD) Population Report and to work with the MHSA Multicultural Collaborative and the CRDP Facilitator/Writer to produce the California Reducing

Disparities (CRD) Strategic Plan. The purpose of the RD Population Reports was to provide inventories of community-defined strength based promising practices, models, and/or other resources and approaches that will be helpful to practitioners, program planners, and policy-makers in designing and implementing effective PEI programs. The intent was to reduce barriers, improve services to better address mental health needs and reduce disparities. Population Reports was to form the foundation for the statewide CRD Strategic Plan.



CALIFORNIA MENTAL HEALTH SERVICES AND PROGRAMS

All services and programs offered by the California DMH are listed on their website at http://www.dmh.ca.go/services_and_programs/default.asp, see *Table 1*. In brief, an array of community and hospital-based services are for adults with a serious mental illness and children with a severe emotional disorder. Services are directly provided by local mental health departments such as: rehabilitation and support, evaluation and assessment, vocational rehabilitation, individual service planning, residential treatment, medication education and management, case management groups, and wrap-around services.

Programs are offered under several categories, such as state hospitals, forensics, community, children and youth, adults, quality assurance, and veteran's mental health services resources. *Table 1* also provides a list of services for each category. This CRDP Population Report is specifically commissioned to provide recommendations for culturally appropriate practices for the MHSA PEI component of community programs. According to the California DMH Section 5840 of the MHSA, acceptable PEI programs are best realized through implementation of two types of prevention activities: (1) those aimed at preventing the development of mental illness among individuals at high risk and (2) those aimed at identifying and preventing mental illness in the general public. The African American Population Report identifies the community perspectives on how to address both areas for PEI programming.

THE AFRICAN AMERICAN CRDP LEAD AGENCY

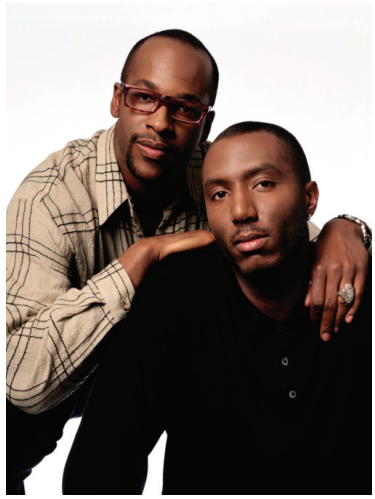
The African American Health Institute of San Bernardino County (AAHI-SBC) was awarded the contract for the African American CRDP. AAHI-SBC is a nonprofit, certified in January 2006 by the Attorney General of the State of California as a 501c3 corporation. AAHI-SBC's corporate office is located in San Bernardino County, California. AAHI-SBC is a Black-led and Black governed organization; 98% participants are Black residents and 2% are other interested people or organizations. AAHI-SBC is registered as a collaborative of diverse grassroots volunteers (this is a non-member organization) that are community-based, faith-based, professional, business, as well as others individual or organizational affiliates. Since its inception, AAHI-SBC has developed a network of local, regional, statewide, national and international partnerships. The impetus to develop AAHI-SBC was realized after the San Bernardino County local residents conducted a countywide strategic planning project under the direction of the County Medical Society, which utilized community-based participatory research (CBPR) methods to identify the health needs of their Black residents. Based on the results of this health planning project, local citizens came together to use their resources to focus on addressing the needs identified, to reduce the disparities in their people and to improve the overall health of the Black population.

In responding to the DMH request for a CRDP proposal, AAHI-SBC submitted a proposal to utilize the same community-based participatory research (CBPR) process successfully utilized in a countywide African American Health Initiative Planning Project (Woods, 2009) at the county level to engage people of African ancestry across California in the process of creating a disparity population report. A fully-executed contract (#09-79055-006; March 1, 2010 to February 29, 2012) for $411,052 was received from the DMH on April 14, 2010 to establish an African American Strategic Planning Workgroup (SPW) that would work collaboratively in developing the report, and to integrate with other state contractors in developing the statewide Strategic Plan.

Table 1: *List of California Mental Health Service Categories and Specific Programs*

Service Categories	Specific Programs
State Hospitals **Atascadero State Hospital** (San Luis Obispo County) **Coalinga State Hospital** (Fresno County) **Metropolitan State Hospital** (Los Angeles County) **Napa State Hospital** (Napa County) **Patton State Hospital** (San Bernardino County) **Porterville Psychiatric Hospital** (Tulare County) **Salinas Valley Psychiatric Program** (Monterey County) **Vacaville Psychiatric Program** (Solano County)	Inpatient Treatment Services for Serious Mental Illness Correctional Programs
Forensics	Forensic Conditional Release Program (CONREP) Mentally Disordered Offender Program Sex Offender Commitment Program
Community	**MHSA Plan Review** Community Services and Supports (CSS) Plan updates Workforce Education and Training (WET) Plan Reviews Prevention and Early Intervention (PEI) Plan Reviews Innovation Plan Reviews MHSA Housing Plan Reviews Capital Facilities Plan Reviews MHSA Program Technical Assistance **County Technical Assistance** Small County Technical Assistance (TA) Center Support for Medi-Cal Specialty Mental Health Services Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Therapeutic Behavioral Services (TBS) Children Placed Out-of-County AB3632 Individualized Education Plans Healthy Families Program DMH/Department of Rehabilitation Cooperative Employment Programs General MHSA Technical Assistance
Children and Youth	Children's System of Care/Interage Enrollee-Based Program (IEBP) Early Mental Health Initiative (EMHI) Early and Periodic Screening, Treatment, & Diagnosis (EPSDT Medi-Cal) Mental Health Services Act (MHSA Prop. 63) Mental Health Services for Special Education Pupils (AB 3632)
Adults	Mental Health Cooperative Programs Employment with Support Caregiver Resource Centers Mental Health Services Act (MHSA Prop. 63) Olmstead Decision – New Freedom Initiative Project for Assistance in Transition from Homelessness (PATH) Substance Abuse and Mental Health Services Administration (SAMHSA) Projects Traumatic Brain Injury
Quality Oversight	Ensure compliance with State and Federal laws
Veteran's Resources	Resources, tools and information

Source: California Department of Mental Health webpage, September 2011



Community engagement processes differ for various ethnic and sub-group populations. Understanding this fact, for the purposes of our CRDP African American Population Report development we purposefully engaged as many diverse people as possible to participate in the process. History has shown us that Black people in America have not been given the opportunity to engage in decision-making efforts. And, many have limited leadership opportunities to make decisions related to their health and mental health outcomes. We have used the information we know about the population to be inclusive and transparent as possible. We understand that Black people have personal unique experiences. Their lived experiences have been respected during this process and we have created a safe opportunity for expression, and a platform for their perspectives to be heard.

It is important, however, to establish the context from which we write our Population Report. We intend to identify what is meaningful to our population in developing PEI programs, and to identify interventions that seem most promising in meeting mental and behavioral health needs of this group. We will discuss various disparity data and factors that directly and indirectly impact poor mental and behavioral health outcomes among this population. The most challenging factor is real and perceived racism.

We also acknowledge that the discussion of racism is explosive, and many Americans (including people of African heritage) are not comfortable, and sometimes fearful of the topic. Race has consequences and a pathological dimension with direct negative impact on physical, mental and behavioral health. Race must be addressed to realize healing. In this context, we present the most current available information on mental health PEI issues in the African American population in California. Further, we will present objective information based on the perspective of the population regarding recommendations for community practices that would be more appropriate in addressing root causes that perpetuate gross disparities and impede effective PEI efforts toward African Americans.

WHO DEVELOPED THE POPULATION REPORT?

This report has been developed with passion and the dedication of a community of interested people of African heritage living in California irrespective of their nationality, including American citizens, Africans born in Africa (Continental Africans), Afro-Caribbean, Afro-Latino, Afro-Native American, Afro-Asian, Afro-Filipino, and African any other nationality. Connecting to our African heritage, we completely embraced a community process called *"Harambee"* to develop the CRDP. *"Harambee"* is a Swahili word that literally means *"all pull together." "Harambee"* is a Kenyan tradition of community self-help events, such as fundraising or development activities. *"Harambee"* is also the official motto of Kenya and appears on its coat of arms.

Harambee events may range from informal affairs lasting a few hours, in which invitations are spread by word-of-mouth, to formal, multi-day events advertised in newspapers. These events have long been important in parts of East Africa, as ways to build and maintain communities. Following Kenya's independence in 1963, the first Prime Minister, and later first President of Kenya, Jomo Kenyatta adopted *"Harambee"* as a concept of pulling the country together to build a new nation. He encouraged communities to work together to raise funds for all sorts of local projects, pledging that the government would provide their startup costs. Under this system, wealthy individuals wishing to get into politics could donate large amounts of money to local *"Harambee"* drives, thereby gaining legitimacy. Encyclopedia, 2010

The connection to our cultural heritage is not a misnomer. Therefore, embracing the concepts of "Harambee" is reality for Blacks in America. Understanding African culture provides the bases for American Black culture. It is a fact, one must understand where you have come from to know where you are going, and how to get there. In the United States, all Black people are placed in a category called "Black/African American." However, when you talk to Black people in America there is a great difference of expression as to the identification of self. Consequently, when we engaged Blacks into the CRDP process it was important for people to self-identify who they were and to unashamedly express their personal worldview on the topic. People expressed great appreciation for being asked to participate in the CRDP African American Population Report development.

To appropriately conduct the CRDP with the Black community, it was critical to embrace the diversity of our population. Therefore, we extended an invitation to everyone to participate including clients, client family members, consumers, advocates, psychologists, psychiatrists, sociologists, social workers, epidemiologists, mental health providers and workers, community and faith-based individuals, public health professionals, social scientists, educators, researchers, and other persons of interest throughout the State of California. People were free to participate at whatever level they felt comfortable.

Interest in the CRDP was overwhelming. The needs are great in the Black population. Irrespective of social status, people did not want to be left out of the process to express how to prevent mental issues and how Black people can regain and maintain good mental health. It appeared everyone had something they wanted to say about the topic. However, people were not readily available to participate or make a commitment to the detailed and time consuming process of developing a report on the population. Those who were available and could make the commitment to serve as a Strategic Planning Workgroup (SPW) member are listed in *Appendix L*, a Profile of SPW Members and Affiliations. The SPW structure is detailed in Section D of this report.

THE INTENDED AUDIENCE

The CRDP is commissioned by the California Department of Mental Health (DMH) and funded by the Mental Health Services Act (MHSA). We understand that this report will be utilized by various sectors of society. Therefore, this report was written for a broad range of interested people, including Black mental health consumers, the general Black population, mental health students and future practitioners, mental health providers, as well as DMH, MHSA policy and decision-makers and international persons of interest. We have not created a scientific manuscript to be published in a peer-reviewed journal. Neither, have we created a "feel good document" to be admired and applauded. This report is a collection of factual information and perspectives from the Black population, a review of archival information, and an objective assessment of current service providers to better understand meaningful practices for prevention and early intervention of mental issues. The African American CRDP Population Report is a descriptive study about Blacks living in California.

We have, however, used a scientific approach and methods for content validation. And, to facilitate readability we have used common terms that are easily understood by diverse readers. A picture speaks louder than a thousand words; therefore, we have displayed relevant data in multiple graphs and tables. People of African heritage as a

cultural practice fully embrace oral communication, movement, and colorful displays. We are a people who are "story tellers." People tell their story so there is understanding of the broad context of where people operate from, and to share their experiences. Listen very carefully, and within our expressive responses, one can understand the deep meanings of the heart and soul of Black people related to mental health issues.



"BLACK LANGUAGE"

A subject that demands critical understanding is the language of Black people. Language is the medium for verbal communication. Every culture has its own means of verbal expressions. Dr. Ernie Smith is a Professor of Medicine, Clinical and Cognitive Linguistics in the Department of Internal Medicine, Division of Geriatrics and Gerontology, at Charles R. Drew University of Medicine and Science in Los Angeles CA. He received his Ph.D. Degree, in Comparative Culture, from the University of California at Irvine. With a specialty in Comparative Culture and a sub-specialty in Comparative Linguistics as an interdisciplinary scholar, Dr. Smith has conducted research and published works in several social science disciplines and taught a variety of behavioral, social science and humanities courses over his 50-year professional career. His research is in cognitive-linguistics, socio-linguistics, cultural and linguistic competency in mental health counseling. Dr. Smith is the Co-Chair of the Los Angeles County Department of Mental Health African and African American Underrepresented Ethnic Populations Committee (UREP), and a member of the Black Los Angeles County Client Coalition (BLACCC).

In a personal interview with Dr. Smith on June 28, 2011, regarding "Black language" and how to write this report to be reflective of the expressions of people of African heritage, his insight is included below in a summary discourse.

Dr. Smith: *"In medicine, treatment without diagnosis is malpractice. It is axiomatic that the consequences of a misdiagnosis can be as devastating as doing no diagnosis at all."*

Medical diagnosis and treatment involves communication. This is also true in psychological diagnosis and treatment. If the care provider and the client speak the same language, they will be able to communicate. If the care provider and the client can communicate the two-way information transfer will be effective. To the extent that the two-way information transfer or communications is effective the diagnosis is more likely to be accurate. Logically, to the extent that the diagnosis is accurate the prescribed treatment regimen is more likely to be effective and the patient is more likely to recover from the illness.

On the other hand if the care provider and the patient do not speak the same language, they will not be able to communicate. If the care provider and the patient cannot communicate the information transfer will be impaired and as a result the diagnosis is more likely to be inaccurate. Clearly if the diagnosis is inaccurate the treatment regimen and medications prescribed are not going to be effective. Because so much hinges on language and effective communications between the service providers and patients, pivotal to the notion of cultural competency is the notion that there is language and linguistic competency.

The fact is, there are Federal and State statutes that mandate all medical and mental health care providers, receiving Federal and State funds to provide the care or services

they deliver in a language the patients can understand. These same Federal and State statutes prohibit discrimination against limited English speaking (LES) and non English speaking (NES) patients on the basis of their race, language or national origin.

In behavioral science literature limited LES -NES patients are also called limited English proficient (LEP) and non English proficient (NEP). Today in educational literature LES -NES and LEP - NEP pupils are referred to as English language learners or ELLs. There are several provisions within current Federal and State statutes and regulations as well as DHS and DMH policy letters related to cultural and linguistic competency in the delivery of personal health and mental health services. The specific DMH Regulations and Letters are: DMH REG. Title 9 CFR Section 1705 DMH Information Notice #94-17 issued December 7, 1994.

Dr. Smith: What do these, the statutes and regulations about LEP and NEP medical and mental health clients have to do with the mental health disparities of African Americans?

In the science of linguistics the notion of linguistic competence is predicated on a distinction that is made between what a person **knows** about any given language and how a person uses what they know about any given language.

In linguistics what a person knows about a language is called their *linguistic competence.* How a person uses what they know, in actual speech production, is called their *linguistic performance.* By analogy, in medical health care delivery, what a person knows about a given culture is their *cultural competence.* How a person uses what they know about a given culture, in the context of a medical or mental health service delivery, is indicia of their *cultural sensitivity* or *performance.*

Dr. Smith: This brings us to the issue of what do most medical and mental health service providers know about the language and culture of African Americans?

Various studies indicate that educators and clinicians need a wider scope of information on the language of descendants of enslaved Niger-Congo Africans. Even after the Linguistic Society of America's 1997 resolution in support of the Oakland Unified School District's finding that the word Ebonics refers to an African language system, the genetic kinship of the native language of African Americans is still for some an unresolved issue.

Of particular concern, in the development of the African American Population Report is the fear of some people of African heritage to identify with their culture. Some people do not want to identify with the name "African." Others reject the art of the "Kente" cloth, which represents the royal lineage of an African nation. And, others are uncomfortable with Black conversational language, as reflected in the title of this report, *"We Ain't Crazy."* According to data collected by the CRDP, in every interview conducted, Black people stated that they **were labeled** "crazy." The title of this report is a response from the Black population (including clients and client family members) refuting the **imposed label** "crazy" and declaring a reality, *"We Ain't Crazy! Just Coping with a Crazy System."* The title of the CRDP African American Population is not calling anyone crazy. It is refusing the implied label. Neither is the title grammatically incorrect. Ain't is a contraction of "am not," "are not," "has not," and "have not." It certainly captures the attention in the market place, and calls for discussion and reflection. **No mental health provider should ever call a person with mental challenges "crazy,"** especially

people of African heritage.



Anyone who has a negative bias toward Black language should STOP IT. Black people, Black culture and Black language **are not bad**. Every cultural and people group have their way of communicating, but when it comes to Black language American society has perpetuated the thought that it is wrong or bad. To be clear, Black language **is not** "trash" talk, or "vulgar or obscene" expressions, or "insulting name calling" or "incorrect sentence structure or syntax." Black people are a versatile population. We cannot be put in a box or labeled. When connected to our environment, or around family and friends, we use common words (or codes) in a relaxed conversational manner that is understood by the population, as well as body and hand gestures, and animated motions in our communication style. We talk "to" people using eye contact, which is understood that you are paying attention to what is being said and that you are respecting the person talking. Several people may talk at the same time (called "talk over") but, this interaction is viewed as engaging in the conversation, or being a part of the discussion. Or, people may shout out words or expressions while another person is talking which gives testimony (agree or disagree) to what the person is saying. This is called "talk back." Within the Black culture, verbal as well as non-verbal communications are ways of connecting to each other, the community and the world. Some Black people choose not to use conversational "Black language" at any time. "Black language" is a major part of Black culture.

GOING FORWARD

This CRDP process provided the opportunity to understand Black culture. The process has been meaningful to the Black community by allowing individual and collective experiences and input into critical decisions affecting our state. Information, thoughts, ideas, opinions and perceptions presented in this report are the voices of Black people living in California. Information is quoted directly from persons identified, or inserted as submitted in writing from the stated author. Acknowledgment is given to ensure respect and ownership of intellectual property. The intent has been to create content that can be used to make a significant difference. It is our hope that the significance be incorporated in PEI program and intervention re-design of our mental health system demonstrating respect and responsiveness to the expressed needs of all cultural and ethnic populations in the great State of California.

This time, we tell our story.

We create our history.

And, we orchestrate our pathways to healing.

“OUR FAITH SUSTAINS US.”



unityrespecthopecompassiondignityfamilycouragepeacetogethernessculturefaithloveu

SECTION B

STATEMENT OF PROBLEM

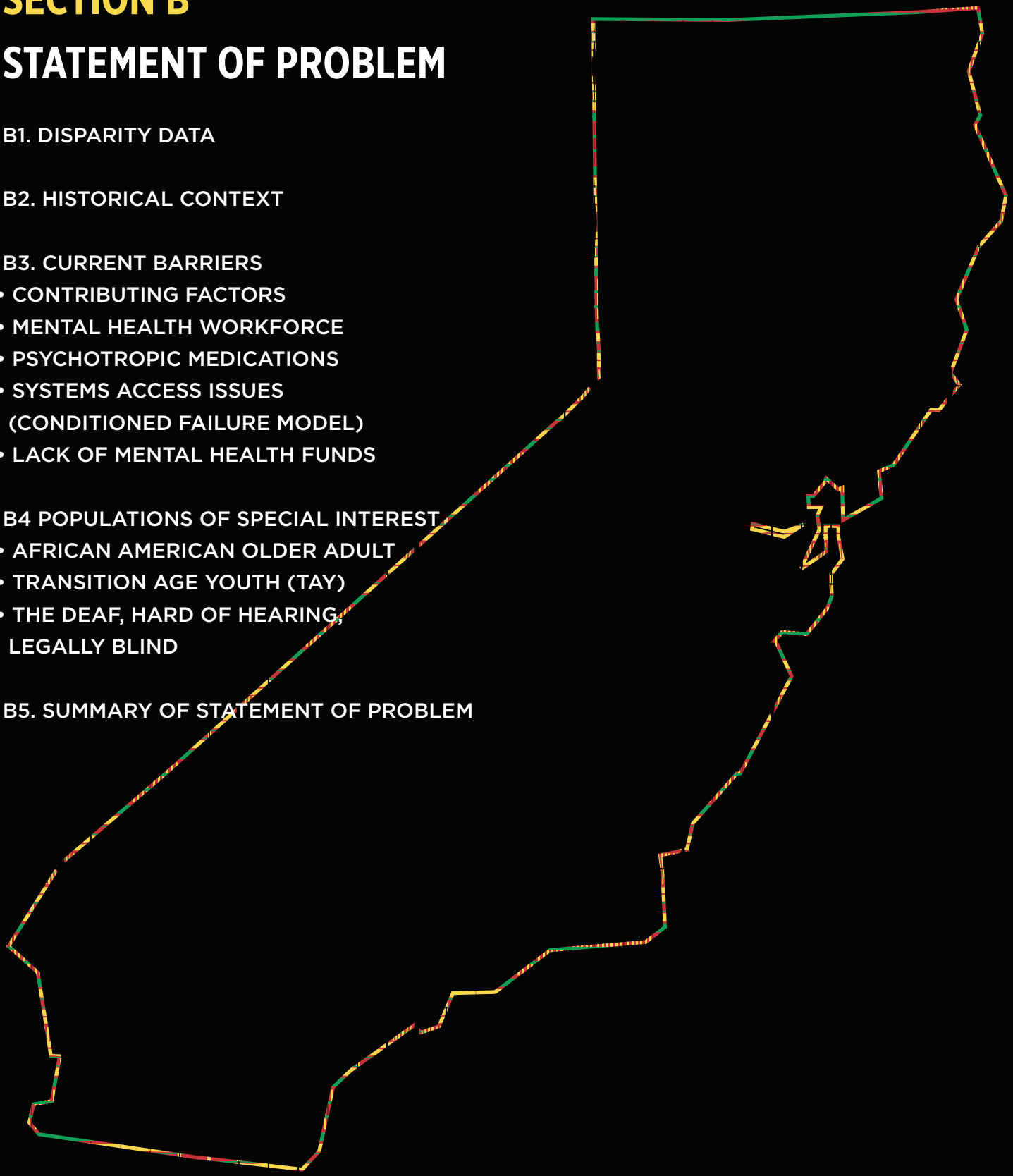
B1. DISPARITY DATA

B2. HISTORICAL CONTEXT

B3. CURRENT BARRIERS
- CONTRIBUTING FACTORS
- MENTAL HEALTH WORKFORCE
- PSYCHOTROPIC MEDICATIONS
- SYSTEMS ACCESS ISSUES (CONDITIONED FAILURE MODEL)
- LACK OF MENTAL HEALTH FUNDS

B4 POPULATIONS OF SPECIAL INTEREST
- AFRICAN AMERICAN OLDER ADULT
- TRANSITION AGE YOUTH (TAY)
- THE DEAF, HARD OF HEARING, LEGALLY BLIND

B5. SUMMARY OF STATEMENT OF PROBLEM



STATEMENT OF PROBLEM

To start a journey without knowing where you are going is not wise. One must know where you have come from, to know where you are going. This Population Report requires documentation of mental health disparities. However, U.S. Census and institutionalized ethnic data collection keeps us from revealing the reality of our existence, and critical data is missing that is needed to more clearly reflect the most vulnerable needs of our population. With this harsh reality, our CRDP project end goal was to engage people of African ancestry throughout California in making recommendations for PEI practices to reduce identified disparities. Our efforts have been to use the best and most current data available to understand the problems, starting with the U.S. Census Bureau data. In 2010, the U.S. population count was 308,745,538 residents (Census Bureau, 2011); see *Table 2* for breakdown by people groups.

Table 2: *United States Population by Race/Ethnicity, 2010*

RACE/ETHNICITY TOTAL POPULATION	%	308,745,538
White	72.4%	223,553,265
Black or African American	12.6%	38,929,319
Some Other Race	6.2%	19,107,368
Asian	4.8%	14,674,252
Two or More Races	2.9%	9,009,073
American Indian and Alaska Native	0.9%	2,932,248
Native Hawaiian and Other Pacific Islander	0.2%	540,013
TOTAL	**100%**	**308,745,538**
ETHNICITY TOTAL POPULATION		
Hispanic/Latino Only	16.3%	50,477,594
Non Hispanic/Latino Only	83.7%	258,267,944

Source: U.S. Census Bureau, 2010 Census Redistricting Data (Public Law 94-171) Summary File, Tables P1 and P2, *Overview of Race and Hispanic Origin*: 2010, March 2011, page 4.

Nationally, an estimated 10% of all African Americans live in the Western region. California is the largest populated state (37,253,956) with the most culturally and ethnically diverse residents, of which 6.2% are Black or African American, see *Table 3* (Census Bureau, 2011).

Table 3: *California Population by Race/Ethnicity, 2010*

RACE/ETHNICITY TOTAL POPULATION	%	37,253,956
White, Non Hispanic	57.6%	21,458,279
Some Other Race	16.9%	6,295,919
Asian	13.0%	4,843,014
Black or African American	6.2%	2,309,745
Two or More Races	4.9%	1,825,444
American Indian/Alaska Native	1.0%	372,540
Native Hawaiian/Other Pacific Islander	0.4%	149,016
TOTAL	**100%**	**37,253,956**
ETHNICITY TOTAL POPULATION		
Hispanic/Latino Only	37.6%	14,007,488
Non Hispanic/Latino Only	62.4%	23,246,468

Source: California-U.S. Census Bureau, 2011

Figure 2a, a GIS mapping of the African American population in California reveals that 73% live in six counties: Los Angeles (37.8%), Alameda (8.5%), San Bernardino (7.7%), San Diego (6.9%), Sacramento (6.3%), and Riverside (5.8%) [Census Bureau, 2010]. To start the CRDP African American Strategic Planning Workgroup (SPW) efforts and to ensure inclusion and area representation from urban as well as rural counties, the state was divided into five regions, as indicated in *Figure 2b*. We have included input from all five regions in this report for identifying the problems and solutions.

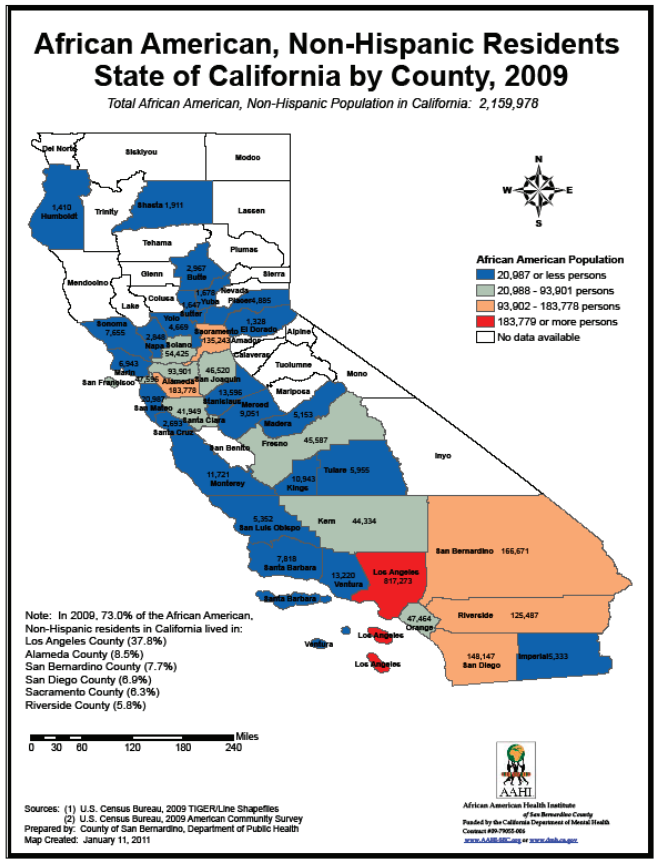


Figure 2a: California's African American Population by County, 2009

According to the Centers for Disease Control and Prevention (CDC, 2011), mental health disorders are common in the United States. One in two Americans has a diagnosable mental illness each year, including 44 million adults and 13.7 million children. This is a serious problem. In 2009, there was an estimated 11.0 million adults aged 18 or older (approximately 4.8% of all U.S. adults) in the U.S. reporting serious mental illness (SMI) in the past year (SAMHSA, 2010). Similarly, 10-20% of children in the U.S. are estimated to have mental disorders with some level of functional impairment (Miles et al., 2010).

A significant outcome of the Surgeon General's report on *Culture, Race, and Ethnicity (DHHS, 2001)* was that each ethnic subgroup, (defined by a common heritage, values, rituals, and traditions), revealed that there is no such thing as a homogeneous racial or ethnic population (White or nonwhite). Each racial or ethnic group contained the full range of variation on almost every social, psychological, and biological dimension presented. Unfortunately, persistent problems, as concluded in the report, are that African Americans were over represented in high need population groups especially at risk for mental illness, including people that are homeless; people who are or have been incarcerated; children in foster care; and people exposed to violence (including the military service men and women) which increases the risk for developing post traumatic stress disorder (PTSD). Additionally, the report detailed mental health disparities among ethnic groups. Recommendations in the report suggest to best address the intrinsic diversity of ethnic subgroups; diverse strategies must be identified and implemented based on common heritage, values, rituals, and traditions. Mental health disparities for people of African ancestry in America exist and are becoming more prevalent (Miranda et al., 2008).

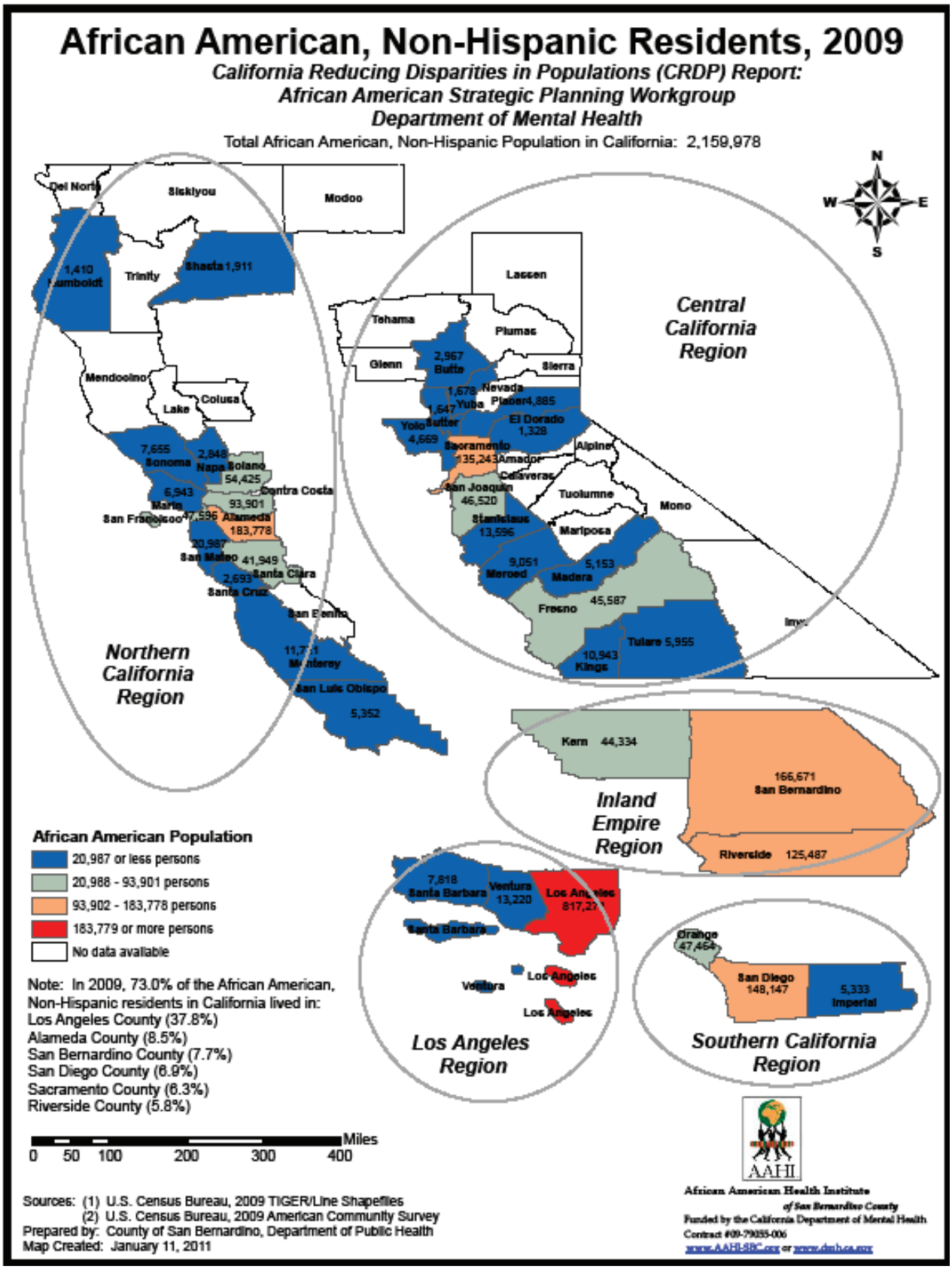


Figure 2b: California's African American Population by County, 2009: SPW Regions

Identifying mental illness disparities as a major problem for ethnic minorities is not an isolated situation. Numerous studies have clearly documented mental health problems. Reports from the Institute of Medicine (IOM, 2003; Smedley et al., 2003) on the effects of health disparities in America clearly identified major factors contributing to the burden of disparate outcomes in our nation, such as previously stated in the findings of the Surgeon General's report on *Culture, Race, and Ethnicity* (DHHS, 2001).

The IOM (Smedley et al., 2003) report concluded (from extensive research) that racial and ethnic minorities in the United States receive lower quality care than Whites which accounts for differential access to care. Further, in the report the authors stated that, *"in examining the roots of these disparities, the committee is struck by the fact that the sources are complex and multifactorial. Included among the factors are clinical uncertainty, stereotypical behavior, and conscious bias that may extend all the way to prejudice."*

In California, during 2005 approximately one in five adults (about 4.9 million people), requested some help for a mental or emotional health problem (Grant, Kravitz-Wirtz, Aguilar-Gaxiola, et al., 2010). During this same time, African Americans (6.3%) were significantly more likely to report symptoms associated with serious psychological distress than Asian immigrants (3.7%) and Whites (3.3%). To identify and document the mental health problems and solutions for people with African heritage in the State of California in a fair, ethical and unbiased manner, we investigated on multiple levels including individual, community and systems.

B1. DISPARITY DATA

The Individual Level

According to national and California data, the African American population continues to display extremely high risk factors for severe mental illnesses, see *Table 4*. These risk factors contribute to gross disparities resulting in persistently high premature death rates and disabilities (Figure 3). Significance of risk factors at the individual level is that African Americans are approximately 13% of the U.S. population, and 6% of California's population (Census Bureau, 2011).

Table 4: *At-Risk Factors for Mental Illness Disparities in African Americans*

RISK FACTOR	US POPULATION	CALIFORNIA POPULATION
Homeless	40% (of the homeless) African Americans	45% (est.) of the homeless are African Americans
Juveniles in Legal Custody	40% African Americans	28% African Americans
Incarceration (all prisoners)	50% African Americans	35% African Americans
Foster Care	31% African Americans	45% African Americans
Below Poverty Level	25% African Americans	20% African Americans

Source: US Census Bureau, 2009
Poverty data: US Census Bureau, American Community Survey, 2005-2009 U.S. Data
Homeless data: Interagency Council on the Homeless Report, 2011
Homeless data: HUD Annual Homeless Assessment Report (AHAR), 2009
Juvenile data: Office of Juvenile Justice & Delinquency Prevention, 2011
Incarceration data: California Department of Corrections and US Department of Justice

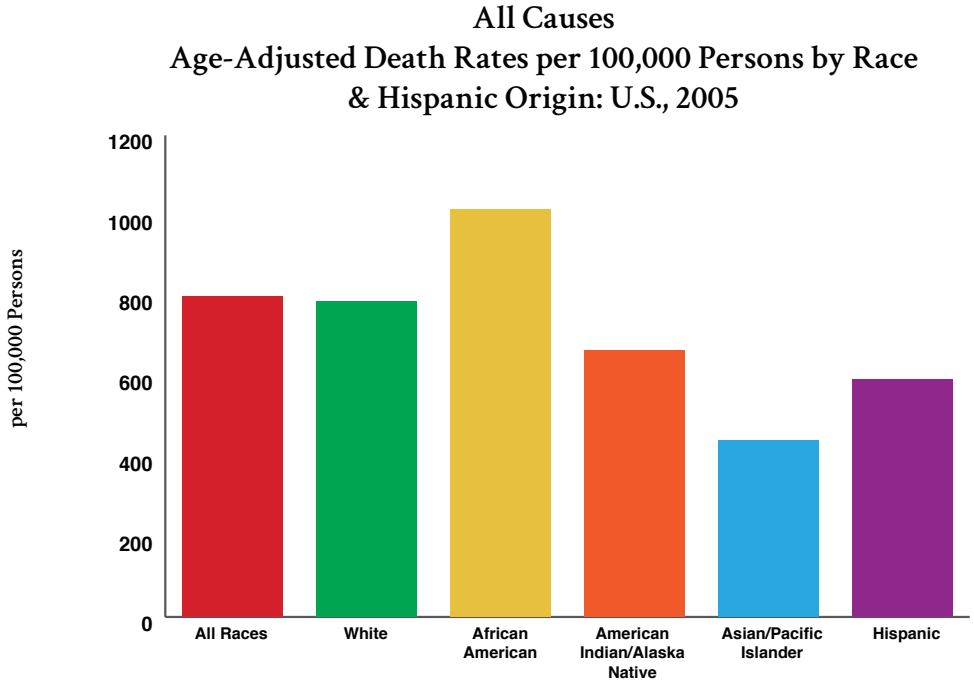


Figure 3: *United States Death Rates by Major Ethnic Groups*

BLACK PERSPECTIVE ON THE PROBLEM STATEMENT

"We don't know what mental health is."

"Not clear about what is the societal, physical, and spiritual causes of mental illness in order to know what should be prevented or/and type of interventions needed."

"The problems are unresolved traumatic events for African American people/families/communities."

"Coping mechanisms that are harmful..."

"The nature of the mental health delivery system adapts a monocultural perspective under the guise of multiculturalism, absent of culturally proficient providers who do not provide the types of services that are necessary to help the African American population, resulting in missed opportunities to recognize problems that lead to serious mental and behavioral health issues."

"...a lack of competent assessments that define healthy for African Americans."

"Mental health as an illness is not recognized as a problem in African American communities."

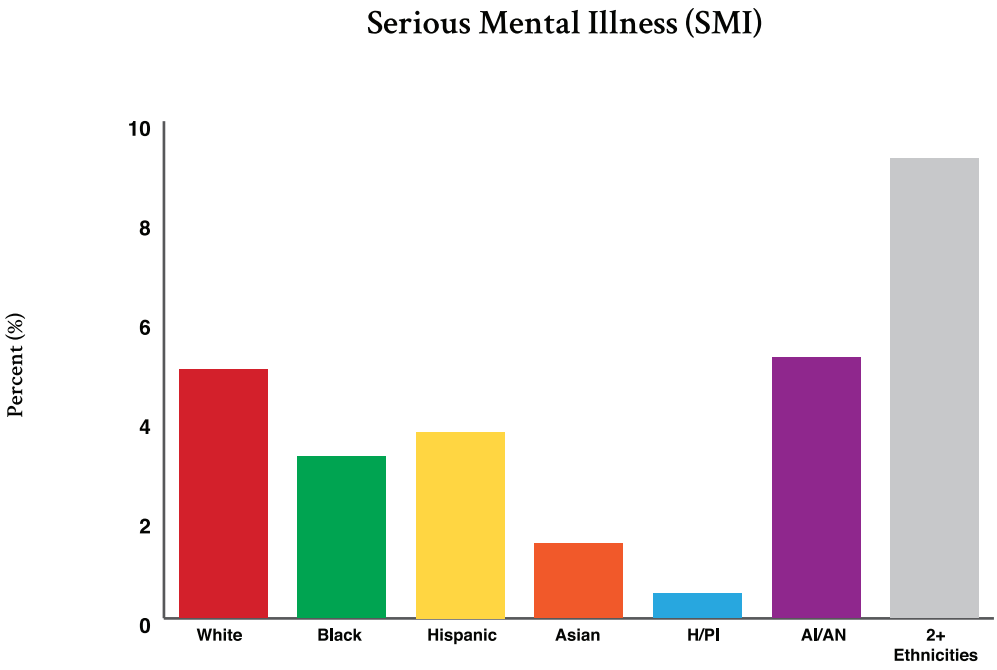
THE COMMUNITY LEVEL: DISPARITY DATA

"African Americans live in an 'extreme mundane stressful' environment and perceive no rewards or relief"
-Dr. Chester Pierce (1974)

In this section of our CRDP Population Report, the disparity data will be presented related to the entire population, the community of people. For the purposes of this report, we believe the discussion of African Americans will be better served if we not emphasize the differences within our group but rather focus on our "same root" (like a tree, the trunk and branches – all are connected to the same roots), then explain how it is related to our health, healing, wholeness, and disparity reduction.

Mental disorders are the leading cause of disability in the U.S. and Canada (NIMH, 2011). In the U.S., mental disorders are diagnosed based on the *Diagnostic and Statistical Manual of Mental Disorders, fourth edition (DSM-IV)*, (APA, 1994). Common mental health disorders are mood disorders, schizophrenia, anxiety disorders, eating disorders, attention deficit hyperactivity disorder (ADHD), autism and personality disorders (NIMH, 2011).

According to the Substance Abuse and Mental Health Services Administration (SAMHSA), in 2009 the prevalence of the U.S. adult population 18 years or older with past year **serious mental illness (SMI)** was less than 5% for major ethnic minority groups such as Asians, African Americans and Hispanics; Whites and American Indians were slightly above 5% *(Figure 4)*. Individuals reporting two or more ethnicities were close to 10%. Estimates for Native Hawaiians or Other Pacific Islanders could not be reported due to low precision. Prevalence refers to all the cumulative cases of a particular condition.



Note: H/PI=Native Hawaiian or Pacific Islander; AI/AN=American Indian or Alaska Native
Source: Substance Abuse and Mental Health Services Administration. (2010). *Results from the 2009 National Survey on Drug Use and Health: Mental Health Findings* (Office of Applied Studies, NSDUH Series H-39, HHS Publication No. SMA 10-4609). Rockville, MD.

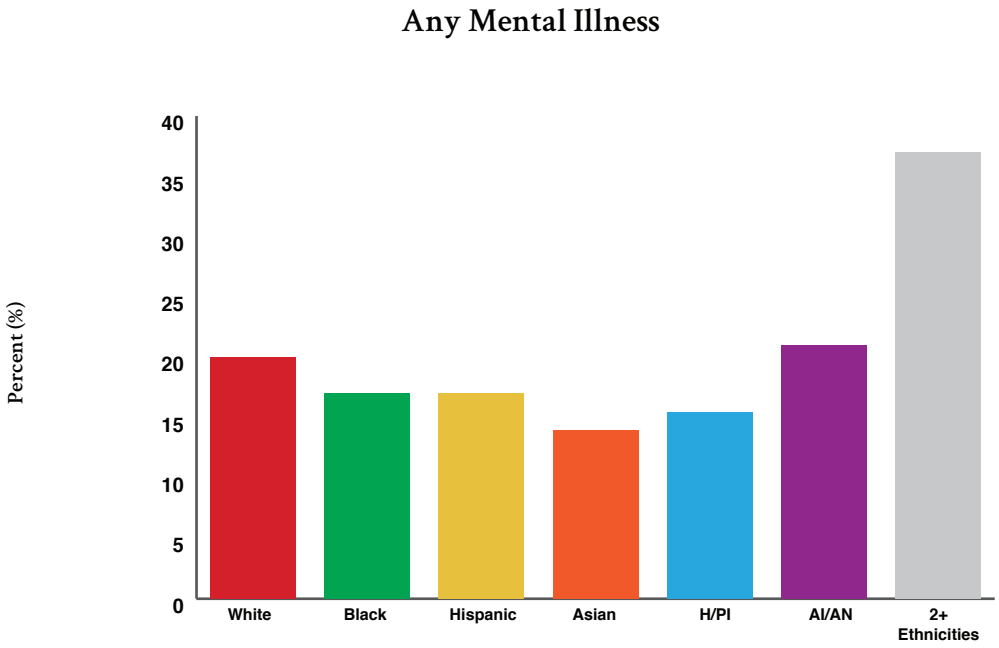
Figure 4: *Prevalence of Serious Mental Illness among U.S. Adults by Ethnic Groups, 2009*

SAMHSA defined SMI as persons aged 18 or older who currently or at any time in the past year have had a diagnosable mental, behavioral, or emotional disorder (excluding developmental and substance use disorders) of sufficient duration to meet diagnostic criteria specified within the 4th edition of the DSM-IV that has resulted in serious functional impairment, which substantially interferes with or limits one or more major life activities.

Figure 5 displays the prevalence of U.S. adults by ethnicity reporting **any mental illnesses**. Any mental illness among adults aged 18 or older is defined as currently or at any time in the past year having had a diagnosable mental, behavioral, or emotional disorder (excluding developmental and substance use disorders) of sufficient duration to meet diagnostic criteria specified within the DSM-IV, regardless of their level of functional impairment (APA, 1994). In 2009, about 17% of Asian, Native Hawaiian/ Other Pacific Islander, Hispanic, and African American groups reported having any mental illness. Whites and American Indians/Alaska Natives were a little higher at 21%. The highest prevalence (32.7%) of any group who reported having any mental illness was among persons of two or more ethnicities.

"...institutional ignorance and denial throughout the society, totally distorts and misrepresents the true psychological picture of Blacks."

-Dr. Kobi K. K. Kambon (1998)



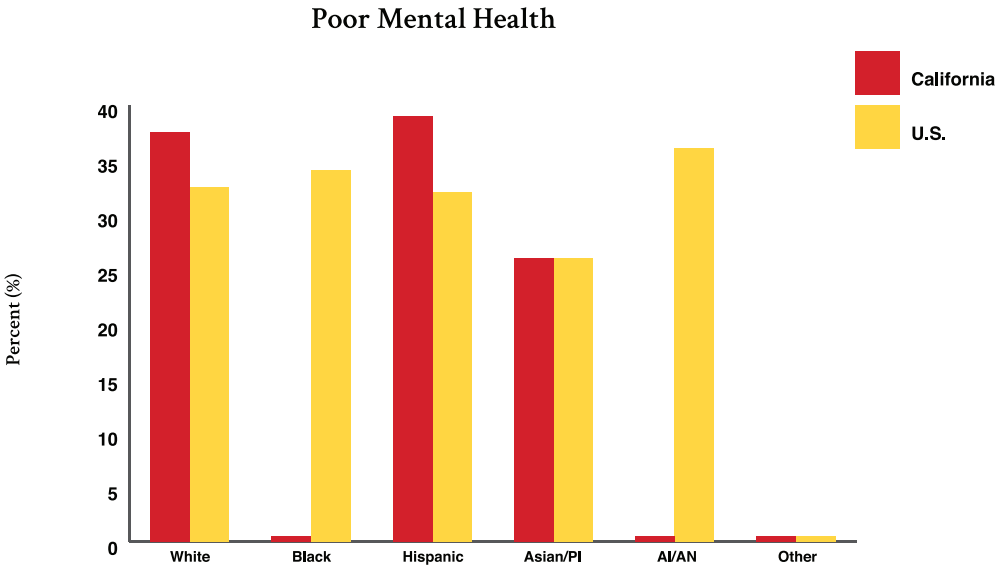
Note: H/PI=Native Hawaiian or Pacific Islander; AI/AN=American Indian or Alaska Native
Source: Substance Abuse and Mental Health Services Administration. (2010). *Results from the 2009 National Survey on Drug Use and Health: Mental Health Findings* (Office of Applied Studies, NSDUH Series H-39, HHS Publication No. SMA 10-4609). Rockville, MD.

Figure 5: *Prevalence of Any Mental Illness among U.S. Adults by Ethnic Groups, 2009*

Of those reporting **poor mental health**, all groups were basically similar between 30-35%; except for Asian/PI. California data was not reported for three populations, African Americans, Asian/Pacific Islanders and those classified as "other." Data for the three populations were too low to count, and was reported as non sufficient data (NSD).

Figure 6 compares U.S. and California data for ethnic groups reporting poor mental health. Poor mental health was defined by adults who reported having poor mental health between one and 30 days in the past 30 days (Kaiser, 2010).

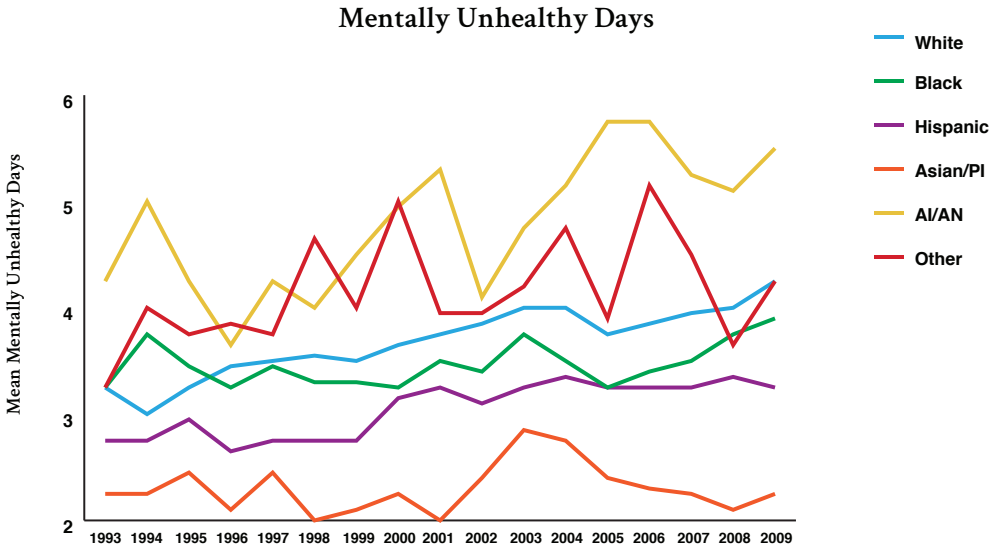
"....To heal a people, we need the resurrection of Black love in order to empower relationships to succeed and to restore the warrior spirit in Black men to stand strong in our communities."
-Dr. Kevin Washington (2011)



Note: PI=Pacific Islander; AI/AN=American Indian or Alaska Native; Missing data (non sufficient data [NSD]; low sample size (n = < 100)
Source: The Kaiser Family Foundation at www.statehealthfacts.org; accessed November 2010

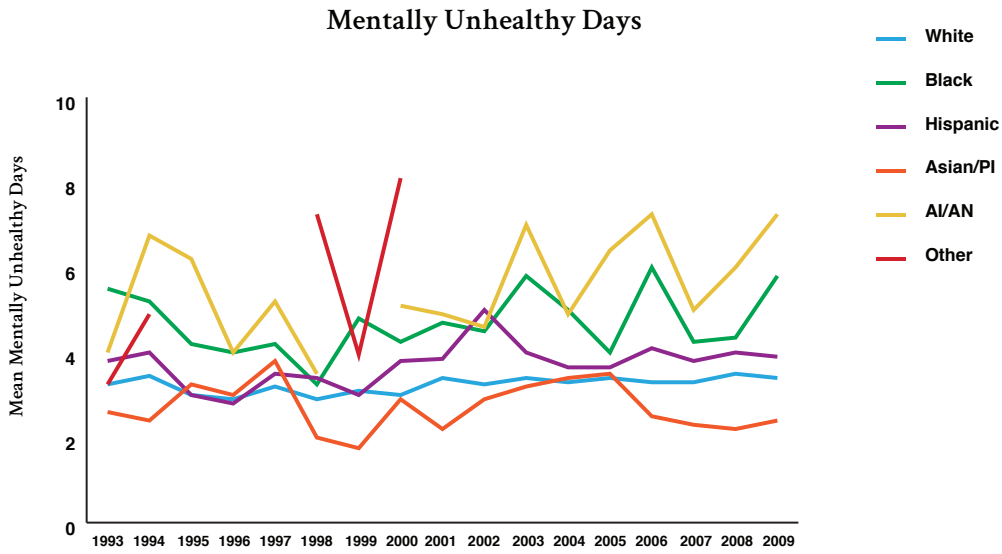
Figure 6: *Percentages of Adults Reporting Poor Mental Health by Race/Ethnicity, 2007*

U.S. and California trends for ethnic groups, who report **mentally unhealthy days** for 1993 to 2009, were not significantly different for Blacks, Hispanics, Whites, and the category "other." The most significant difference was in the American Indian/Alaska Native (AI/AN) group, which reported the highest number of mentally unhealthy days; Asian/Pacific Islanders reported the lowest, see *Figure 7* and *Figure 8.* Mentally unhealthy days is defined as an estimate of the overall number of days during the previous 30 days when an individual felt mental health was not good (CDC, 2010).



Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System (BRFSS) Survey Data, 1993-2009.
Accessed November 2010 from http://www.cdc.gov/brfss/index.htm; .Downloaded from http://apps.nccd.cdc.gov/HRQOL.

Figure 7: *U.S. Trends of Mentally Unhealthy Days for Adults by Ethnic Groups, 1993-2009*



Note: Missing data due to low sample size in the respective year (n= < 100)
Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System (BRFSS) Survey Data, 1993-2009. Accessed November 2010 from http://www.cdc.gov/brfss/index.htm; .Downloaded from http://apps.nccd.cdc.gov/HRQOL.

Figure 8: *California Trends of Mentally Unhealthy Days for Adults by Ethnic Groups, 1993-2009*

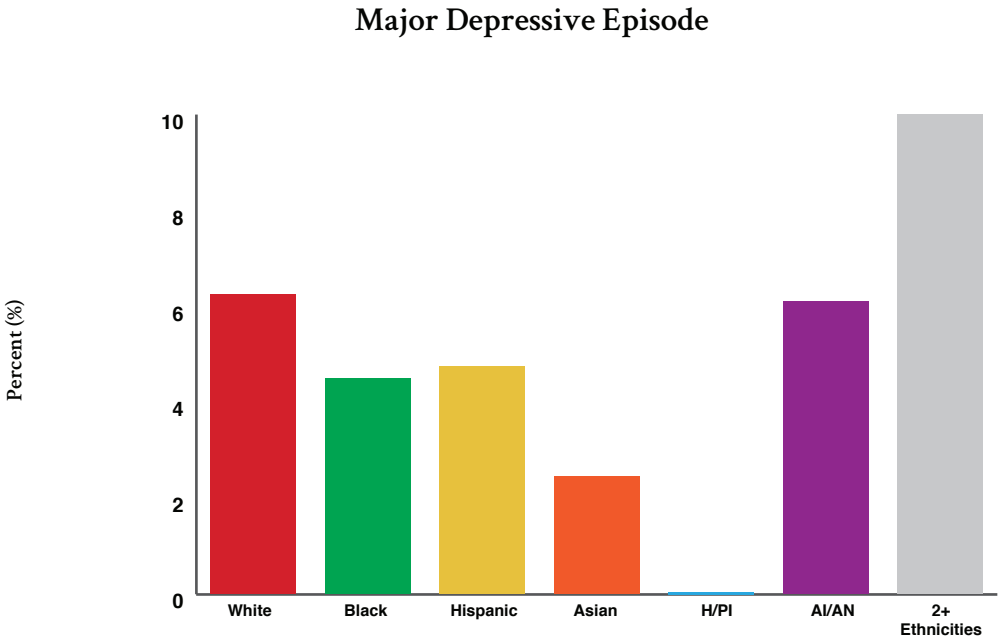
"Behavioral health care has not been a major priority in African American communities over many decades. These issues have been known throughout the communities but have not garnered the priority given to other social and economic or bread and butter issues such as jobs and housing. African American activism has been directed principally at civil rights issues with large – desegregation, voting, legal justice, equal pay, jobs, non-discrimination in housing and education, and access to political office. Behavioral health has not garnered this level of priority although its effects are widely known but perhaps not as visible. In addition, African American civil rights organizations have not placed their resources towards barriers and inequities in behavioral health. To date there are few African American voluntary organizations that focus exclusively on advocacy issues related to behavioral health. Furthermore, a limited number of African Americans participate in established behavioral health advocacy organizations at the national or local level. The voices of African Americans are often not heard in these voluntary organizations that seek to influence the quality of treatment, access to services, or changes in public behavioral health policies. This is where 'do something' must start."

-Dr. King Davis, 2011

"Behavioral health care has not been a priority in African American communities."
-Dr. King Davis (2011)

It is generally thought that the major psychiatric disorders in the U.S. exist in similar rates among every population. Data does not particularly support this assumption. Even though the percent of populations reporting **major depressive episodes** is low, the most disparate population, however, are those who identify with two or more ethnicities *(Figure 9)*. Major depressive episode is defined as a period of two weeks or longer during which there is either depressed mood or loss of interest or pleasure and at least four other symptoms that reflect a change in functioning (such as problems with sleeping, eating, energy, concentration, and self image (SAMHSA, 2009). There are pertinent differences between African Americans and Whites in the U.S. (in scientific reports Whites are still considered the reference population because they are the majority population). African Americans are 30% more likely to be diagnosed with

serious psychological distress than Whites, and in 2007, were 50% more likely to report symptoms of depressive episodes. However, Whites are more than twice as likely to receive antidepressants prescription treatments as are African Americans (DHHS, OMH, 2011).

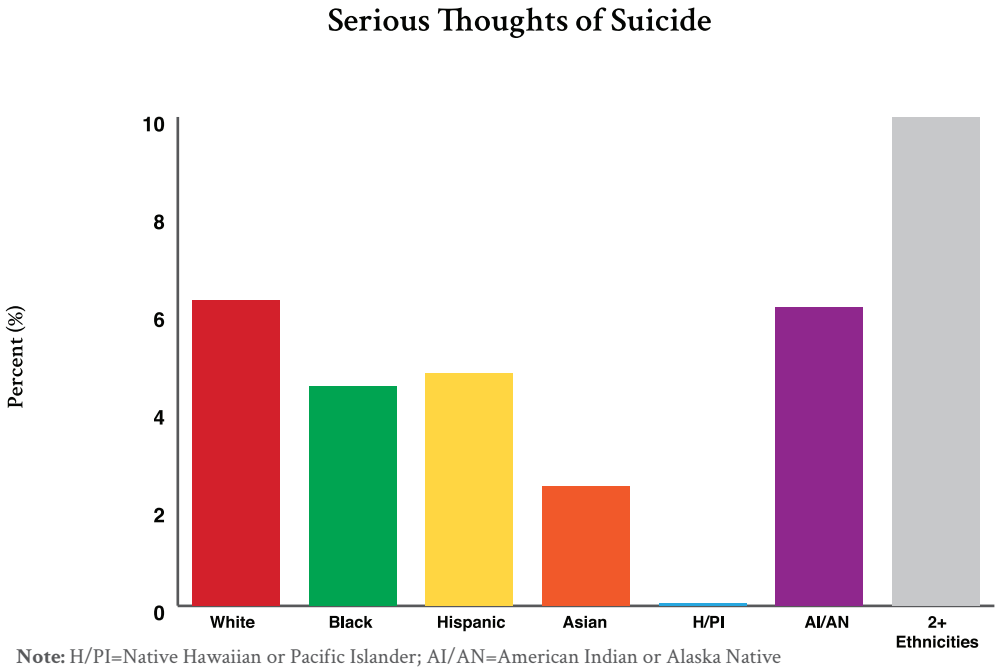


Note: H/PI=Native Hawaiian or Pacific Islander; AI/AN=American Indian or Alaska Native
Source: Substance Abuse and Mental Health Services Administration. (2010). *Results from the 2009 National Survey on Drug Use and Health: Mental Health Findings* (Office of Applied Studies, NSDUH Series H-39, HHS Publication No. SMA 10-4609). Rockville, MD.

Figure 9: *Prevalence of Major Depressive Episode among U.S. Adults by Ethnic Groups, 2009*

"African Americans suffer from 'Post Traumatic Slave Syndrome', a toxic effect of intergenerational trauma that has damaged the collective African American psyche."
-Dr. Joy DeGruy-Leary (2005)

In 2007 in the U.S., students in grades 9-12, African American males were 1.6 times more likely to attempt suicide, than White males; and African American females were twice more likely to attempt suicide than White females (DHHS, OMH, 2011). However, in 2009 the prevalence of adults with **serious thoughts of suicide** is less than 10% among all populations (see *Figure 10*). White, Black and Hispanic populations all have about the same prevalence, 3%. Obvious disparities are with the Asian population having the lowest prevalence, and the highest is those reporting two or more ethnicities. The second highest prevalence is with the American Indian/Alaska Native.

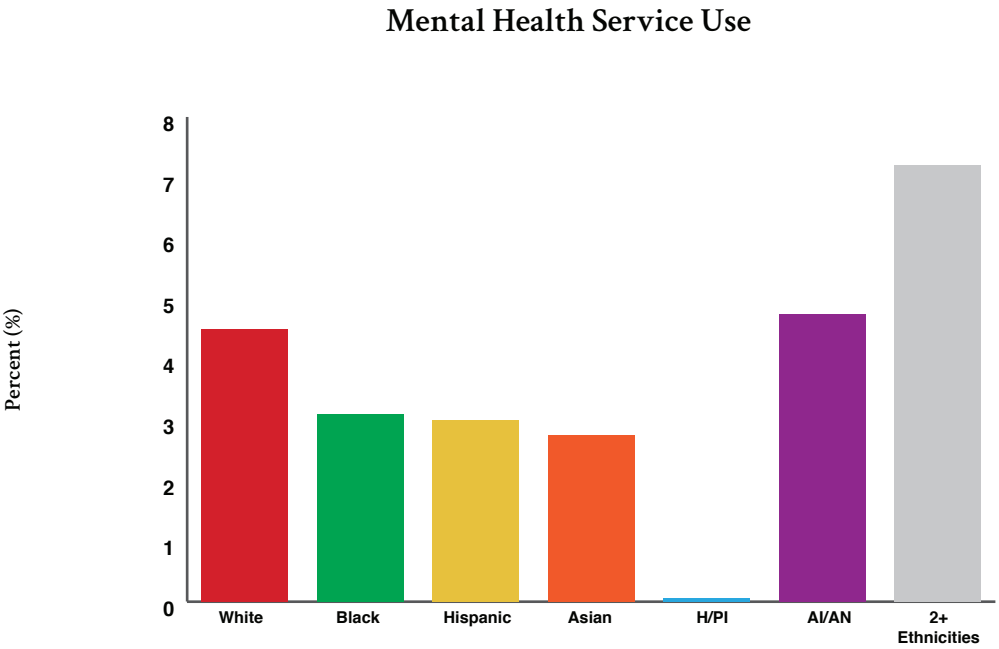


Note: H/PI=Native Hawaiian or Pacific Islander; AI/AN=American Indian or Alaska Native
Source: Substance Abuse and Mental Health Services Administration. (2010). *Results from the 2009 National Survey on Drug Use and Health: Mental Health Findings* (Office of Applied Studies, NSDUH Series H-39, HHS Publication No. SMA 10-4609). Rockville, MD.

Figure 10: *Prevalence of Serious Thoughts of Suicide among U.S. Adults by Ethnic Groups, 2009*

"Victims of 'self-destructive disorder' respond through practices of personal and / or social destruction."
-Dr. Na'im Akbar (1985)

The U.S. population with two or more ethnicities (17%), along with the White population (15%) reports the highest **use of mental health services**. Blacks and Hispanics are the third highest users of mental health services; prevalence is approximately 6% (see *Figure 11*).



Note: H/PI=Native Hawaiian or Pacific Islander; AI/AN=American Indian or Alaska Native
Source: Substance Abuse and Mental Health Services Administration. (2010). *Results from the 2009 National Survey on Drug Use and Health: Mental Health Findings* (Office of Applied Studies, NSDUH Series H-39, HHS Publication No. SMA 10-4609). Rockville, MD.

Figure 11: *Prevalence of Mental Health Service Use among U.S. Adults by Ethnic Groups, 2009*

"NIMH research does not get used to help people as mental health professionals rarely use it."
-Dr. Carl C. Bell (2011)

National reports indicate that data regarding mental health diagnosis and treatment for people of African ancestry in the U.S. are equally if not more dismal (DHHS, 2001). Blacks are over diagnosed for poorer treatment outcomes, such as schizophrenia, while anxiety and mood disorders often go untreated. Blacks are far more likely to have their first contact of mental health in an emergency room and are underrepresented in outpatient care. Black children experience missed opportunities in our public school system for prevention and early interventions associated with health screening and low academic scores which could indicate mental illness, learning disability, developmentally delayed or medical problems (organic disorders) that look like a mental illness. Black youth are over diagnosed for conduct disorder, and under diagnosed for depression. **Mental health disparities are problems of access, quality of care, misdiagnosis, research, and mental health outcomes,** even when access and care quality are on par, outcomes are often poorer (DHHS, 2001). Dramatic disparities in mental health are reported for African Americans, who are less likely to receive care, and when they do receive care, it was more likely to be of poor quality. While research is underway to understand the complexity of these health disparate outcomes, African Americans remain sorely underrepresented in mental health research.

The National Survey of American Life (NSAL), which included 6,199 African Americans, Caribbean Blacks, and Whites, indicated that **for mental illness in America, the challenge is health equity (NIMH, 2011). Health equity is achieving equal and optimal health care for all populations (DHHS, 2011).** Although literature shows that people of African ancestry may not exhibit greater levels of mental health disorders in comparison to their Caucasian counterparts, they experience greater mental health issues related to "stress." Those "stressors" typically lead to multiple health issues. One major stressor is poverty. Mental health illnesses rise as poverty rises. African Americans living below the poverty level, as compared to those over twice the poverty level, are four times likely to report psychological distress (DHHS, OMH, 2011).

-CAUTION-

For some people, research reports are very technical and cumbersome to read. But, research is critical in standardizing findings and removing biases so that ***truth is revealed***. Research studies in our Population Report are to facilitate the reader's understanding of the Black perspective.

Living in America for African Americans has been a consistent pattern of invalidation, negation, dehumanization, disregard and disenfranchisement. The psychiatrist Chester Pierce (1974) has indicated that life in the urban area is often characterized by an "extreme mundane stressful" environment. By "extreme mundane stress," Pierce refers to stress that result when actors perceive no rewards or relief from their constantly worrisome quest to survive on a day-to-day basis.

> ***Traumatic Life Experiences:*** *"Like you lose...something. You might go into deep depression....You might felt attacked and feel like your whole world come down crushing on you."*
>
> -FG: 20 year old Black male Oxnard College student

The extreme environment of the ghetto is loaded with "offensive put-downs" which Pierce classifies as social trace contaminants that promote acceptance of (1) a devalued state and (2) hopelessness. Pierce (1970) has contended that the African American population is constantly bombarded by *micro-aggressions,* small scale assaults on the psyche

of the person by which they are hindered in their attempts to realize basic functional imperatives required for normal adjustment in society. This constant bombardment, he contends, produces a condition of "status dislocation" wherein the individual cannot effectively function in society and seeks escape mechanisms to enable him to survive. Later Pierce (1974) indicated that life in a mundane stressful environment characterized by the urban ghetto requires accessible escape mechanisms in order for the human organism to continue to function at a level of minimum survivability.

The twin interactional and mutually reinforcing effects of racism and stress condition those so victimized to opt for addictive escapism. These negative effects usually persist throughout the life span of the victim unless they are effectively mediated, dampened, and neutralized by positive experiential interventions. Akbar (1985) has indicated that the impact of living in an oppressive, racist environment produces a condition he characterized as "self-destructive disorder." The victim of self destructive disorder responds to conditions of oppression by attempting to destroy their involvement with reality through practices of personal and/or social destruction.

Pieterse, Carter, Evans & Walther (2010) examined perceptions of racial/ethnic discrimination, racial climate, and trauma-related symptoms among 289 racially diverse college undergraduates. Study measures included the Perceived Stress Scale, the Perceived Ethnic Discrimination Questionnaire, the Posttraumatic Stress Disorder (PTSD) Checklist—Civilian Version, and the Racial Climate Scale. These researchers suggest that the call to consider racial and/or ethnic discrimination as an etiological factor in traumatic symptoms or traumatic stress reactions challenges the somewhat narrow criteria for PTSD, as described in the Diagnostic and *Statistical Manual of Mental Disorders* (4th ed., text rev.; DSM–IV–TR; American Psychiatric Association, 2000). In discussions of race and ethnicity as sources of psychological trauma, scholars have emphasized the need to understand that trauma associated with racial and/or ethnic discrimination can be viewed as cumulative in nature. To illustrate, Walters and Simonie (2002) and Shepard, O'Neill, and Guenette (2006) have argued that one cannot fully appreciate or effectively respond to the psychosocial needs of Native American women without recognizing the ongoing intergenerational trauma associated with loss of land, identity, and rights.

In reference to people of African ancestry, scholars have also highlighted the need to take into account both current experiences of discrimination and historical legacies (e.g., slavery, colonization) on which those experiences are built, to gain an accurate understanding of the psychological responses to racial and ethnic discrimination (Bryant-Davis, 2007; Bulhan, 1985). Franklin and Boyd-Franklin's (2000) description of racial discrimination as a type of invisibility provides a useful illustration of the cumulative and recurring nature of discrimination and racism as experienced by Black men. According to these authors, the psychological response to discrimination and/or racism is predicated on numerous prior experiences of discrimination. As a coping strategy, some Black men have developed a sense of vigilance and therefore tend to consistently anticipate discrimination or racial hostility. Additionally, psychological reactivity (e.g., anger, hostility) displayed by some Black men could be viewed as a type of defense in response to, or in anticipation of, racial discrimination. The range of psychological responses noted by Franklin and Boyd-Franklin appear to be consistent with the common responses to trauma, including avoidance, identity confusion, difficulties in interpersonal relationships, and feelings of guilt and shame, as documented by Carlson (1997).

Results of a multivariate analysis of variance (MANOVA) indicated that Asian and Black students reported more discrimination than White students. A hierarchical regression analysis controlled for generic life stress and found perceptions of discrimination contributed an additional 10% of variance in trauma-related symptoms for Black students. These findings offer tentative support for the suggestion that experiences of racial and/or ethnic discrimination can be viewed from the perspective of psychological trauma (Butts, 2002; Franklin, Boyd-Franklin, & Kelly, 2006). Scholars have argued that a traumatic response not only might be reflective of a single event but also might be associated with patterns of discrimination that are both accumulative, recurring, and intergenerational in nature (Bryant-Davis, 2007; Cross, 1998; Ford, 2008).

Although the findings do support an association between racial and/or ethnic discrimination and trauma-related symptoms, it is important to note that scholars have cautioned against overpathologizing the psychological response to discrimination and have argued against the adoption of a disease model per se. Carter et al. (2005) proposed an alternative concept for understanding the traumatic effects of racial discrimination and harassment, namely race-based traumatic stress. Drawing on work by Carlson (1997), Carter (2007) argued that much of the trauma associated with racial and/or ethnic discrimination is related to the perception of an event as emotionally painful (negative), sudden, and out of one's control, criteria that are consistent with Carlson's definition of trauma.

Thus, Carter (2005) proposed that race-related trauma be viewed as an emotional and/or psychological injury and not necessarily as a mental disorder, such as PTSD. Regardless of the current findings, the tension that exists between those who have called for the inclusion of racism and experiences of racial and/or ethnic discrimination in the criteria for traumatic stress (Sanchez-Hucles, 1999) and those who are calling for an elaboration of the concept of psychological trauma to include racial and/or ethnic discrimination (Carter, 2007) will need further attention before it is resolved. Additionally, recent work examining PTSD in the absence of a single traumatic event (Elhai et al., 2009) might provide additional insights into the nature of racial and/or ethnic-related trauma and could shed further light on the association between racial and/or ethnic discrimination and traumatic stress.

There is also research on attachment injuries from significant others and interpersonal losses as forms of trauma. Bowser (2000) found that HIV risk behaviors across ethnic & racial groups were significantly related to the loss of a significant other before the age of 15 and a lack of sufficient grieving for the person experiencing the loss.

National reports (Carten, 2006), indicate that African Americans are assigned more severe psychiatric diagnosis and over diagnosed for schizophrenia and under diagnosed for affective disorders. **The prevalence of African Americans is under reported, and much of the diagnosis may be misdiagnosis due to bias of the psychological testing, interview situations, predisposition of the clinician, and institutional racism.** It is largely believed that error in diagnosis may be due to clinicians' unfamiliarity with mental illness as it is manifested in African Americans. Yet, in 2006, Blacks were 50% less likely to receive psychiatric treatment and 60% less likely to receive psychiatric medications (DHHS, 2011).

In the report, *Pathways to Integrated Health Care: Strategies for African American Communities and Organizations* (Davis, 2011), the following information on mental health disparities is noted:

Close to 10% of African Americans who develop behavioral health disorders will access services through churches and ministers (Neighbors et al., 1998). Of particular importance is the finding that if African Americans obtain behavioral health care first from their ministers, the likelihood of their becoming involved in a traditional mental health setting diminishes considerably. Farris (2005) noted in her study that African American ministers tend not refer to mental health providers since they attribute causation to spiritual factors that are within their purview of intervention. This finding suggests that there is a marked absence of networking and mutual referral processes between African American ministers and behavioral health providers.

These data also confirm that African Americans significantly underutilize behavioral health care services and may over-rely on more informal approaches to behavioral disorders. Furthermore, help-seeking behavior by African Americans tends to be significantly delayed following the onset of behavioral health symptoms. Neighbors noted that after the onset of depressive symptoms [clinical and bipolar], African Americans may delay obtaining help by up to 30 years resulting in more chronic and disabling conditions, (Neighbors, 2007). Help-seeking by African Americans with behavioral health problems is also characterized by heavy use of emergency rooms and non-compliance with medication following service use, (Chun-Chung Chow, Jaffee, & Snowden, 2003; Snowden, 1999).

These data suggest that approaches to the design and delivery of integrated or holistic care to African American populations must consider the established paths that are currently used to obtain help. It is also important to recognize the substantial strengths that have characterized these communities for decades and enabled their members to manage adversity. It is because of this history that we must further develop practice-based evidence (PBE). PBE interventions are practices developed in our communities that are successfully providing high quality care even though they have yet to be formally evaluated. Through researching the core practice standards and criteria associated with the high quality care of PBEs, they can be moved on to the lists of evidence-based practices (EBPs).

Help seeking behavior involves a number of pro-active steps that take a person, family, or community from the point of recognizing a problem exists to using internal or external resources to solve, lessen, or cure the problem. The help seeking behavior of African Americans is notable by delay and reliance on the Black Church. African American consumers tend to delay help seeking for some behavioral health problems for many years or even decades. A new approach must be found that integrates established cultural beliefs and patterns into the design and implementation of services (Davis, 2010, pp.12-13).

FG#12: Client Family Members, Consumers, and Community Mental Health Advocates, Lodi - Conversation between focus group participants.

Angela (41 year old female): *"... I think a lot of people go to the church and if the church don't lead you to the stuff that's in the community, then they don't know. For us as African Americans, we gone pray it off. We gone pray about it and God's 'gonna remove it and we gone be okay. You know even though I'm still 'special' and still going through*

it, and can't sleep, and can't eat. You know, coming outside with those strip socks on. You know, I'm still praying for ya, you know. But instead of our leader saying you need some extra help here. You know God, you know he can help you but you need to see somebody else."

Patricia (55 year old female): *"This is why God put us here, to help you." (laughs…..)*

Angela (41 year old female): *"For African Americans, our leaders cause you know, most African Americans go to church, connected to church some kind of way. We need our leaders to be on board to say it's okay to go over and get our medication or it's okay you know to go talk to somebody.*

"When ministers are trained in counseling and recognizing mental illness, people get the help they need. The minister will know if he or she can help with the situation, or the minister will refer the person in the right directions. But, the minister needs to know how to give mental health counseling."
-In-depth Interview: Pastor Jules Nelson,
Inland Empire Concerned African American Churches

"Our parishioners come to us for help. We have a responsibility to help them. Our biggest need is for community mental health resources to help our people get the right assistance they need."
-FG#1: Reverend Joyce M. Whitfield,
Sojourner Truth Presbyterian Church, Richmond

PEOPLE OF AFRICAN ANCESTRY IN AMERICA

It is critical, therefore, to recognize that people of African ancestry living in America are not a homogenous group (Surgeon General's Report Mental Health: Culture, Race, and Ethnicity, 2001). They vary according to country of origin. Blacks are a people of diverse cultural practices, languages, and preferences but, share a common ancestral heritage - Africa. The diversity among African Americans continues to increase due to the continual influx of immigrants from Africa and the Caribbean; 6% of all Blacks in America are foreign-born (DHHS, 2001). To successfully address mental and behavioral health issues, attention must be given to individual and group worldview.

"I have a problem…I have three daughters, 12, 11, and 10…and my grandfather has made them a couple in my country in Africa. They call it engagement… I have difficulty with that rule…I have a broken spirit. I don't like it."
-FG#15: Fatima, 39 year old female,
Sudan Muslim wife/mother, San Diego

In a report from the Migration Policy Institute (2009) based on data from the US Department of Homeland Security, Office of Immigration Statistics, the number of African immigrants in the United States grew 40-fold between 1960 and 2007, from 35,355 to 1.4 million. Most of this growth has taken place since 1990. African immigrants made up 3.7% of all immigrants in 2007. About one-third of African immigrants were from West Africa. Top countries of origin for African born immigrants were Nigeria, Egypt, and Ethiopia. In the United States, Africans are concentrated in New York, California, Texas, Maryland, and Virginia. The United States admitted **60,680 refugees** and asylees in 2007. About one-third (32.9%, or 19,986) were from Africa. The top five countries of origin of African-born refugees and asylees admitted in 2007 were Somalia (7,031, or 11.6% of all refugees and asylees), Burundi (4,571, or 7.5%), Liberia (1,655, or 2.7%), Ethiopia (1,525, or 2.5%), and Eritrea (1,116, or 1.8%).

According to the Lewis Mumford Center (2009), in the 2000 Census the non-Hispanic Black population in America had grown by over six million people. The diversity of the American Black population demonstrates its complexity. Over 1.5 million Blacks were classified as Afro-Caribbean, and over 600,000 as Africans. These two groups alone account for about 17% of the six million increases in the non-Hispanic Black population. They are considered one of the emerging fast-growing populations. According to Lewis Mumford Center, Afro-Caribbean now out numbers and are growing faster than well-established ethnic minorities such as Cubans and Koreans.

African People in California

Of particular concern to African born people and African Americans is the identification of where our people are residing and the conditions under which they live; acculturation experiences; and what must be done to intervene in the trauma of relocating to places that are not indigenous to culture. African people live throughout the state of California. Where they are located is no clearly known. There is no demographic profile of people of African ancestry for the State of California at the neighborhood or community level.

THE BANCHE PROJECT

Our CRDP conducted a simple geographic information system (GIS) mapping. We called it the *Banche Project*, conducted from March 2010 to June 2010 to obtain data that would identify people of African ancestry by county, country of origin, or cultural identity. The purpose of this information was to outreach to African born people and obtain their input related to mental health issues. An undergraduate college student used this project to fulfill credits for graduation. Below is a summary of the *Banche Project* by Banchamlak Shita, BA student in the Department of Psychology, University of California, Riverside (UCR). Miss Shita is an African student that worked as an intern with AAHI-SBC specifically for this project.

The Banche Project Overview

In order to understand why data like this should be collected we must first understand why the African Diaspora occurred. Merriam-Webster defines Diaspora as the movement, migration, or scattering of a people away from an established or ancestral homeland. One of the largest migrations in human history happened through one of the first African Diaspora which began during the slave trade. Africans were sold into slavery and shipped throughout Europe, the Caribbean Islands, and North America. **Over nearly four centuries, 3 to 4 million Africans** were forced into migrating to their new homes. Later various other migrations happened as a result of displacement because of political views, famine, and rivalry between various African ethnic groups. Although the African Diaspora forced Africans out of their homeland many managed to retain may of their traditions, family views and culture while still being able to successfully integrate themselves into American culture. No longer needing to be forced into migrating north, countless African people later longed to be a part of the American dream essentially causing a constant Diaspora of African from their native homes.

We focused our attention on the African population that traveled to California. This research was conducted because there are population break downs in categories as White, Black, Asian, and Hispanic; however, we are unable to accurately give a population breakdown of the various African ethnic groups in California. The CRDP extensive literature review was unable to identify disaggregated data on African immigrants in California, and their utilization of the mental health system. Further, geographic identification of the population will provide invaluable information for program planning, primary prevention intervention, and appropriate healing practices based on cultural needs. Although knowing this information may give us more questions than answers, like why did these groups decide to move to their respective areas? Or, why are these groups concentrating in a few specific areas? However, the intent and aim of this simple GIS population mapping project was to provide a guide for more in-depth disparity information gathering. Further research is needed to significantly study this issue, of which this CRDP is limited in scope and purpose.

Irrespective of migration reasons and nationality, African people in California must be given opportunity for input into defining meaningful practices for good mental health. All people in California are free to use the public DMH system of care. The expected outcome of the Banche Project was to identify clusters of African people, and then extend an invitation to participate in the CRDP to include their voices in this important process.

Methods

We used convenient sampling methods with a cross sectional ecological study design.

Participants

Target specific recruitment involved college campus international student union associations. Miss Shita was the president of the UCR Abyssinian Student Union and could obtain immediate access to college student associations throughout California. Due to limited project funds, participation in this study was completely voluntary, no incentives were offered. Verbal consent to participant in the study was obtained.

Survey

Each participant completed a nine question (one page) self-administered demographic survey (Appendix A). Questions included, *"What country were you born?" "What African country's culture do you identify with?"* as well as, demographics for age, ethnicity, gender, education, employment, resident city by zip code, and how long in America.

Procedure/ Sample Sites

The survey administration took place at four separate meetings with statewide attendees. The first sample site was a Southern conference of the Abyssinian Student Union cultural groups. The schools in attendance included California State University San Diego, California State University Northridge, University of California Riverside (UCR), University of California Santa Barbara, University of California Los Angeles, and University of California San Diego. The second sample site was at UCR's Nigerian Student Association meeting. The third sample site was at the African Black Coalition Conference at UCR during two of the conference workshops. And a final administration was at the UCR Abyssinian Student Union's 3rd Annual Culture show.

Analysis

We analyzed the data using the statistical package for the social sciences (SPSS) software. We also conducted descriptive statistics (univariate analyses, frequencies and cross tabulation) of several variables; such as ethnic culture and age, ethnic culture and county of permanent residence, county of permanent residence and resident city, and ethnic culture and birth country.

Results

Total sample size was 200 people who self identified as having African ancestry. Of the 200 participants, 170 (85%) were current students and the remaining 30 (15%) were not currently enrolled in school; 62% (124) were females and 38% (76) were males. Age range was 18 to 65 years old. Age categorical breakdown indicated that 82.5% (165) were between 18-24 years old; 9.0% (18) were over 30; and 8.5% (17) were between 25-30 years old. See below for country of birth:

COUNTRY OF BIRTH	# PARTICIPANTS (N=200)	% OF TOTAL
United States	138	69.0%
Ethiopia	25	12.5%
Sudan	15	7.5%
Nigeria	10	5.0%
Eritrea	3	1.5%
Kenya	3	1.5%
Somalia	2	1.0%
Italy	1	0.5%
Philippines	1	0.5%
Liberia	1	0.5%
Uganda	1	0.5%
Jerusalem	1	0.5%

When asked "what culture" you identified with, the following responses were noted:

CULTURE IDENTIFIED	IDENTIFY WITH 1 CULTURE (N=200)	IDENTIFY WITH 2 CULTURES
Ethiopia	70	6
Nigeria	52	
Eritrea	46	1
Somalia	10	2
Ghana	7	
Kenya	5	
Sudan	4	
Uganda	2	
Egypt	2	
Liberia	1	
Sir Leone	1	1

All identified with one culture, but 10 identified with two cultures (probably because of mixed marriages).

However, when asked identification with geographical location in California, 14 different counties was identified, see below:

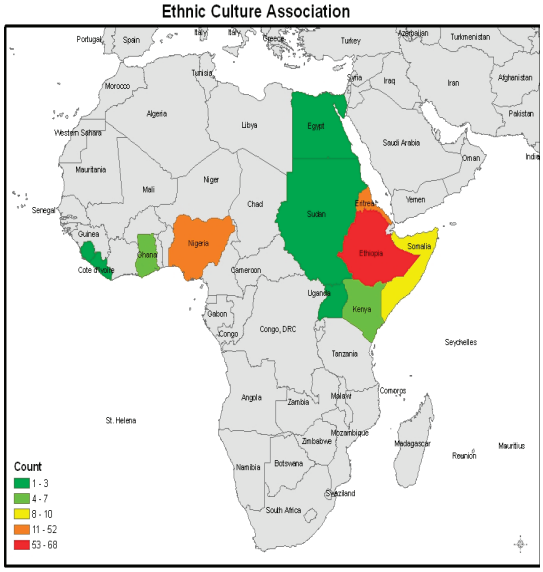
CALIFORNIA COUNTY	RESPONDENTS (N=200)	% OF RESPONDENTS
Los Angeles	89	44.5%
Riverside	20	10.0%
San Diego	20	10.0%
Alameda	14	7.0%
San Bernardino	11	5.5%
Fresno	10	5.0%
Orange	6	3.0%
Other: Kern, Sacramento, Contra Costa, Yolo, Sonoma, Placer, Stanislaus	30	15.0%

In cross tabulation with ethnic culture and California County of permanent resident, participants identified as below:

CALIFORNIA COUNTY	ETHNIC CULTURE	RESPONDENTS (N=200)
Los Angeles, n=89	Ethiopia	37
	Nigeria	21
	Eritrea	16
	Somalia	8
	Ghana	3
	Egypt	2
	Sir Leon Sudan	1
	Uganda	1
Riverside, n=20	Nigeria	10
	Eritrea	3
	Ethiopia	2
	Kenya	2
	Sudan	2
	Uganda	1
San Diego, n=20	Eritrea	16
	Ethiopia	3
	Somalia	1
Alameda, n=14	Eritrea	4
	Ethiopia	4
	Nigeria	3
	Kenya	2
	Ghana	1
San Bernardino, n=11	Nigeria	7
	Ethiopia	4
Fresno, n= 10	Ethiopia	10
Orange, n=6	Nigeria	3
	Ethiopia	3
Yolo, Kern, Sacramento, Central Costa, Sonoma, Stanislaus	-	30

The results indicated that 84% identified with Ethiopian (35%), Nigerian (26%), or Eritrean (23%) culture. Participants where spread across 45 cities in California, with a majority of the participants concentrated in LA County, Riverside County, San Diego County, and Alameda County. See Figures below mapping participants from African cultures and mapping clusters of participants by resident regions in California. No generalizations are drawn from these findings based on a convenient sample; the intent was to identify clusters of African people and to invite participation in the CRDP.

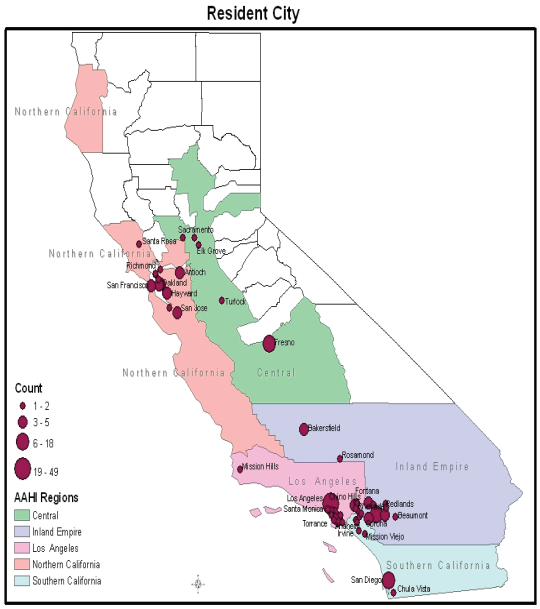
GIS Mapping of African Culture of Participants in the Banche Project



Study Limitations

One limitation was time, due to the fact that this survey was completed in spring quarter many universities were unable or unwilling to participate. The next limitation was the number of participants; a larger sample size was anticipated. Finally, how much time needed to collect and analyze the data and write the report, limited follow-up and more investigation of identified locations as well as traveling to other association meetings around the state for a more representative sample. Ten weeks for an undergraduate project in the spring quarter was limiting.

GIS Cluster Mapping of the California Resident Region of Sample Population in Banche Project



Signi ficance to Mental Health

Population growth and shifts in the population are of concern as we move toward identifying practices that will enhance access and reduce disparities for unserved and underserved individuals throughout California. For our Population Report, we attempted to include data from diverse African subpopulations, by regions within California. Understanding the Black population in California is critical to counties as they expand community programs to assist consumers in getting "whatever it takes" to promote "help first" for prevention and early intervention for people at risk and in need of mental and behavioral health services.

African people in California are not all the same. Understanding the differences and experiences of Africans in California will help to bridge the gaps and connect Africans and African Americans based on individual and community needs. People of African ancestry cannot fit into one box; there must be respect of diverse values, norms, and practices.

The CRDP was successful in conducting a focus group with Africans in San Diego who were from countries identified in the *Banche Project*; both refugees and immigrants. We also conducted a small group meeting in Santa Clara with Ethiopians. Several Africans participated in focus groups and public forums in Alameda, San Diego, and San Bernardino Counties. Of critical significance is that this CRDP acknowledged the importance of including diverse people of African ancestry, and demonstrated the value of obtaining cultural perspectives from lived experiences of Black people. Black people in America vary greatly related to personal preference. Not one group can speak for the entire population. We must hear the worldview of people from their perspective and respect personal preferences. We must never forget our roots, where we have come from, because therein lies the answers as to where we are going and how to get there.

Similar to the *Banche Project* is one of the primary critical reference resources for this CRDP is the Los Angeles County DMH Mapping Project for Africans and African Americans conducted by Dr. Karen S. Gunn (*African/African American Report*, 2011) in Service Area 6 (which includes high concentrations of the population in Compton, Watts, Lynnwood, Paramount, Florence/Firestone, Baldwin Hills, and USC East & South). Funded by the MHSA, the primary goals of the Mapping Project were: (1) to develop a repository and informational manual of MHSA relevant resources for African/African Americans communities in Service Area 6; (2) identify and document existing community resources and needs; and (3) provide a platform for resource consortium through which African/African American providers can network and build collaborations. A complete copy of the *African/African American Report* (2011) can be obtained from the County of Los Angeles DMH Planning, Outreach and Engagement Division. Significant resources, such as the "Life Links," a resource listing for residents of South Los Angeles County, are identified that will facilitate access to culturally appropriate mental health resources. Additional plans are underway with the Los Angeles DMH to provide culturally appropriate information for African people within their county. Thank you, Los Angeles County for this important initiative.

THE SYSTEM LEVEL: CALIFORNIA DISPARITY DATA

> *"There really is a difference. Sometimes, I'm in the community and there is a meeting about mental health. You see the White consumers, and they are talking about it like it's nothing. Something that you just go to your counselor, get treatment because this is what is owed, basically, and it's okay. It's totally different... with African Americans.*
> **-FG#10: Sharon, 53 year old Black female,**
> ***The Children of Promise*, Sacramento**

In California, the Department of Mental Health conducted a series of data analytic and systems reviews as reported in the California External Quality Review Organization: Statewide Report Year Four FY07-08 (July 2007 to June 2008, Volume I & II (August 2008) as part of the Centers for Medicare & Medicaid Services (CMS), mandated external quality review of Medicaid managed care programs. Under Section 1915(b) of the Social Security Act (1915[b] wavier), California may operate a statewide system of

"Where is our help? I am serious. Black people are not getting treated like everybody else. This happened to me personally."
-FG#33: Marilyn, 57 year old Black female Resource Volunteer, San Bernardino County

individual mental health plans (MHP) in each county, i.e. the mental health managed care program. Essentially, the California public mental health system is directed by individual county mental health plans (MHPs).

According to this Statewide Report (2008), the public mental health environment in California is challenging and the MHPs have significant conflicting priorities that affect many aspects of the system, such as program governance and service delivery. One critical structural challenge noted in the report was a lack of data and performance management, which directly impacts the CRDP project and its effort to document mental health disparities and make recommendations for improvement based on available data. Also, noted in the report was that most MHPs acknowledge the importance of using data for performance management, many have only begun to collect data on basic indicators like timeliness of service delivery and quality outcome measures. Another result of the Statewide Report (2008) was that the outcome analysis indicated **notable and highly consistent disparities in access, cost and the types of services received by different groups.**

In conversation with the California Department of Mental Health (Bryan Fisher, personal communication, April 14, 2011), on July 1, 2006 changes were implemented in data collection to better meet federal reporting requirements. As such, the DMH requires counties to report client and service information by separate fields for ethnicity and race, and has discontinued the collection of a combined field of ethnicity/race. **To ensure that this CRDP had the most current data from the DMH CSI, a request was made to provide specific reports.**

Table 5 displays the most accurate data (as of March 17, 2011) of the unduplicated count of clients served by race for all modes of services in all California counties for fiscal year 2007-2008. Unduplicated count means any person who came to the DMH and registered for services, and was seen for services during a specific year has been reported only once. As reported by the DMH CSI system for fiscal year 2007-2008, the highest users of mental health services in California were Whites (36.0%), followed by Hispanics (30.7%) and African Americans (16.6%).

Table 5: *California Department of Mental Health Client and Service Information (CSI) System Unduplicated Count of Clients Served by Race for All Modes of Services, All Counties, Fiscal Year 2007-2008*

RACE	UNDUPLICATED CLIENTS SERVED	%
White or Caucasian	241,610	36.0%
Hispanic	205,957	30.7%
Black or African American	**111,373**	**16.6%**
Asian[1]	34,193	5.1%
Other Race	16,393	2.4%
Multi-Race	13,418	2.0%
American Indian or Alaska Native	4,862	0.7%
Hawaiian Native or Other Pacific Islander	2,970	0.4%
Not Reported/Unknown	40,567	6.0%
Total	**671,343**	**100.0%**

Source: California Department of Mental Health, Client and Service Information System. Data as of March 17, 2011.
[1]The Asian category contains all Asian Indian, Cambodian, Chinese, Hmong, Filipino, Japanese, Korean, Laotian, Mein, and Vietnamese clients. A small percentage of other Asian races may be included in the Pacific Islander category due to historic collection methods.

When considering age groups for the highest number of clients served, individuals age 26 to 59 were consistent across all races except Hispanic (*Table 6* and *Figure 12*). The Hispanic age group served the most during this time was less than 16 years old.

Table 6: *California Department of Mental Health Client and Service Information (CSI) System Unduplicated Count of Clients Served by Age and Race for All Modes of Services, All Counties, Fiscal Year 2007-2008*

	AGE IN YEARS					
RACE	16 AND UNDER	16-25	26-59	60 AND OLDER	NOT REPORTED	TOTAL
White or Caucasian	39,912	38,346	142,633	20,687	32	241,610
Hispanic	79,999	45,871	72,854	7,210	23	205,957
Black or African American	**27,686**	**21,748**	**57,329**	**4,600**	**10**	**111,373**
Asian[1]	4,093	4,370	20,645	5,081	4	34,193
Other Race	4,203	3,110	7,718	1,358	4	16,393
Multi-Race	4,792	2,840	5,279	507	0	13,418
American Indian or Alaska Native	1,186	818	2,704	224	0	4,862
Hawaiian Native or Other Pacific Islander	545	505	1,611	309	0	2,970
Not Reported/ Unknown	6,643	7.951	22,611	3,355	7	40,567
TOTAL	168,989	125,559	333,384	43,331	80	671,343

Source: California Department of Mental Health, Client and Service Information System. Data as of March 17, 2011.
[1]The Asian category contains all Asian Indian, Cambodian, Chinese, Hmong, Filipino, Japanese, Korean, Laotian, Mein, and Vietnamese clients. A small percentage of other Asian races may be included in the Pacific Islander category due to historic collection methods.

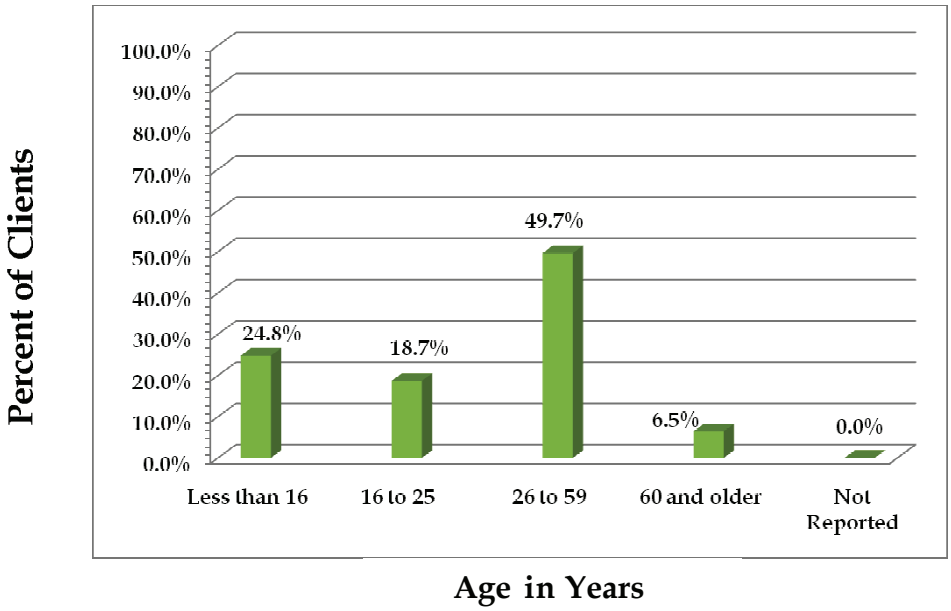


Figure 12: *California Department of Mental Health Client and Service Information (CSI) System Percent of Total Unduplicated Count of Clients Served by Age Group for All Modes of Services, all Counties, Fiscal Year 2007-2008*

See *Figure 13* for the total African Americans served by age group.

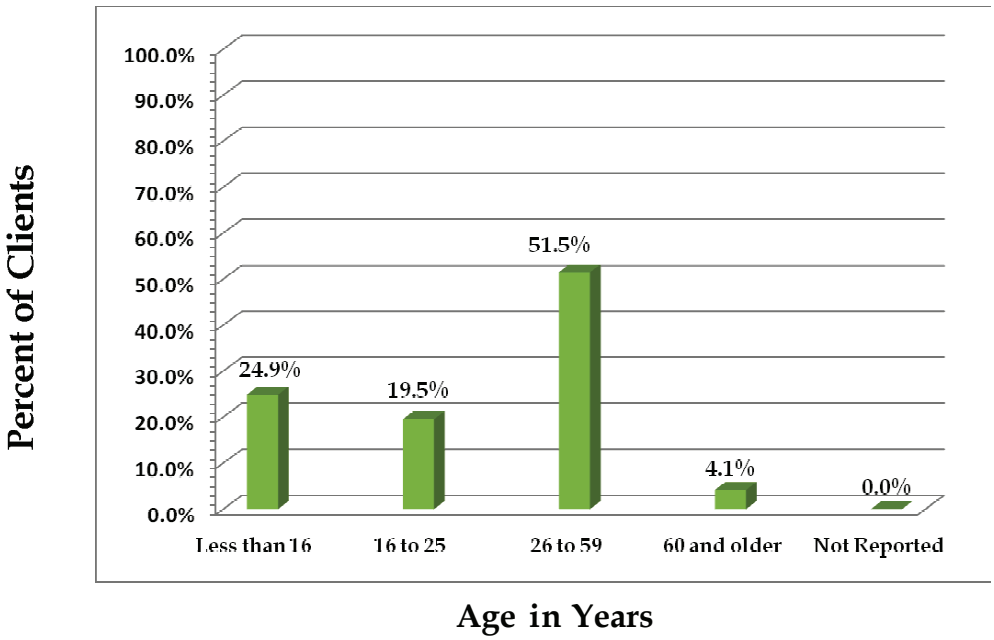


Figure 13: *California Department of Mental Health Client and Service Information (CSI) System Percent of African Americans within the Total Unduplicated Count of African American Clients Served by Age Group for All Modes of Services, All Counties, Fiscal Year 2007-2008*

In 2007-2008, more male clients (52.2%) were served than females (47.4%), except for Asian, American Indian or Alaska Native, and Hawaiian Native or Other Pacific Islander (*Table 7*).

Table 7: *California Department of Mental Health Client and Service Information (CSI) System Total Unduplicated Count of Clients Served by Gender for All Modes of Services, All Counties, Fiscal Year 2007-2008*

RACE	MALE	FEMALE	OTHER	NOT REPORTED	TOTAL
White or Caucasian	121,234	119,728	32	616	241,610
Hispanic	110,364	95,288	10	305	205,957
Black or African American	**61,669**	**49,558**	**1**	**145**	**111,373**
Asian[1]	15,337	18,566	1	289	34,193
Other Race	8,243	8,055	0	95	16,393
Multi-Race	7,009	6,376	1	32	13,418
American Indian or Alaska Native	2,210	2,641	1	10	4,862
Hawaiian Native or Other Pacific Islander	1,407	1,558	0	5	2,970
Not Reported/ Unknown	23,199	16,575	5	788	40,567
Total	**350,662**	**318,343**	**51**	**2,285**	**671,343**

Source: California Department of Mental Health, Client and Service Information System. Data as of March 17, 2011.
[1]The Asian category contains all Asian Indian, Cambodian, Chinese, Hmong, Filipino, Japanese, Korean, Laotian, Mein, and Vietnamese clients. A small percentage of other Asian races may be included in the Pacific Islander category due to historic collection methods.

See *Figure 14* for gender distribution of African Americans served during fiscal year 2007-2008.

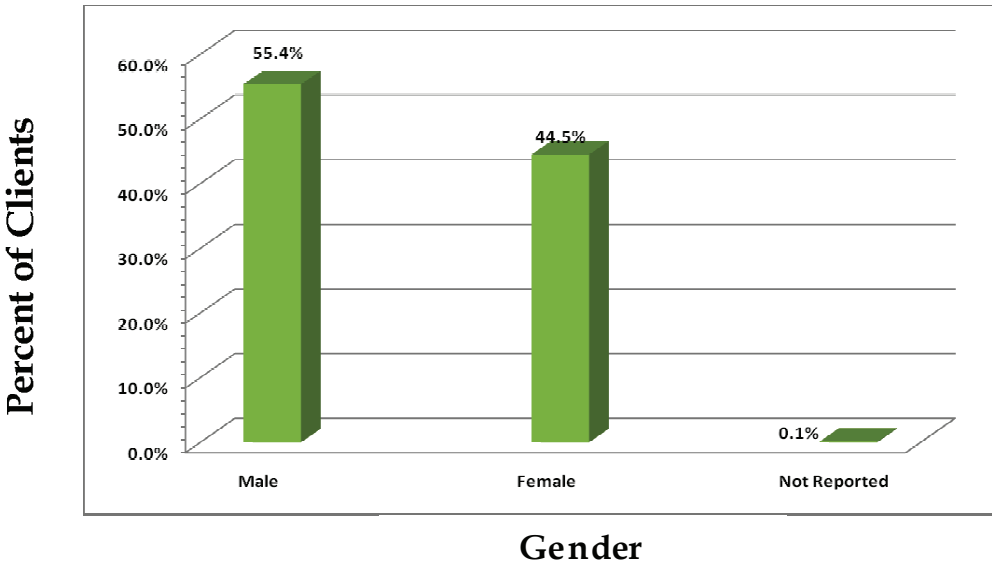
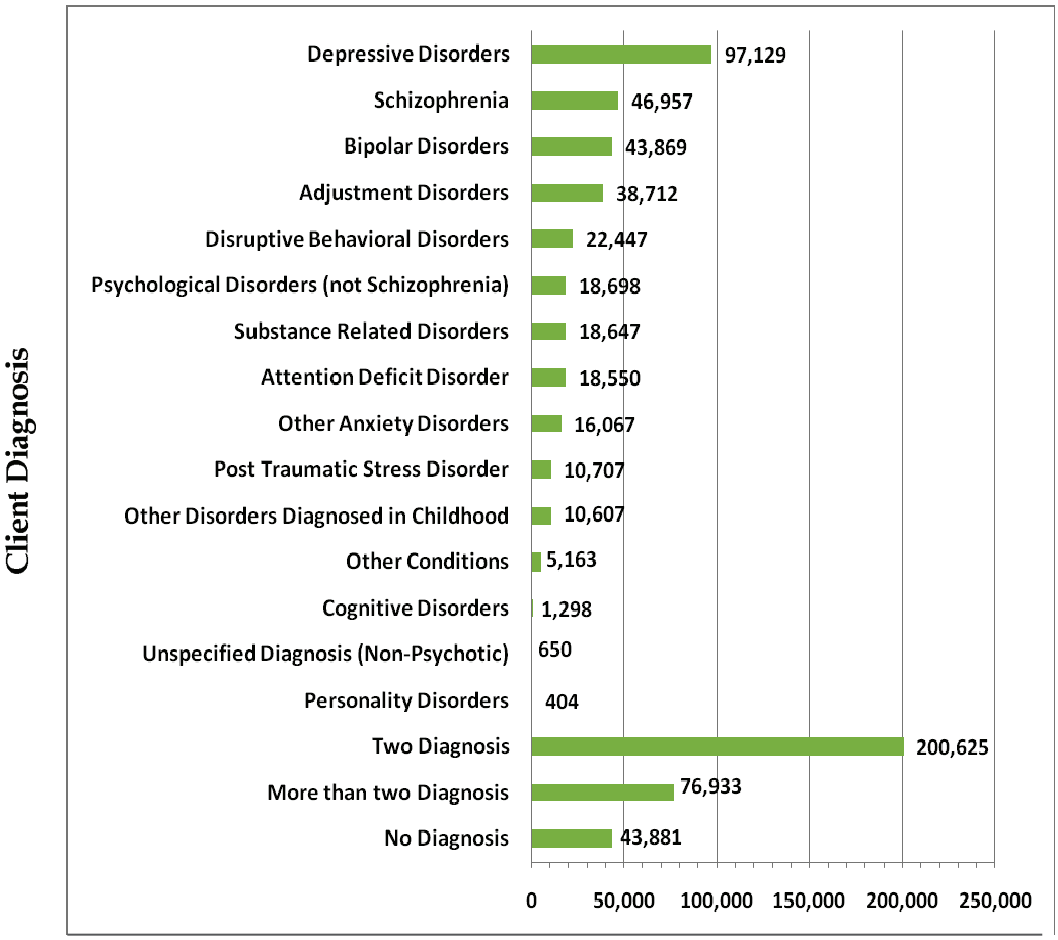


Figure 14: *California Department of Mental Health Client and Service Information (CSI) System Percent of African Americans within the Total Unduplicated Count of African American Clients Served by Gender for All Modes of Services, All Counties, Fiscal Year 2007-2008*

Of the total unduplicated count of clients served in fiscal year 2007-2008, *Figure 15* is the rank order of all modes of services for all counties by diagnosis. The top three conditions were depressive disorders, schizophrenia, and bipolar disorders, respectively.



Source: California Department of Mental Health, Client and Service Information System. Data as of March 17, 2011.

Figure 15: California Department of Mental Health Client and Service Information (CSI) System of Total Unduplicated Count of Clients Served by Diagnosis for All Modes of Services, All Counties, Fiscal Year 2007-2008

See *Table 8* for all diagnosis of clients served, and *Figure 16* for the diagnosis reported for nearly 70% of African American clients served during fiscal year 2007-2008.

Table 8: *California Department of Mental Health Client and Service Information (CSI) System of Total Unduplicated Count of Clients Served by Diagnosis in Rank Order by Race for All Modes of Services, All Counties, Fiscal Year 2007-2008*

	Total	White	Hispanic	Black	Asian[1]	Other Race	Multi-Race	American Indian or Alaska Native	Hawaiian Native or Other Pacific Islander	Not Reported
Two Diagnosis	200,625	81,840	61,478	30,774	9,235	4,564	4,352	1,720	664	5,998
Depressive Disorders	97,129	30,944	32,371	13,985	8,036	3,010	1,407	589	716	6,071
More than two Diagnosis	76,933	34,790	21,084	13,014	2,057	1,288	2,093	721	237	1,649
Schizophrenia	46,956	18,989	9,241	9,348	4,926	1,055	598	268	320	2,211
No Diagnosis	43,881	11,707	11,799	8,427	1,472	1,007	1,259	242	250	7,718
Bipolar Disorders	43,869	20,902	9,025	6,921	1,580	933	736	326	148	3,298
Adjustment Disorders	38,712	9,681	16,754	5,633	1,432	1,179	947	292	160	2,634
Disruptive Behavioral Disorders	22,447	3,397	11,754	4,421	651	572	472	94	69	1,017
Psychological Disorders (not Schizophrenia)	18,698	5,388	4,479	4,800	1,419	494	171	108	97	1,742
Substance Related Disorders	18,647	5,836	4,023	4,080	242	298	126	92	40	3,910
Attention Deficit Disorder	18,550	5,192	7,346	3,701	434	399	407	94	53	924
Other Anxiety Disorders	16,067	5,345	6,277	1,492	710	523	250	129	54	1,287
Post Traumatic Stress Disorder	10,707	2,674	3,510	1,751	1,204	373	245	90	85	775
Other Disorders Childhood Diagnosis	10,607	2,347	4,679	1,718	453	496	249	56	38	571
Other Conditions	5,163	1,558	1,689	918	227	141	59	27	29	515
Cognitive Disorders	1,298	576	193	211	81	41	27	6	6	157
Unspecified Diagnosis (Non-Psychotic)	650	232	177	128	24	16	14	6	2	51
Personality Disorders	404	212	78	51	10	4	6	2	2	39
Total	671,343	241,610	205,957	111,373	34,193	16,393	13,418	4,862	2,970	40,567

Source: California Department of Mental Health, Client and Service Information System. Data as of March 17, 2011.
[1]The Asian category contains all Asian Indian, Cambodian, Chinese, Hmong, Filipino, Japanese, Korean, Laotian, Mein, and Vietnamese clients. A small percentage of other Asian races may be included in the Pacific Islander category due to historic collection methods.

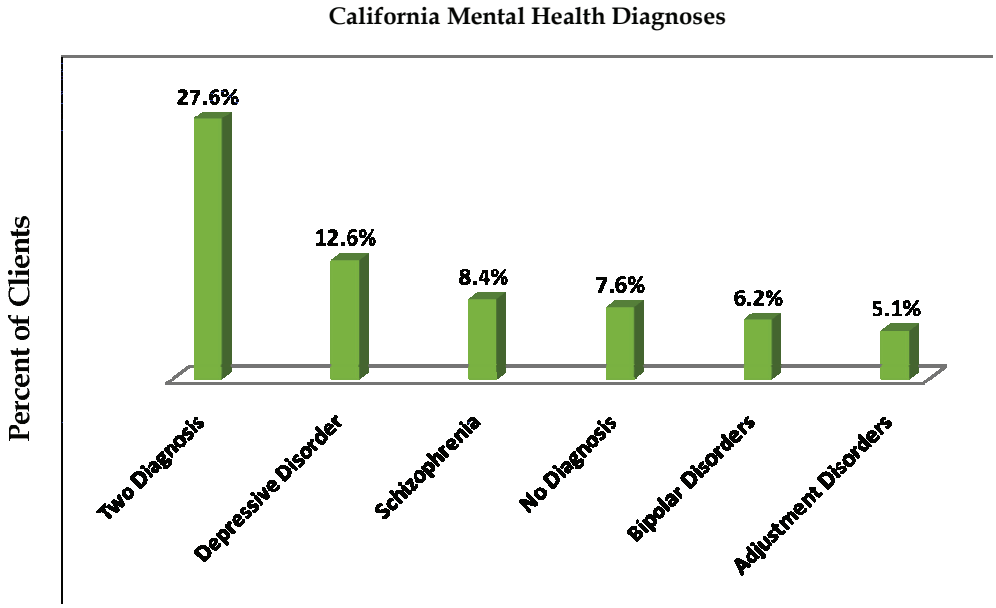


Figure 16: *California Department of Mental Health Client and Service Information (CSI) System Percent of African Americans within the Total Unduplicated Count of African American Clients Served by Top Six Diagnosis in Rank Order for All Modes of Services, all Counties, Fiscal Year 2007-2008*

Source: California Department of Mental Health, data reported as of March 17, 2011.

MENTAL HEALTH IN PEOPLE OF AFRICAN ANCESTRY IN CALIFORNIA

How do African Americans use the mental health system in California?

The best source of mental health service usage is the California DMH Client and Services Information (CSI) System, which collects data related to mental health clients and services received at the county level (DMH, CSI, 2011). Service providers are required to report data monthly. According to the CSI description at the online database, a basic principle of the CSI system is that it reflects both Medi-Cal and non-Medi-Cal clients, and services provided in the County/City/Mental Health Plan program. This includes all providers whose legal entities are reported to the County Cost Report under the treatment program.

In county-staffed providers, all clients and services must be reported. In contract providers, those clients and services provided under the contract with the county mental health program must be reported. Clients to be reported to the CSI system are persons with Medi-Cal eligibility; persons who are medically indigent; persons with private insurance, Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), Medicare, and Healthy Families Program; persons having Uniform Method for Determining Ability to Pay (UMDAP) liability; and, persons receiving any public funds to pay for all or part of their services.

In California, mental health service usage is reflected in the retention and penetration rates. The penetration rate is a comparison of total clients versus an estimate of the prevalence of people with serious mental illness and serious emotional disturbance (CDMH, 2011). Prevalence is the total of all existing clients as reported under the CSI retention data. California statistics in 1997 to 1998 showed that Blacks comprised 15.66% of all unduplicated mental health clients, behind Hispanics at 19.52% and Whites at 52%, (CDMH, 2011). However, the penetration rate, showed Blacks at 2.66%,

Whites, 1.18% and Hispanics, 0.73%. In California during 2007 to 2008, the reported penetration rates for African Americans was 86.51%, Whites 73.71%, Asian/Pacific Islanders 49.48%, Native Americans 41.06%, and Latinos 26.77% (CDMH, 2011). One might draw an erroneous conclusion, and think that African Americans in California have significantly improved in using the mental health system and do not need any specific PEI. A more careful examination will reveal this is not the case.

According to the California DMH, of the estimated **three million residents that had a serious emotional disturbance or serious mental illness in 2004**, only 20% were served through county mental health departments. This did not include people experiencing less severe mental health conditions. For California Fiscal Year 2005-2006 (CDMH, 2011), the total number of African American clients served in county mental health programs was 103,220; 15.7% of the total clients seen. Of the 103,220 clients served, the number of African American clients receiving day services was 19.1% (13,218); number receiving inpatient services was 14.8% (6,414).

> *"I have been in the mental health system since 1997. I know for a fact African American people are not being seen. When I go in I make sure I am seen, and somebody is going to take care of my needs, or I ain't leaving the clinic until I am seen."*
> **-Inter-depth Interview: Charlyne: 54 year old Black female, diagnosed bipolar, Los Angeles County Skid Row resident**

Ojedea & McGuire (2006) examined the relationship between race/ethnicity and outpatient mental health service use, controlling for socio-demographic, health status, insurance, and geographic characteristics, focusing on Latinos and African Americans. Latinas and African American women and men exhibited low use of outpatient mental health services. Similar results were observed in an insured subsample. Service use by minorities was more affected by financial and social barriers (e.g., stigma). No gender differences were observed in self-reported barriers to care.

The RFP for the CRDP project required documenting demonstrated disparities, population data and information. The lack of readily available California specific data on the African American population distorts the understanding of the reality of mental health problems. Very specific data reports requested in April 2011 from the DMH on African American diagnosis and the type of care received was not available. The DMH CSI system is currently under revision and update. Data in this report was obtained from the CSI as of April 2011.

Inconsistent data reporting does not provide a clear view of how the African American population has been served and the type of services received. For example, Table 8 representing fiscal year 2007-2008 total number of clients served by number of services taken from data on the CSI website, as of April 2011, has a total number of services received by African Americans at 67,287. Generated data reports from the DMH at the time of this report (April 12, 2011) for the fiscal year 2007-2008 identified that 111,373 African Americans ("unduplicated" counts) used serves, a variance of 55,914 service units (nearly one half of the actual population served). **Data reporting lag time could certainly account for this variance.**

Nevertheless, the available data could misrepresent the reality. Using the updated "unduplicated" count (111,373) and comparing it to the total African Americans in the State of California (2,159,978), it means that 5.16% of the African American population used the DMH services. When we compare the 111,373 to the total California population,

African Americans are less than 1% of the population using the DMH services. Let's compare the total number of all "unduplicated" client services in the DMH (671,343) to each ethnic population (see Table 5) again we have African Americans at 16.6% of all the clients seen in DMH, compared to 36% White clients and 30.7% Latino clients. This information provides a different view of African American utilization.

To understand the mental health problems of African Americans it is imperative that data collected and reported on the population provide information about how the system is being used and what mental health conditions are being presented, not just the number of clients served. Service outcome data gives better directions into what must be prevented or where early detection efforts must be targeted.

In the California DMH, prevalence of mental health conditions is a critical factor in determining underutilization or over utilization of services, as well as identifying points of target specific approaches for PEI. See Table 8 and Figure 16 for the current prevalence of specific mental health conditions reported by the California DMH for services received by African Americans. No other prevalence data regarding service types were available from DMH at the time of this report. However, we believe this is gross underserving the needs of the population because many people of African ancestry stay away from mental health service providers (Ojedea & McGuire, 2006).

A critical approach for PEI efforts is to identify at risk African Americans for developing mental health disorders. A large share of people reporting symptoms stay away from community mental health centers altogether, but goes in for primary care (Davis, 2011). Successful PEI activities will require integrating with primary care providers.

Mental Health Disparities for African American Consumers in Los Angeles County: Community Psychiatrist's Prospectus

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African Americans who seek mental health services in Los Angeles County experience significant challenges. The difficulties that they face arise from a variety of sources that include, but are not limited to, socioeconomic disparities that make access to care difficult, a lack of culturally congruent providers, and long held cultural beliefs that inhibit them from openly acknowledging mental health difficulties. Often when they do receive help, it comes later in the course of illness and frequently when things have already reached a crisis point. All too often, these episodes result in their involvement in the criminal justice system where they are an over represented group.

Access to Affordable Services

Traditionally, African Americans are perceived as being overrepresented statistically as a group compared to their overall population numbers among those who receive services in safety-net settings. This data may be distorted since it fails to take into account the high level of unreported and undiagnosed chronic mental health and substance abuse problems among this population. Exceptionally high rates of violence, poverty, community disorganization and racial discrimination contribute to higher rates of mental distress among African Americans compared to other minority groups in urban Los Angeles (DHHS, 2001). Recent 2011 California budget cuts in state and local funding for indigent care have led many directly operated county clinics and contracted agencies to reduce the number of available slots for treating those who lack any resources or funding.

The result has been overcrowding of psychiatric emergency rooms and long waits for both inpatient and outpatient services. Only those with the most severe circumstances that involve imminent safety risks are addressed immediately. Several smaller agencies that depend on county funding have experienced reductions in workforce and some have closed as a result of the realignment of services and associated operating costs required to adapt to funding streams associated with the Mental Health Services Act (MHSA).

The stakeholder process that determines which new services will be funded requires communities to be organized and cohesive with clear advocacy goals. Unfortunately, the diversity within the African American and African communities within Los Angeles have made it difficult for this group to develop a strategic plan or consensus around which services are most important to pursue.

Culturally Congruent Services

Most studies have shown that individuals are often more comfortable seeking services from someone with whom they share a racial or cultural background. For African American consumers, only a limited number of mental health clinicians meet this expectation. Nationally, the percentage of psychiatrists, psychologists and social workers who are African American is low (2-4% according to most studies), and Los Angeles County is no exception.

This affects all African American consumers' ability to obtain culturally congruent services regardless of where they go for care. Safety-net hospitals and clinics that treat indigent patients have a limited number of African American professionals. African American providers who enter private practice often do not take public or even private insurances since the competitive economic climate in Los Angeles encourages self-pay. Often they treat a diverse clientele and their practices may not be in areas that are easily accessible to African American patients.

Local training programs for psychiatrists do not have a strong history of recruiting or retaining African American physicians. One exception were the residency programs affiliated with Charles Drew University and Martin Luther King, Jr. Hospital (one of the 4 Historically Black Medical Schools) which graduate up to 7 psychiatrists per year, often of African ancestry. The vast majority of these physicians chose to remain in Los Angeles after training to provide services in the communities surrounding South Los Angeles. The closure of the hospital and subsequently the residency program resulted in a loss of 36% of residency training spots sponsored by historically Black medical schools in the United States and a much greater negative impact on the percentage of minority psychiatrists working in the urban areas of Los Angeles County.

Faculty composition at local medical schools also does not reflect the diversity of the community, and several local academic psychiatry departments have no African American psychiatrists on their teaching faculties. Medical school and psychiatry residency training curricula often do not include critical information about differential responses to pharmacotherapy in African American patients since non-minority faculty are often unaware of and not invested in disseminating this information.

The number of local research faculty of African American or African descent is woefully inadequate. This deficiency is reflected in the relatively limited amount of research underway to address the special needs of African Americans with mental health problems. Loan repayment programs that target urban communities and underrepresented minority providers are one way to increase the number of service providers equipped to serve African American consumers.

Stigma

Negative attitudes and beliefs about mental illness and general prohibitions about verbalizing mental health problems for fear that this will be perceived as weakness or laziness is pervasive in the African American community. This area has been well documented, but successful interventions have demonstrated some effectiveness in reaching beyond this barrier. Black Barbershop and Beauty Shop Outreach Programs are good examples of culturally specific programs focused on education and engagement of African American consumers around areas of general health. But, they have not always had sufficient volunteers to address mental health issues. Faith based outreach programs have also proven effective through health fairs and breakfast meetings for pastors, but members of the religious community continue to report that they have difficulty linking members of their congregations to mental health services that meet their needs. Community education about available resources is needed to reduce the impact of stigma in the local African American community.

Criminal Justice Involvement

African American consumers in Los Angeles County are more likely than others to have their first episode of mental health treatment occur through the criminal justice system rather than through more appropriate therapeutic venues. One contributor to

this problem is the lack of readily accessible emergency mental health interventions in underserved communities and a tendency for police officers to respond to 911 calls rather than Psychiatric Mobile Response Teams (PMRT) with trained mental health personnel performing a thorough assessment. When mental health problems co-exist with substance abuse issues, criminal behavior is a common current that generally trumps health treatment when transportation decisions are made. The State of California has mandated Crisis Intervention Training for Law Enforcement (CIT). The purpose is to train law enforcement on how to respond to individuals that have a mental illness, during a "crisis" intervention. Using the CIT is intended to possibly prevent hospitalization or a 5150 process. There needs to be an assessment of the CIT, and examining alternatives for jointly utilizing PMRT.

The populations of mentally ill inmates receiving services at Twin Towers Correctional Facility in Los Angeles are overwhelmingly Black and Latino with the largest collection of inmates being from geographic service areas in the Black Community. Reviews of their service treatment records often indicate that they receive more mental health services while incarcerated than they do while they are in the community. Unfortunately, this cycle of recidivism results in repeat arrests for minor infractions once a criminal record is established. Their re-entry into the community is hampered by the lack of housing, employment and also easily accessible mental health treatment. In addition, because of their inability to comply with rules and to advocate for themselves as a result of being very symptomatic they often end up spending longer in custody than those who do not have mental illness.

Training programs to educate custody staff and community patrol officers that go beyond the minimal education that they currently receive can help to reduce incarceration among this group and by preventing the cycle from ever starting. Non-violent offenders should be steered clear of institutional containment and sent instead to court ordered treatment programs. The Sequential Intercept Model developed by Mark Munetz and Patricia Griffin can be used to direct community leaders to points of intervention so that the burden of imprisonment can be reduced.

Overall, African Americans consumers with mental illness face many challenges in receiving mental health treatment comparable to their peers. These disparities also extend to physical health, but in this area, more research exists to point to genetic vulnerabilities and acceptable treatment interventions. For instance, we know a great deal about the origins, identification and treatment of hypertension in Blacks than we do about schizophrenia in the same population. Nevertheless, the risk factors of poverty, stress and bias can be balanced by the many strengths that African Americans posses as a group. Leveraging the positive traditions of strong faith based values and community participation may help to lead us to clues about how to design and implement successful programs and interventions for African Americans throughout Los Angeles County.

What service units are recorded in the CSI database for actual mental health clients served?
Table 9 identifies for fiscal year 2007-2008, all services provided by ethnicity; Table 10 contains a description of the service categories. *NOTE: At the time of this report, data in Table 9 for clients served by number of services was the only current data available from CSI. As of January 16, 2012, this data is still posted on the CSI website. The total number (534,812) is different from the total in Table 5 (671,343), because the data report generated for Table 5 was prepared for this CRDP with the most current data available in the CSI system. The DMH staff was unable to generate updated reports on the services in Table 9.*

Table 9: *California Department of Mental Health Client and Service Information (CSI) System Total Number of Clients Served by Number of Services, by Ethnicity All Counties, Fiscal Year 2007-2008*

ETHNICITY	24-HOUR IN-PATIENT	1-DAY OUT-PATIENT	2-4 DAYS OF SER-VICE	5-15 DAYS OF SERVICE	GREATER THAN 15 DAYS OF SERVICE	TOTAL
White	1,812	40,624	44,062	60,086	57,665	204,249
Hispanic	768	31,630	34,100	43,858	40,027	150,383
African American	694	15,617	16,875	17,898	16,205	67,287
Asian/Pacific Islander	152	4,873	6,472	11,018	7,961	30,476
Native American	18	746	914	1,188	1,202	4,068
Other	625	16,350	18,708	23,670	19,994	79,347
Total	4,069	109,840	121,131	157,718	143,054	535,812

Source: California Health and Human Services, Department of Mental Health, Data Management and Analysis Section, CSI Report, retention data as of June 8, 2010
NOTE: At the time of this report, data in Table 9 for clients served by number of services was the only current data available from CSI. As of January 16, 2012, this data is still posted on the CSI website. The DMH staff was unable to generate updated reports on the services in Table 9.

Table 10: *California Department of Mental Health Client and Service Information (CSI) System Description for Service Category, Fiscal Year 2007-2008*

24-HOUR SERVICES	DAY SERVICES	OUTPATIENT SERVICES
Hospital Inpatient	Crisis Stabilization-Emergency Room	Case Management Brokerage-Collateral
Hospital Administrative Day	Crisis Stabilization-Urgent Care	Professional Inpatient Visit-Collateral
Psychiatric Health Facility	Vocational Services	Mental Health Services (MHS)
SNF Intensive	Socialization	Professional Inpatient Visit-MHS
IMD Basic (no Patch)	SNF Augmentation	Medication Support (MS)
IMD With a Patch	Day Treatment Intensive-Half Day	Professional Inpatient Visit-MS
Adult Crisis Residential	Day Treatment Intensive-Full Day	Crisis Intervention-(CI)
Jail Inpatient	Day Rehabilitation-Half Day	Professional Inpatient Visit-CI
Residential-Other	Day Rehabilitation-Full Day	
Adult Residential		
Semi-Supervised Living		
Independent Living		
Mental Health Rehab Center		

Source: California Department of Mental Health, Client and Service Information System, Data Dictionary, Page 5-06.0 SERVICE FUNCTION, revised June 2001.

Although African American clients are counted as being served, questions that need to be answered are, *"What is the actual service received? What is the mental and behavioral health wellness status of the African American population in California, weather served in the DMH/or private service providers, or if they are not served at all?"* Wellness indicators provide a more appropriate insight into the outcome impact and success of mental health services and the wellness condition of African Americans. This information is extremely relevant and critical to PEI strategies, programs and services that need to be provided.

To obtain wellness indicator data is beyond the scope of the CRDP project. Understanding the mental health status of African Americans currently in the California DMH system will provide insight into the recommendations needed for PEI services. One key factor is to understand from the perspective of people of African ancestry in California, *"What does good mental health mean?"* In order to prevent and intervene early in a deteriorating condition, and to recognize and understand warning signs, there must be an understanding as to what is considered good or balanced mental health for African Americans.

Similarly, to effectively target PEI efforts, a greater question needs to be answered, *"How are population needs determined?"* How do we identify those at need? And, who and where should PEI efforts be directed and targeted? Traditional target populations are high risk individuals such as the homeless, children in foster care, formerly incarcerated, and people exposed to violence (DHHS, 2001). What about those who are not a part of high-risk populations? Early detection is essential for appropriate access and intervention. To forecast the number of African Americans to reach, there must be a real assessment of the need. The question remains, *"How are the mental health needs of the African American population determined?"*

As reported by the DMH, service outcome data was not available as of 04/12/2012.

DETERMINING MENTAL HEALTH NEEDS OF BLACKS IN CALIFORNIA

A Kaiser Foundation (2007) report indicated that Black/African American families in California have about three or more members. Unfortunately, most African American children grow up in one parent homes. African Americans are relatively poor with about 22% having incomes below the poverty line. Many African Americans live in poor neighborhoods, among other African Americans who are poor. Other factors such as economics, chronic health problems, foster care, incarceration and psychiatric assessments provide a perspective to better understanding the mental health needs of Blacks.

Economics

According to the 2005-2007 American Community Survey (Census Bureau), in 2007 California had approximately 2.3 million African American residents. During this same time, the median household income was $41,748, of which 17.1% of the families lived in generational and situational poverty. The highest poverty rates among Black families in California are female householders with no husband (28.9%) and female householders with no husband and with children under 18 years old (35.3%). But, the greatest poverty rate (37.7%) was in female householders with no husband, and children under 5 years old.

A major report, *State of Black California* (2007), commissioned by the California Legislative Black Caucus revealed a "brief" snapshot of the African American population in California compared to Whites and other ethnic and racial groups. The report illuminates the social and economic status of Blacks in California by using an Equality Index (*Table 11*). The Equality Index uses a single index to measure overall well being in areas such as economic, housing, health, education, criminal justice and civic engagement outcomes. Whites are baseline with a constant index of 1.00. **A score less than 1.00 indicate the group is doing poorly relative to the Index.** The results indicated that Blacks in California are fare worst than Whites across all indices except civic participation. The civic engagement index measured (1) armed services participation, (2) union representation (membership), and (3) English fluency.

Table 11: *Results of State of Black California Equality Index, 2007*

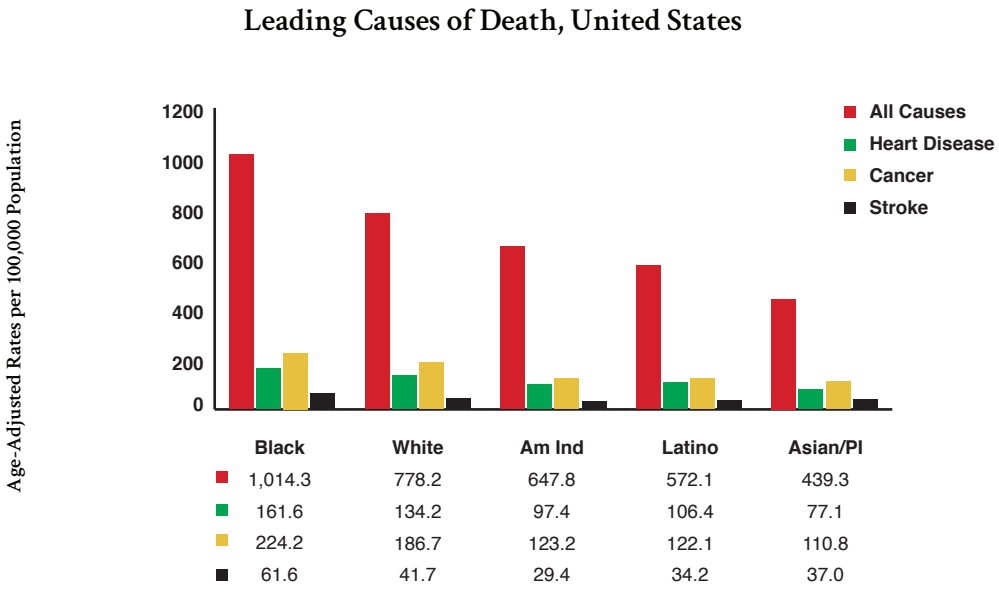
INDEX	SCORE
Overall Equality	0.69
Economic	0.59
Housing	0.66
Health	0.68
Education	0.69
Criminal Justice	0.68
Civic Participation	1.30

Source: *The State of Black California:* A Report from The California Legislative Black Caucus. Sacramento, CA: California Legislative Black Caucus, 2007.

Chronic Health Problems

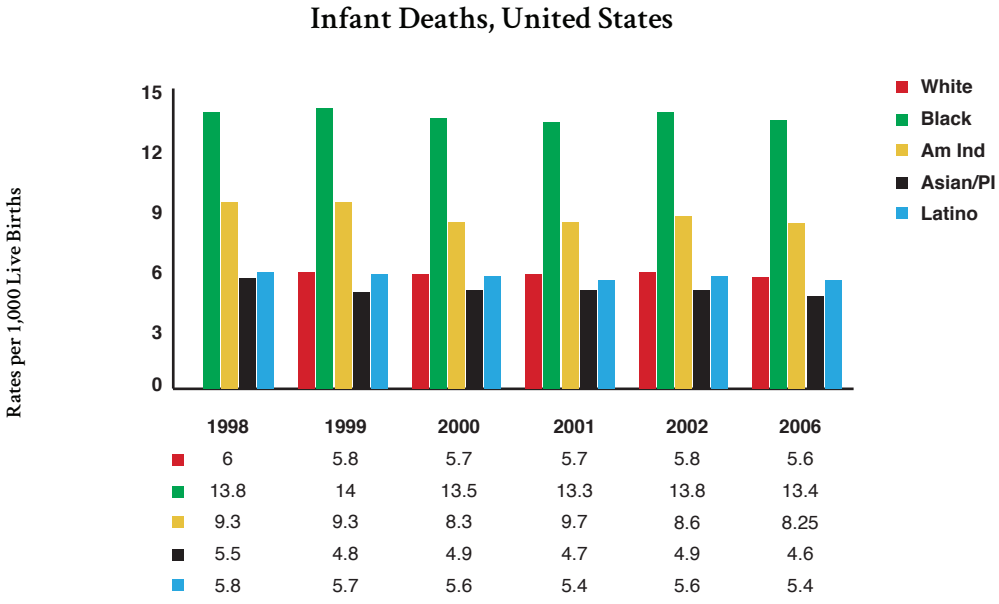
The consequences of higher mental health prevalence rates among African Americans also have a direct relationship to poorer overall health; overall health and mental health are co-occurring. African Americans are persistently overrepresented in all leading preventable health problems (CDC, 2011), such as heart disease, cancer, stroke

(*Figure 17*), HIV/AIDS, infant deaths (Figure 18), respiratory disease, and autoimmune conditions such as arthritis and lupus, to name a few. Measurement of a population's health status is reflected in its infant death rates (WHO, 2008).



Source: CDC, MMWR, 2011

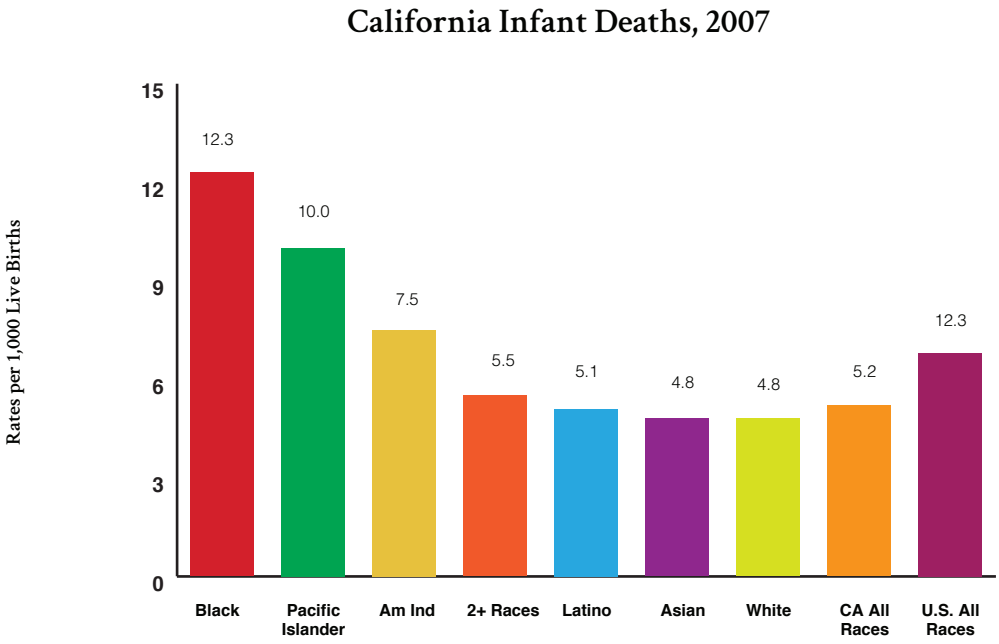
***Figure 17**: U.S. Leading Causes of Death by Major Ethnic Groups, 2006*



Source: CDC, MMWR, 2011

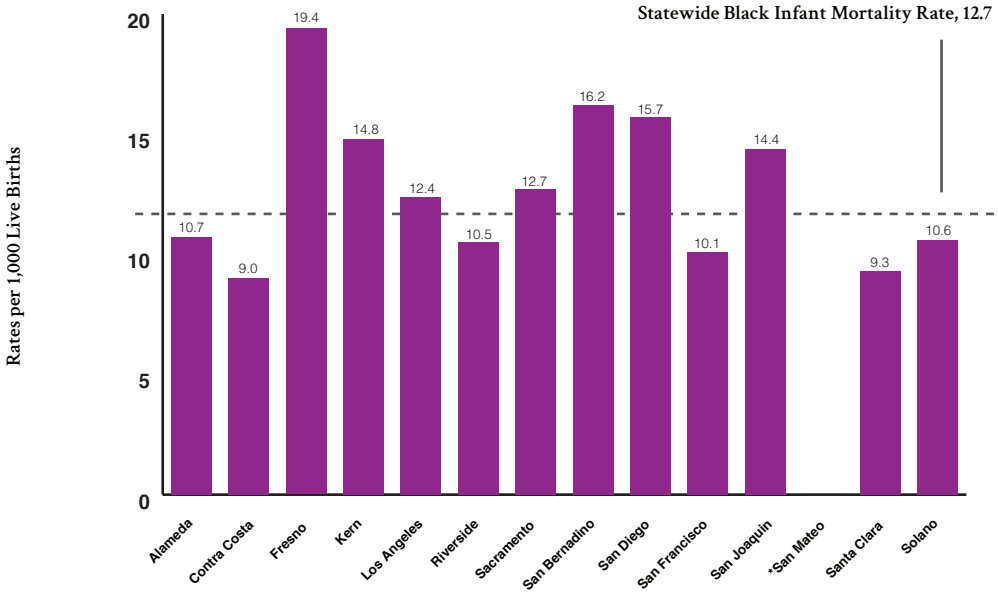
***Figure 18:** U.S. Infant Death Rates by Major Ethnic Groups, 2006*

Unfortunately, the infant death rate for African Americans continues to be the highest in the nation (*Figure 18*). The African American infant death rate (*Figure 19*) in California is two times that of other ethnic populations, except for Pacific Islanders and Native Americans. In California's Black Infant Health Project, nearly all of the targeted counties had death rates over two times the California rates for all races/ethnicities (*Figure 20*).



Source: State of California, Department of Public Health, 2007 Birth Cohort Files; 2011

Figure 19: *California Infant Death Rates by Major Ethnic Groups, 2007*



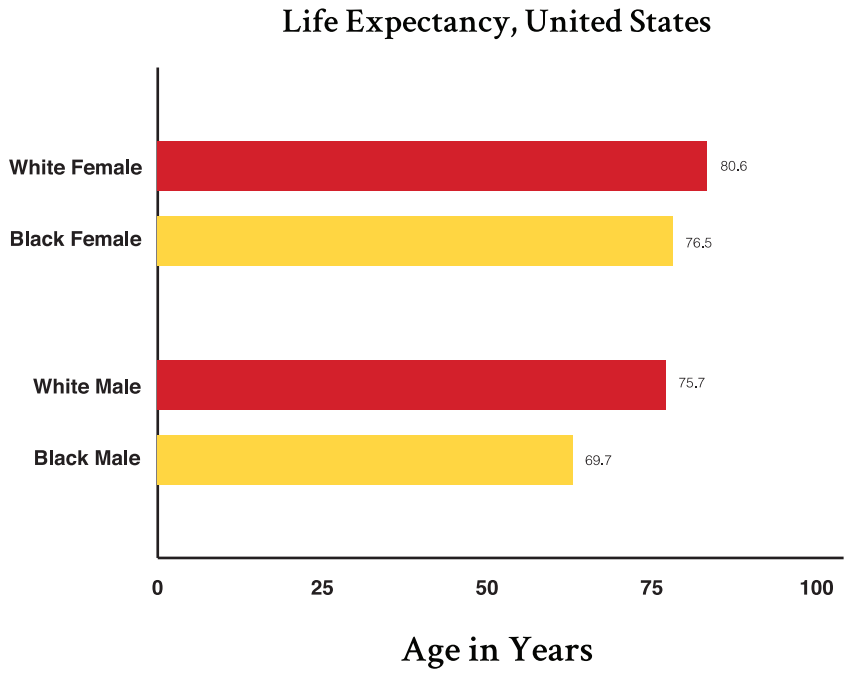
*Rates not shown for <5 deaths Rates based on maternal county of residence. Race/ethnicity for those listing 2 or more is first one listed.

Data Source: CA Birth and Death Statistical Master Files, 2000-2002

Figure 20: *California African American Infant Death Rates by Black Infant Health Project Counties, 2000-2002*

People of African ancestry are also more likely to develop critical and chronic health problems, and less likely to receive care than persons from other ethnic/racial groups (DHHS, 2011). Additionally, African Americans have been disproportionately affected by discriminatory social policies, the HIV/AIDS epidemic, substance use disorders, arrests, unfair sentencing practices and imprisonment. With these poor

disparate outcomes as well as many others, the U.S. life expectancy at birth for Blacks is 73.2 years, ***five years shorter*** than Whites (78.2 years) [DHHS, 2010]. When comparing male and female life expectancy, the differences are six years between males, and four years between females, see *Figure 21* (data only reported by Black/White).



Source: CDC/NCHS National Vital Statistics Reports, 2010

Figure 21: U.S. Life Expectancy at Birth by Age, Gender and Ethnicity, 2006

According to a 2007 report from the Public Policy Institute of California, *California Counts, Death in the Golden State*, there have been no significant or sustained reductions in the gap between African Americans and Whites since the end of World War II (WWII). As an example, people of African ancestry, in California are less than 7% of the state population, however:

- They are 40% of California's 283,000 felons
- African American men have a life expectancy of seven (7) years less than White men
- African American women are 60% of California's new or current HIV/AIDS cases
- African American women are 20 times more likely to be diagnosed with HIV/AIDS in comparison to their White counterpart
- African American children (0 – 18) account for (nearly) 39% of California's 80,000 most vulnerable population, foster youth (in out-of-home placement)
- African American males are three (3) times more likely to experience negative disciplinary actions (detention, suspension and expulsion) in high school, in comparison to all other racial or ethnic groups, or their White counterpart
- African American infant mortality at 12.4 per 1,000 live births is twice as much for all racial/ethnic groups, and nearly three times that of Whites in 2007

HIV/AIDS Epidemic

Since June 6, 1981, the date of the first recorded case of what is now known as the acquired immunodeficiency syndrome (AIDS) caused by a retrovirus, the human immunodeficiency virus (HIV), the scourge of HIV/AIDS has been a constant in the world. Unfortunately, the scourge of HIV/AIDS has been even more of a constant in the African American community throughout this epidemic. In California, by the beginning of 2007 African Americans, who constituted less than 7% of California's population, represented 18% of all cumulative reported AIDS cases (California Department of Health Services, Office of AIDS, 2008). Likewise, at the beginning of 2006 African Americans accounted for 40% of all AIDS cases in the United States.

The National Institute of Health (NIH, 2006), on the 25th anniversary of its first published reports (June 1, 2006) on AIDS, released statistics that were overwhelming. HIV/AIDS had affected 65 million people worldwide, of whom 25 million have died. In the United States, it was estimated that one million people were living with HIV infection, and 40,000 new infections were occurring each year. The reports indicated a progressive trend for climbing HIV infection rates among women, racial and ethnic minorities and people over 50 years of age. During this time in the United States, African Americans made up approximately 13% of the population but accounted for 49% of the new HIV/AIDS cases diagnosed.

According to the Kaiser Family Foundation Fact Sheet (August 2011) on Black Americans and HIV/AIDS, the devastating epidemic has not changed its course. In 2009, even though Black Americans were 12% of the US population, they were 44% of new HIV infections, 46% of people living with HIV, and 48% of all new AIDS diagnoses. Further, the AIDS diagnosis rate was the highest among Black men (78.0/100,000 population) than any other ethnic group, and Black women followed at 35.1/100,000. When comparing the AIDS diagnosis rate for adults and adolescents per 100,000 populations in 2009 across all ethnic groups, Blacks were alarmingly higher than any group; Blacks (44.4), multiple races (15.1), Latino (13.9), Native Hawaiian/Pacific Islander (11.2), American Indian/Alaska Native (6.6), White (4.7), and Asian (3.1). The overall US rate is 11.2/100,000. And, in California in 2009 the statistics were unchanged; African Americans represented 19% of HIV cases and 18% of all AIDS cases (California Department of Public Health, Office of AIDS, July 2009).

The impact of sustained premature death, disability, and loss in quality of life for individuals living with HIV/AIDS has untold psychological effect. Crisis level prevention and early intervention are critical at this point in time to aggressively address the systemic suffering and devastation within the African American community.

Foster Care

The National Survey of Child and Adolescent Well-being: One Year in Foster Care Report (DHHS, 2001) indicates that 25% of foster children have physical and mental health problems, as well as fall below the norm in cognitive skills, language development, behavioral problems, and academic achievement. In California, nearly 500,000 children each year encounter the child welfare officials through reports of suspected child abuse or neglect, of which 75% (on July 1, 2008) were African American, Latino, and Asian/Pacific Islander (Reed & Karpilow, 2009). All foster children are required to have a mental health screening. However, according to Reed and Karpilow (2009), California lacks a universal process to ensure that all foster children are screened, diagnosed and referred to a broad range of mental health services, including early intervention. Findings of the California Child and Family Services Review Statewide Assessment

(CDSS, 2007) identified that only 60% of foster children were screened and, of those who needed services, only 65% received them. The DMH provides services through the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) program to children and youth who are in the foster care system.

According to Reed and Karpilow (2009) African American children in the California foster care system are:

- More likely to have longer stays in out-of-home care
- Less likely to reunify than any other group
- From low-income African American families with few resources and inadequate support services to help keep families stable and children safely at home
- Are brought to the system because of several contributing factors, such as racial bias, cultural misunderstandings, and distrust between child welfare workers and families
- Experiencing difficulty in finding appropriate permanent homes
- Have longer stays in foster care

Children and youth of African ancestry in foster care have been exposed to violence, abuse and neglect, substandard limited and limiting environments, homelessness, crime, and perpetual stress. Stressful living conditions predispose to many health conditions such as mental illness. In the United States, African Americans make up approximately 40% of homeless populations, and nearly, 40% of juveniles in legal custody are African Americans (DHHS, 2009).

Children and Youth

Of particular concern within the African American community is the psychological impact of intergenerational trauma on the young. Patricia Nunley, Ph.D., of the Bay Area Association for Black Psychologist, presents the following exposé on children and youth sub-groups within the African American community.

Children and Youth

by Patricia Nunley, Ph.D.
Bay Area Association for Black Psychologist

The well being of young children, pregnant teens and women, Black male youth who have police contact and the Mothers of these youth, children and youth with incarcerated parents, students with untreated trauma, and abortion consumers should be of particular concern to African Americans based on the fact that mental health begins at the point of conception and is first experienced in the womb (Abdullah, 2007). Growing acknowledgment that racism is a source of stress supports those who posit a correlation between racism and the overrepresentation in the death rates for Black Infants born in the U.S. (Parker-Dominguez, 2009). Geronimus' (1992) concept on Black Women's health entitled "*Weathering*" is supported by negative health outcomes that include disproportionate negative outcomes for infant delivery and birth. These experiences include **infant death, low and very low birth weight, and premature delivery** that results in underdeveloped vital organs (Abdullah, 2007; Center for Disease Control and Prevention, 2008). These issues require significant resources to address mental health care needs in effected individuals and their families.

Black infant abortion rate (Cohen, 2008), as well as teen pregnancy are life conditions that have individual and community impacts that includes a mental health component that go unaddressed. The collective Black church, a place where support and healing may be possible, typically does not have a healthy model for addressing these two life conditions that disproportionately impact our community. Statistics show California has the highest **teen pregnancy** rate and is one of the leading abortion consumer States. Significantly a 2008 Associated Press article, entitled, *"Who's Getting Abortions? Not Who You Think"*, noted the national abortion consumers are Black and Brown women over the age of 25 who already have children. As economic conditions become more severe the election of this birth control option conceivably will increase.

Literature is readily available on **incarcerated individuals** but less is available on the impact on **their families and youth who, while not physically incarcerated, are disproportionately subjected to surveillance, interrogation, and threats of imprisonment** (Alexander, 2010; Rois, 2011). A fact sheet on the *Children of Incarcerated Parents* by the Annie Casey Foundation notes the disparate impact this phenomenon has on our children. They report a Black child is nine times more likely than their White counterparts to have a parent incarcerated (La Vigne, et al., 2005; Nieto, 2002). It is conceivable that these children will experience a sense of loss and/or abandonment that can negatively impact their attachment capacity and other related human skills.

Increasingly interest in issues related to re-entry has generated efforts to address the challenges faced as a result of incarceration, yet I am not aware of the same efforts being directed toward addressing the trauma experienced as a result of encounters with representatives of the criminal justice system, including but not limited to, police, probation, public defenders, and judges. New concepts such as ***Racial Micro-aggressions*** by Yosso, Smith, Solorzano and others and ***Racial Battle Fatigue*** (Smith, et al., 2007) are relevant but do not begin to address the developmental impact on young children and youth who experience and/or witness chronic, negative police encounters.

In a personal conversation with the father of two of the young men who were with Oscar Grant on the day of his assignation, New Year's Day 2009 in Oakland, CA, by

Bart Police Officer Johannez Mehserlee, the father shared a story that best illustrates the need for concern. He said when his son was driving in the car with Grant's daughter in the back seat the young child saw a police car and immediately stated her fear that the officer was going to kill her. Studies have been conducted on the **unique, contextualized community violence experiences of urban Black children** (Jipguep & Sanders-Phillips, 2003; Jones, 2007; Oravecz, et al., 2008; Zalot, et al., 2007) and the requisite unique skills for effectively addressing the resultant trauma (Parson, 1994). These authors have conceived concepts such as Urban Violence Traumatic Stress Response Syndrome or U-VTS (Parson, 1994) and Chronic Community Violence or CVV (Jones, 2007).

In his book, Punished, Policing the Lives of Black and Latino Boys, Victor (2011) provides details from his study on how **Black and Brown youth are targeted and dehumanized by the police and other representatives of this system.** We are keenly aware of the fact that Black males are overrepresented in the typical quality of life indicators (Alameda County Public Health, 2010; Noguera, 2008; Toldson, 2008) and some argue many have drifted into a state of complacency that made also explain why more documented concern for the mental well-being of the mothers of these Black males is not found. These mothers share a common fear that crosses socio-economic boundaries; the disproportionate untimely incarceration and/or death of their child.

The personal experiences of professional Black mother's of sons suggest the **Black male youth that do not fit the Urban Black Male stereotype** may experience greater risk for unwarranted police contact. As a result of the privileges that come with a middle class income, they are not part of the criminal justice system and thereby represent a potential "threat" to White males by virtue of their non inclusion in what Alexander (2010) dubs as the New Jim Crow system. According to these mothers their son's become a rarely discussed "target" for police harassment. It is critical that we address the unique fears, pain, etc of **Black Mothers**. Statistically all Black male youth are at highest risk for becoming a victim of violence. The issue of violence related to Black male youth and the trauma from being a Black male victim of violence is masterfully addressed in the book, *Wrong Place, Wrong Time* (Rich, 2009). Rich describes the Black male victim of violence phenomenon and has published other related literature (Rich & Gray, 2005; Rich, et al., 2009) on the issues. Rich is an emergency room physician.

As reflected in the experiences of Black males in this Nation's Public Education System, the negative societal images of Black male youth is not limited to the criminal justice system. The school environment, a place that some studies have found can represent a protective factor against the multiple risk factors experienced by low-income (Henry, et al., 1999; Toldson, 2008), children and youth of color, is also an environment where the mental psyche of Black's is disproportionately under attack (Hu, 2007) as evidenced by their experiences of suspension and expulsion (Fenning & Rose, 2007; Lewis, et al., 2010). There is a need for **school psychologists** to possess and use a skill set that moves the members of our next generation from the place of at risk articulated in a *Task Force Report on Resiliency in Black Children and Youth* (2008) to a place of "at promise."

A seminal study on the adverse impact of early childhood experiences (Felitti, et al, 1998) provides evidence of a need to critically assess the mental health of **our youngest Black children and particularly our Black males**. As a result of another seminal study we now know the youngest Black male students are subjected to the same disparage treatment of their older male counterparts (Gilliam, 2005; Stewart, 2005). We are also aware of the overrepresentation of the diagnosis of Black males with ADHD and

behavioral disorders (Fenning & Rose, 2007). In an in-depth literature review, I found support for my suspicion that it is possible the classroom behaviors teachers identified as challenging may be trauma informed. While internalized behavior is the more likely trauma response for young children (Levine & Kline, 2007), I posit for the young, urban Black male the intersection of racism, sexism, classism, and chronic exposure to community violence from the point of conception creates a unique developmental trajectory that manifests itself as "externalizing" classroom behaviors (Nunley, 2011) that may represent untreated trauma (Kaplow, et al, 2006; Perry, 2001;2002; 2009; Shore, 1997). Just as specific trauma intervention models are suggested for Black youth living in neighborhoods were community violence is prevalent (Parson, 1994), trauma treatment should also consider the individual developmental life stage. Perry and the Child Trauma Academy offer such treatment. Perry's comprehension of the need for client concern that exceeds professional boundaries as stated in his books (Perry & Szalavitz, 2006; Szalavitz & Perry, 2010) suggests a comprehension of the African sense of community and healing.

Lastly, more needs to be done on **resiliency as it relates to low-income, young children** growing and developing in urban communities were community violence is prevalent. Poverty translates to lack, as such residing in this environment creates negatively subjects children to what Akom (2011) and others call *Eco-Apartheid*. The out-of-school factors that negatively impact poor student's school experience (Berlinger, 2009) are magnified when the student is also one of our young children. The U.S. ranks first as the most violence industrialized nation and is the only nation that has a governmental agency, *Child Protective Services*, to protect its children from their parents (Perry, 2002). As a resident in this violence prone Nations where the incidence of violence is most likely to occur in the home and the most dangerous person for a young child is his/her mother, special consideration should be given to the mental well-being of young Black children who are also member of an ethnic group who have experienced untreated, and for many, unacknowledged historical trauma, i.e. Post Traumatic Slave Disorder (Leary, 2005). This same child may also live in a household where domestic violence occurs. If this child is fortunate enough not to be subjected to this cross racial and socio-economic phenomenon, exposure to an act of violence is more likely to be waiting outside the door of this child's home.

These realities support my call for teachers to become trauma-informed, literature such as Healing Invisible Wounds (Adams, 2010) provide support for this position. Based on the negative student-teacher relationship that typically exists between many teachers and their Black male students (Nanam, 2000; Neal, et al, 2003; Kesner, 2000), care must be taken to avoid teachers using their trauma knowledge as a means for placing yet another label on our students. The behaviors of a traumatized child can mimic that of a child who has been diagnosis with ADHD or other behavior disorders (Carlowe, 2007; Kaplow, et al., 2008); therefore it is conceivable untreated trauma victims are among the Black students with ADHD and other labels. Our belief in the collective, group resiliency of the African people group should also be carefully considered when applied to young Black children. Studies show traumatic experiences can defer the development of young children (Perry, 2009, Shore, 1997); consequently our children should be provided an opportunity to grow and develop in environments where thriving, as opposed to surviving, is the norm.

# # # #

Incarceration

In 2003, of the 159,654 prisoners in California, 47,819 (30%) were African American, including 3,030 women, yet African Americans represented less than 7% of California's population (CA Dept of Corrections, 2003). These barriers create collateral consequences for their children and families and clearly intensify the health disparities already, historically evident throughout Black America (Iguchi, Bell, Ramchand, & Fain, 2005). Additionally, if we consider that in 2001, homicide was the number one cause of death for Blacks between the ages of 15 and 34 and the racial and psychological dynamic implications of homicide, then we must conclude that the disparities in mental health merits every concern as its impact is deep and painful. By the end of June 2005, there were over 2.1 million people incarcerated in jails and prisons in the United States. Of those, 548,300 were African American males between the ages of 20 and 39, creating devastating obstacles for their families, children and communities; including high unemployment, disenfranchisement, trauma, poor health, mental illness, limited housing options, poverty and stigmatization.

According to the *Judicial Council of California Task Force for Criminal Justice Collaboration on Mental Illness: Final Report* (2011, p.291), data from the Bureau of Justice Statistics on mental illness indicate that 56% of state prisoners and 64% of jail inmates nationwide were clinically diagnosed as having a mental disorder, received treatment by a mental health professional, or experienced symptoms of a mental disorder in the previous 12 months. Additionally, it is reported that a significant portion of this population has a serious mental illness, which is usually defined to include mental disorders that cause the most serious impairment, such as schizophrenia and other psychotic disorders, bipolar disorder, other severe forms of depression, and some anxiety disorders. Although only 5.7% of the general population has a serious mental illness, 14.5% of male and 31% of female jail inmates have a serious mental illness. Similar to jail populations, approximately 23% of California's prison inmates have a serious mental illness. According to the Judicial Council's report, it was noted that inmates with serious mental illness often need the most resources and can be the most challenging to serve while incarcerated.

Furthermore, the task force reported that California's state psychiatric hospitals currently provide treatment primarily to a forensic population. California's forensic state hospital population of approximately 4,600 includes mostly individuals who have been found Not Guilty by Reason of Insanity (NGI) and Incompetent to Stand Trial (IST) or who are categorized as Mentally Disordered Offenders (MDO) and Sexually Violent Predators (SVP) (page 291). In many instances, according to the Judicial Council, the traditional adversarial approach is ineffective when processing cases in which the defendant has a mental illness. Connecting the defendant to mental health treatment and support services is often essential to changing behavior and reducing recidivism. The report suggested that the courts need to adopt new collaborative approaches in working more closely with criminal justice partners and other community agencies if outcomes for offenders with mental illness are to be improved.

The report accurately identified the cycling of mentally ill persons in the criminal justice system. Acknowledging that once this population is released back to the community from either jail or prison, it is difficult to secure housing, treatment, and other necessary support services. In part, this is because many community agencies are hesitant to serve those with a criminal history and because services are often uncoordinated and supported by different funding sources. Many federal, state, county, and city government programs have complicated, overlapping, and sometimes conflicting eligibility requirements and

fiscal restraints that can serve as barriers to accessing needed services and supports such as health coverage, housing, and employment.

Nationally large numbers of people with mental illness are released back to the community on probation or parole only to recidivate and return to the criminal justice system often because they lack access to services that support a smooth transition back into the community (Judicial Council of California, 2011, p. 292). One study cited in the Judicial Council's report found that recidivism rates for probationers with mental illness are nearly double that of those without mental illness (54% compared to 30%). In addition, probationers with mental illness are significantly more likely to have their probation revoked than those without mental illness (37% compared to 24%). Similarly, parolees with mental health issues are at a much higher risk of committing violations than those without mental health issues (36% higher risk of all types of violations and 70%higher risk of technical violations other than absconding).

The Center for Nonviolence and Social Justice (Edley & Ruiz de Velasco, 2010) examined whether the institution engaged with boys and young men of color are being responsive to those who have experienced trauma. Their analysis revealed three key findings:

> **Key Finding #1:** Trauma is seldom explored by the array of systems (schools, juvenile justice, courts, health care, mental health) assigned to help boys and young men of color.
>
> **Key Finding #2:** Those institutions often take a punitive rather healing approach to these young men, interpreting their symptoms as a sign that they are delinquents or sociopaths rather than a sign of both physical and emotional traumatic injury.
>
> **Key Finding #3:** There is a best practice, the *Sanctuary Model* (2010), that allows institutions that engage with boys and young men of color to change their organizational culture in a way that will allow them to best respond to their psychologically and socially traumatic experiences.

The *Sanctuary Model* (2011) represents a trauma-informed method for creating or changing an organizational culture in order to more effectively provide a cohesive context within which healing psychological and social traumatic experiences can be addressed.

Psychiatric Assessment

Psychiatric assessments of the mental health problems in African Americans are a part of the problem that leads to disparate outcomes. The traditional mental health model that exists in the United States is based on a linear, western model of symptom identification that involves the observation of a cluster of behaviors, called symptoms that are outlined by majority culture experts. The DSM-IV contains disease categories that are identified primarily by the clinician's observation. With the advent of the DSM tradition, the study of mental health outcomes generally focused on symptom reduction or symptom management, without being informed by the body of research that clearly connects etiology with a number of risk factors. These risk factors are overlooked as targets for treatment and proactive prevention. Outcomes from this tradition shed no light on mental health disparities and subsequent treatment needs of people of African ancestry because they are not informed by indigenous frameworks that are congruent with African-centered world views about health, mental health and successful functioning when one cultural group is surrounded by a majority culture group with a different world view. Specifically, they are based on a model of disease/cure, rather than one of wound/heal.

Psychosocial assessments do not identify imbalances between mental, physical, social and spiritual dimensions of living. They rarely track outcomes related to bio-psychosocial functioning. As globalization continues, there are those who have called for an examination of the western concept of mental health, versus those concepts around the globe that relate to a person's or group's successful functioning in life (New York Times, 2010). Treatment as usual for African Americans does not assess the consumer's definition of mental health or optimal functioning. Instead, the assignment of a diagnosis by those trained only in majority culture assessments leads to a plan for symptom management with no awareness of research data that supports inclusion of family and community in the healing process.

> *"National Institutes of Mental Health (NIMH) research does not get used to help people as mental health professionals rarely use it."*
> **-Dr. Carl C. Bell, 2011**

Treatment approaches rarely examine environmental difficulties or the fit between the person and their interpersonal and social context. Neither do they provide a holistic, cross cultural approach that addresses the power and race differentials between provider and consumer, or the fit between consumer and family, and family and community. In addition, the impact of physical health is ignored. For example, lowered life expectancies lead to premature losses, less transfer of wealth between generations, and the early onset of chronic disease that leads to depression. The overall physical health of African Americans is not included as a target area for mental health treatment, neither is the mental health of family members, or the level of burden that may come from the overall health and well-being of the extended family.

Other risk factors such as criminality, economic disparities, educational disparities, drug involvement, gang involvement, and sexually risky behavior are noted in psychosocial assessments, but rarely become a target for change that is weighted equally with observed symptoms. A person's perception of discrimination and unfair treatment is also incidental when it comes to symptom and behavior management.

SUMMARY OF DISPARITY DATA

The mental health disparity data presented was the most current and available at the time this report was developed. It was also the data that the African American SPW was given access to. It is believed that other data was available, but this SPW was not given access to the information.

Using utilization data to understand mental health prevention and early intervention needs does not tell an accurate story for the African American population. Data must be properly interpreted relative to population size, and disparity data must be compared across populations. During 2007-2008, African Americans were 5.8% of California's population but accounted for 16.59% of clients served in the California DMH system; Whites served were 35.99% and Latinos were 30.68%. Based on this data, African Americans were the third highest group served according to actual "unduplicated" persons counted in the CSI system. Compared to the largest population groups in California during 2007-2008, Whites (57.6%) and Latinos (37.6%), this would indicate that the Black population was in **CRISIS**, or that the predominantly urban residence pattern or other demographic factors of the population accounts for its greater access to services.

In 2009, African Americans accounted for almost the same percent of mental health disorders as the two largest populations (i.e., Whites and Latinos) in the State. Based on this fact alone (that reported data for Blacks is almost the same as the majority population), all of the disparity data reported indicate that the Black population is in **CRISIS**.

But, data is missing that would clarify how "persons" use the system, and the actual level of care received which is critical in determining the **severity of the intensity of the crisis**. From the perspective of African American clients in the DMH system, many indicate they register at the clinic to be seen; and someone often comes to take basic background information, but does not see them to assess the mental health issues or concerns. It is believed the person is then counted as using the system. But, to African Americans the service is only "counting bodies" not providing care. Therefore, according to client's perception, reported diagnoses are not accurate. They believe disparity data comparisons are suspect. They also believe diagnoses and disparity data are not to be trusted as an accurate source of how African Americans truly receive services, or how they are treated in the mental health system, or what prevention and early interventions are needed for the population.

Based on the data reviewed, the following statistics are associated with mental issues in Blacks:

- In 2009, 17% of U.S. African Americans reported having any mental illness
- In 2007, U.S. African Americans were 50% more likely to report symptoms of depressive episodes
- In 2007, U.S. African Americans were 30% more likely to be diagnosed with serious psychological distress
- In 2007, U.S. African American males in grades 9-12 were 1.6 times more likely to attempt suicide than White males
- In 2007, U.S. African American females in grades 9-12 were twice more likely to attempt suicide than White females

- During 2007 to 2008, in California African Americans were the third highest users of mental health services, 16.6%, compared to Whites at 36.0% and Latinos at 30.7%
- During 2007 to 2008, in California the top three mental health diagnoses in African Americans were depressive disorders (12.6%), schizophrenia (8.4%), and bipolar disorder (6.2%)
- During 2007 to 2008, in California 27.6% of African Americans using mental health serves were diagnosed with dual diagnoses, probably a mental health disorder and substance abuse disorder
- During 2007 to 2008, in California less than 1% of the statewide African American population used the DMH services
- During 2007 to 2008, in California the total African Americans who used the DMH services (111,373) represented 5.16% of the total statewide African American population (2,159,978).

Further, it is the perception of Blacks that prevention and early intervention efforts should not be based on the current data collected by the DMH, because it is inaccurate and does not properly reflect the needs of the population.

"Mental health is not really available in a timely manner. Mental health staff does not listen to what the client is saying about how they feel and what the medication is doing... Case managers need to pay attention to the level of mental health people are in... and conduct better assessment of people in their mental disorder."
-In-depth Interview: Charlyne, 54 year old Black female, Skid Row Los Angeles resident: Diagnosed bipolar disorder, LA County

"The majority of Blacks are going undiagnosed and unidentified."
-Consumer, Client, Client Family Member Survey: Sherman Blackwell, Board of Directors, NAMI California, 61year old father of an institutionalized son with developmental disabilities, and another son diagnosed bipolar schizoid, Sonoma County

"White folk go to rehab, and they send us to jail, 'cause Black folk are suppose to deal with mental health from a different level."
-FG: Marie, 66 year old female, The Children of Promise, Sacramento County

"First, the medical field needs to have protocols to get people help. When people come for intake, whether a child or adult, the protocol needs to include follow-up. There needs to be an assessment and proper diagnosis. One size does not fit all. People are told to take medication, continue on the treatment plan, and it does not work. Clients are told to keep on the plan for 12months."
-In-depth Interview: Beverly Earl, 58 year old female Executive Director Catholic Charities, San Bernardino County

More data is needed to determine what type of PEI services African Americans receive and their outcomes.

Data is needed to determine what level of mental illness in the African American population the MHSA initiative will use for PEI.

Data is needed to more accurately target African Americans that need to be reached by efforts under the MHSA initiative.

Data is needed to understand what symptoms are warning signs for Blacks with early indication of mental challenges.

Data is needed to calculate incidence rates of mental illness in Blacks.

Too much specific data is missing regarding the Black population to properly plan for PEI.

B.2. HISTORICAL CONTEXT

It is impossible to understand PEI mental and behavioral health needs, the perspective of the population, and what help people of African ancestry living in California need, unless there is clear unbiased exploration of past history. This CRDP could not just list practices, programs, interventions or strategies for PEI without a contextual examination of potential recommendations to appropriately understand the perspective. Mental health just as in physical health, when there is a deep festering purulent infection, it will **NOT heal** unless all the infection is removed. Then healing begins from the inside out.

While this historical view will not be comprehensive, the intent is to acknowledge the beginning struggles of African people in America and its impact on mental and behavioral health; howbeit, its impact on total overall health and well being. Starting with the European conquest, African people have been an integral part of the American society. Unfortunately, the first encounters are a legacy of slavery. This is an unpleasant, nevertheless real fact. The post-traumatic effects of slavery have not yet abated.

Enslaved Africans

Enslaved Africans experienced an almost total loss of their languages, cultures, kinship bonds, religion, and family functions. This social condition was extremely traumatic, especially since the losses were against the will of the affected people. The intent was to keep the enslaved people in a submissive state by force and fear. An entire system was created to reinforce the subjection of the enslaved African people. This was a conscious effort to destroy the intrinsic sense of self. Oppressive systems to keep a group of people under the control of a dominate group is called racism. Murray (1998) in her article on Racism and Mental Health provides a clear distention between racism, prejudice, and discrimination.

> *"Prejudice is a type of attitude; generally negative toward the members of some social groups; discrimination refers to unfair or unjust actions toward those individuals. Racism refers to more than attitudes and behaviors of individuals; it is the institutionalization of that attitude* (Murray, 1996, p 345)."

Research supports the case that African Americans in general, including those who are doing well, have been significantly impacted by the legacy of slavery, and the pain and struggle that followed (DeGruy-Leary, 2005). Leary argues that understanding the degree to which the current cultural disparities in health and social circumstance are related to maladaptive lifestyle behaviors associated with the intergenerational trauma of slavery is necessary for the healing process. Overt and subtle forms of racism have damaged the collective African American psyche, which the harm is manifested through poor mental and physical health, family and relationship dysfunction, and self-destructive impulses. While it may not tell the whole story, it helps to explain the high rates of heart disease, HIV/AIDS, hypertension, obesity, crime, substance abuse, and other maladaptive behaviors.

> *"African Americans have unwittingly adopted habits and traditions that influence how we think, what we eat, what we believe about health and health care, how we manage interpersonal conflict and even how we behave sexually. No cursory view of African American lifestyle will explain the state of slavery's children* (DeGury-Leary, 2005, p147)."

Racism

Camara Jones, a family physician (MD) with a PhD in epidemiology, at the time of this report was Research Director on Social Determinants of Health and Equity at the Centers for Disease Control and Prevention (CDC) in Atlanta, Georgia. Dr. Jones has developed a framework for understanding racism on three levels (Jones, 2000) – institutionalized, personally mediated, and internalized. This framework helps to develop measures of racism, to impact health and well-being and to provide insight into the root causes of perpetual disparate health outcomes for African Americans. Jones proposes that segregating practices like racism, sexism, and capitalism creates an environment where one group succeeds and another struggles, causing continual stress. Research (Brondolo et al., 2009; Dailey, 2008; Jones, 2009; LaVeist, 2002; Williams & Mohammed, 2009;) indicates a direct correlation between this systematic approach and poor health outcomes, such as environmental stress. It is clear racism causes stress. Understanding precipitating factors provides the opportunity for developing effective PEI to mediate the factors.

Racism/White supremacy, conscious or unconscious, limit the capacity to develop theoretical frameworks that promote true understanding and accurate diagnoses/ treatment of nonwhite populations. White psychologists are vulnerable to such misdiagnoses as classically demonstrated by Dr. Frantz Fanon (1965) in the early 21st century in his study of a supposed shared Paranoid Delusion that rendered the African populations of the French Antilles seemingly afraid to speak to one another in public. Dr. Fanon discovered that Africans did not meet in groups because only a few decades earlier, French laws severely punished Africans who publicly met in groups of more than two (Fanon, 1965).

Racism/White supremacy's effect on the psyche of African Americans was most famously demonstrated with the Clark Doll Experiment of the 1954 *Brown v. Board of Education* Civil Rights court case. In spite of the tremendous forward leaps and bounds enjoyed by many Californians of African ancestry, too many still do not view themselves as equal or worthy. A more conclusive study demonstrated the effects of racism/ White supremacy on young African Americans, who when shown pictures of Blacks performing jobs compared to Whites performing the same jobs decided they preferred the jobs depicting Whites (Bigler, Averhart & Liben, 2003).

Misdiagnosis

Analogously, White psychiatrists are more likely to misdiagnose Blacks with bipolar disorder as schizophrenic. The White psychologists were unable to see the direct link between their racist policies and the psychological and behavioral outcomes for their formally enslaved populations. Similarly, even today, the debate over IQ differences in the field of psychology, still not settled by psychologists who maintain the possibility that the IQ differences among races may constitute an actual difference in intellectual capacity, highlights the continued need for vigilance against racism/White Supremacy in the mental health field, as highlighted below as one of the unanswered questions in the 1996 APA Report on Intelligence,

> *"The differential between the mean intelligence test scores of Blacks and Whites (about one standard deviation, although it may be diminishing) does not result from any obvious biases in test construction and administration, nor does it simply reflect differences in socio-economic status. Explanations based on factors of caste and culture may be appropriate, but so far have little direct empirical support. There is certainly no such support for a genetic interpretation. At present, no one knows what causes this differential* (Neisser et al, 1996)."

Serious mental illnesses are diseases of the brain that cause disturbances in a person's thinking, feeling, moods, and ability to relate to others. They can diminish a person's capacity for coping with the regular demands of ordinary life and can place tremendous burdens on family members and loved ones. Unfortunately, both ignorance and fear continue to play leading roles in perpetuating the stigma that those with these no-fault brain disorders face. This stigma leads to underfunding of government programs for public mental health services, discrimination by insurance companies, lack of appropriate housing and employment options, and pervasive media portrayals of persons with mental illnesses as violent, dangerous, or hopeless.

And yet, mental illnesses do not discriminate. These disorders affect people of every race, ethnic heritage, gender, language, age, and religious orientation. According to SAMHSA (2011), at any given moment more than 48 million Americans are suffering from a "diagnosable" mental illness, and 11 million are suffering from a "severe" mental illness.

> "I watch other providers pathologize our children and their parents. Not of conscious malice, but out of ease, generalization and bias; at times, it is clearly punishment for 'not doing what they are told' or not fitting into the practitioner's paradigm of what is true."
> **-57 year old African American County Service Provider**

Genetics

Racism is a structural barrier to good mental and behavioral health. Because of the Human Genome Mapping Project, the sequencing of the human genome has clearly established that for 99.9% of the genome, all human beings are similar (Guttmacher & Collins, 2004). This is conclusive scientific evidence that mankind, *Homo sapiens* is **one species**. There are **no human subspecies**. It is a scientific fact that human race and the term "racial" groups are social constructs not based on biology. Race is a social classification of an interpretation of how people look. **Race is not a gene. There is no biological base for the concepts of human race.** The term race perpetuates a sociopolitical construct that reinforces socially constructed stereotypes which denotes superiority and inferiority of one group over another. Californians of African ancestry are unlikely to eagerly seek help from institutions that believe them intellectually inferior. The system of racism must be deconstructed and eradicated in order to create PEI programs and systems that will improve the mental and behavioral health for all people groups. All humans are 99.9% biologically the same. Humans are basically equal biologically. How we are socialized makes the difference in how we view the world. This is where culture plays a critical role for humans.

Culture

Dr. Wade Nobles (2003), expert in African and African American culture, and author of the seminal article *"African Philosophy: Foundations for Black Psychology"* (1972) articulates values, customs, attitudes and behaviors of Africans in Africa and the New World (p. 18). Dr. Nobles provides concepts for understanding the attitude of mind, logic, and perception behind the manner in which African people think, act, or speak in different situations of life. African Americans and all people of African ancestry lives are grounded in both environmental conditions and a complex structure of cultural precepts, virtues, values, customs, themes, and prerequisites. Traditional cultural values alone consist of respect for elders, race pride, collective responsibility, restraint, spiritual devotion, reciprocity, patience, cognitive flexibility, courage, resilience, defiance, integrity, self-mastery, persistence, and productivity. The complete set of cultural components results in over 54 distinct yet interrelated ideas and

beliefs that serve as the CRUCIAL (more often than not disregarded and misunderstood) African American cultural template (see *Table 12*).

Table 12: *Key Components of* ***African American Cultural Orientation***©

CULTURAL LAWS	CULTURAL VIRTUES	CULTURAL PREREQUISITES
Consubstantiation	(Ma'at)	Sense of Family
Interdependence	Truth	Sense of History
Egalitarianism	Justice	Language Orientation
Collectivism	Righteousness	Significance of Names/naming
Transformation	Harmony	Importance of Sings & Symbols
Cooperation	Balance	Sound (Music) & Rhythm (dance)
Humanness	Propriety	Dietary Habits
Synergy	Order	
CULTURAL CUSTOMS	**CULTURAL VALUES**	**CULTURAL THEMES**
Belief in God (Moral Character)	Respect (Elders)	Spirituality
Sanctity of Family & Children (relationships)	Self Mastery (thought/behavior)	Resilience
Sense of Excellence	Patience	Humanism
Sense of Appropriateness	Race Pride	Communalism
Importance of History	Collective Responsibility	Orality and Verbal
	Restraint	Expressiveness
	Devotion	Personal Style and Uniqueness
	Cognitive Flexibility	Realness
	Persistence	Emotional Vitality
	Reciprocity	Musicality/Rhythm
	Productivity	
	Resiliency	
	Defiance	
	Integrity	

Note: Used by permission of Wade W. Nobles, Ph.D., © 1981, The Institute for the Advanced Study of Black Family Life & Culture, Inc. Oakland, CA

African American Culture

The U.S. Census Bureau sees race as a person's self-identification (Belgrave and Allison, 2010). Thus, the Census Bureau defines Black or African American as: "A person having origins in any of the Black racial groups of Africa" (p.97). Literature suggests that racial identity refers to a sense of group or collective identity based on one's perception that one shares with others (Yip, Seaton, & Sellers, 2006). Currently, there is no consensus as to the best way to conceptualize or capture African American cultural reality (Marks, Settles, Cooke, Morgan & Sellers, 2004).

When examining African American reality, one has to take into account the group's lineage, place of origin, current residential status in the geopolitical state of U.S.A., and their experiences of systematic discrimination by practices, laws and social policies (Alexander, 2010; Steinhorn and Diggs-Brown, 1999; King, Moody, Thompson, and Bennett, 1983); this context makes up the African American culture.

Due to the historical legacy of enslavement, acculturation, and racial oppression, all Black people around the world share a history which gives relevance to an African heritage and

culture. No one has yet to demonstrate or substantiate how African American people are not fundamentally African. At best, social commentary, not scientific fact has simply declared that African Americans somehow magically stopped being African due to crossing the Atlantic and living for a long time in America, even though that stay has been for the most part isolated, rejected and segregated from mainstream society. There is an African American culture in America, which is unique, rich, and distinguishing (Belgrave and Allison, 2010).

Table 12 clearly outlines components of African American culture. Major aspects of African American culture is Black family kinship (Stack, 1974), healthy psychological functioning (Martin and Martin, 1978), and collective personhood (Penningroth, 2009; Rowe & Webb-Msemaji, 2004). The intricate relationship between culture and mental health remains an important topic of discussion. There cannot be mental health without culture and, therefore it has been argued for the need to see culture and mental health as mutually embedded.

> *"I personally need help, and I have been trying to get it from the mental health department. With my problem I've had since I was a child, I went to a therapist; all he did was give me medication. I need to have a good assessment of the problem. I am not getting the help I need."*
> **-In-depth Interview: Paris Jonell Warr, 29 year old female mental health client, San Francisco**

Unmet Mental Health Needs of People of African Ancestry

Throughout America, there is seemly a lack of recognition that there is African American culture, or a misunderstanding of African American culture. The lack of understanding Blacks in America has created a deficit of unmet needs, especially in mental health. Ignoring African American culture is relative to how individuals are socialized and the exchange of knowledge about the population. For example, western training of psychotherapists focuses on self as the basis of identity. This orientation may not reflect the sense that individuals of African ancestry have of being connected to and with a more communal sense of self through family and community identities (Akinyela, 2005). Psychoanalysis (and psychiatry) is the only form of psychic healing that attempts to cure people by detaching them from society and relationships. All other forms – shamanism, faith healing, prayer– bring the community into the healing process; indeed use the interdependence of patient and others as the central mechanism in the healing process. Modern psychiatry isolates the troubled individual from the currents of emotional interdependence and deals with the trouble by distancing from it and manipulating it through intellectual/verbal discussion, interpretation, and analysis (Vernoff, et al., 1981).

Many African Americans at highest risk fail to access health services, because they feel the services offered are not relevant to their experience (Davis, 2011). Other issues are no insurance coverage for psychiatric care, and some people make too much money (the working poor), yet they do not qualify to use the public system. Consumers should be encouraged to participate in all aspects of treatment planning; being empowered to exercise personal judgment and responsibility to make informed decisions about their service options whenever possible. African Americans enter treatment with multiple problems. People with dual diagnosis of alcohol or other drug addictions and mental illness should be treated concurrently; likewise, people assessed with HIV/AIDS or other infectious diseases should receive treatment, counseling and education to improve health outcomes and reduce preventable harm and potential risk to others. Since race plays an integral part in the lives of African Americans, consumer concerns and/or anxieties related to race should not be overlooked. Socio-economic circumstances, historically linked to class and race disadvantages are a critical factor, elevating a host of risk factors, institutional distrust, and "cultural pain" (Bell, P. 2002, Chemical Dependency and the African American).

B3. CURRENT BARRIERS

B3A. CONTRIBUTING FACTORS TO MENTAL ISSUES IN BLACKS

Stress

Trauma exposure is high in African Americans who live in stressful urban environments. Posttraumatic stress disorder (PTSD) and depression are common outcomes of trauma exposure and are understudied in African Americans (Alim et al., 2006). In a study where 96% of participants were African-Americans, Alim et al (2006) found that the rate of PTSD exceeded that of the general population. They emphasize the importance of screening for PTSD and depression in primary care settings.

Perceived Discrimination

A study by Burgess (2008) revealed that people who reported perceived discrimination from within health care settings had significantly higher odds of delaying or avoiding seeking health care in a model adjusted for access to health care as well as overall health. Other significant covariates that were inversely associated with underutilization include low income, no regular source of care, poor health and depression. People who reported experiencing very frequent everyday discrimination and people who reported experiencing somewhat frequent everyday discrimination had significantly greater odds of underutilization of mental health care than people who reported infrequent everyday discrimination, and U.S.-born Blacks, had greater odds of underutilization among those experiencing everyday discrimination very frequently.

Personal Crises

Some individuals tend to seek treatment only in crises (Alim et al., 2006). Patients with co-occurring issues, such as substance abuse, have been observed to be less likely to obtain mental health services. They were more likely to obtain treatment when in crisis than on a regular outpatient basis (Alim, et al., 2006; Alvidrez et al., 2009). One contributing factor to this phenomenon could be financial.

Insurance Coverage

Adults 18 and over may not have access to viable insurance coverage. Their insurance may not cover mental health services, or the cost of insurance may be prohibitive, and many may be unable to pay for services and medicine for chronic mental health problems. There is a significant association between no health insurance and underutilization of health services (Burgess, 2008). Patients may literally have to make the decision between paying the rent or paying for a prescription.

Table 13 displays the percent of the US population that has insurance coverage. For Blacks, 44.7% of their insurance coverage is provided by employment. The economic crisis in America has caused Blacks to lose not only their jobs, but insurance coverage as well. Those without jobs become high risk for Medicare, and will need to be covered.

On March 23, 2010, history related to health insurance coverage was changed forever in America. President Barack Hussein Obama signed into law the Patient Protection and Affordable Care Act (ACA) of 2010. ACA and the nation's health reform initiative will make health insurance more affordable for individuals. Under the ACA, prevention and early intervention and treatment of mental and substance use disorders is supported and are an integral part of improving and maintaining overall health (SAMHSA, 2011).

***Table 13**: Insurance Coverage by Race & Hispanic Origin, U.S. 2009*

ETHNIC GROUP	TOTAL INSURED	EMPLOYMENT-BASED	DIRECT PURCHASE	MEDICAID	MEDICARE	MILITARY	NOT COVERED
White, alone	88.0%	62.5%	11.3%	10.7%	17.1%	4.6%	12.0%
All Races	83.3%	55.8%	8.9%	15.7%	14.3%	4.1%	16.7%
Asian, alone	82.5%	58.4%	9.4%	13.9%	9.3%	2.6%	17.2%
Black, alone	**79.0%**	**44.7%**	**4.5%**	**27.1%**	**11.9%**	**4.1%**	**21.0%**
Hispanic (any race)	67.6%	36.5%	3.3%	26.5%	6.7%	2.0%	32.4%

Note: No other ethnic groups were identified for 2009
Source: U.S. Census Bureau, Current Population Survey, 2000 to 2010 Annual Social and Economic Supplements

Financial Resources
Access to health care is often limited by financial resources and the availability of resources and localized systems of care. A study done by the National Women's Law Center (2001) found that 39% of African-American adults reported having no regular physician compared to 26% of White adults. African-Americans were also twice as likely to report having "very little" or "no choice" in where to go for medical care."

Communication
Burgess (2008) found that comfort in asking questions or raising issues with health care providers was associated with a lower likelihood of unmet health care needs for some ethnic groups, and this emphasizes the need for training providers in effective cross-cultural communication.

Racism
Experiences of sexism and racism can directly or indirectly impact the physical and mental health of African-American women, as the inequities created by race institutions are closely correlated with poor physical and mental health status (Clark, 2003). Racism is a perpetual problem in America; an unresolved current barrier.

Stigma
Other barriers to treatment include the unique aspects of shame and stigma that Blacks associate with diagnosis and treatment of mental health issues, and the Black cultural mistrust of the mental health system (Breland-Noble, 2004). Recent research by Shim, Compton, Rust, Druss, and Kaslow (2009) suggest that African Americans are not impeded by stigma or embarrassment when deciding to seek mental health services. This leads to more complex questions about what are current barriers to seeking services, as perceived by clients. Perceptions, values, and beliefs are just as critical as trust in mental health treatment and should be considered as potential barriers to care.

Lack of African American Providers
Some providers may not reflect the racial or ethnic minority composition of families, and this could be a barrier to mental health treatment (Copeland, 2006). Even where the provider may be of the same race or ethnicity, and this is relatively low in the African-American community, they may not have been trained to be culturally sensitive.

B3B. MENTAL AND BEHAVIORAL HEALTH WORKFORCE

African Americans prefer trusted providers. A critical issue for seeking and obtaining services is to find a trusted, caring, respectful, and compassionate provider. Across many spectrums of the American workforce, the needs are critical and dismal (IOM, 2003). For the purposes of this report, the intent of the workforce discussion is to document disparities associated with those responsible for providing mental and behavioral health services, with special emphases on those providing PEI services. According to SAMHSA (2007), workforce data has not been consistently collected using a standardized data set making it difficult to present an accurate portrayal of the mental and behavioral health workforce. Current workforce special studies will meliorate this concern.

Based on the best available information, the licensed mental health professional workforce considered to be essential to the operations of the public, community-based mental health service system are generally Licensed Clinical Social Workers (LCSW), Marriage and Family Therapists (MFT), Advanced Practice Nurses (Psych/Mental Health Nurse Practitioners and Certified Nurse Specialists), Clinical Psychologists, Licensed Clinical Psychologists (LCP), and psychiatrists (Shea, 2009). *Table 14* is the statewide demographic profile of mental health professionals with current valid California license (Department of Consumer Affairs, 2011).

Table 14: *Number and Percent of California Licensed Mental Health Professional Workforce*

PROFESSIONAL CATEGORY	NUMBER	%
Marriage and Family Therapist (MFT)	31,157	32.02%
Licensed Clinical Social Worker (LCSW)	18,373	18.79%
Psychologist	17,283	17.67%
MFT Intern (IMF)	13,308	13.61%
Associate Clinical Social Worker (ASW)	9,022	9.22%
Psychiatrist	6,439	6.58%
Licensed Educational Psychologist (LEP)	1,825	1.86%
Psychiatric/Mental Health Nurse	359	0.37%
TOTAL	**97,766**	**100%**

Source: California Department of Consumer Affairs (DCA), Licensee and Registrant Statistics, 2011
Note: Licensed Clinical Psychologists were not listed by the DCA.

At first glance, there is an obvious critical shortage of professionally trained mental and behavioral health workers. California has over 36 million residents, and has less than 100,000 properly trained mental health professionals. Most of the mental health workforce resides in urban areas. In 2006, the California Board of Behavioral Sciences (BBS, 2007) conducted a demographic survey of its active licensees and registrants. Of the approximately 64,000 active licensees and registrants, only 25,909 responded to the survey. Figure 22 identifies by ethnicity, the percent of respondents. There were 25,548 who identified their ethnicity; 3.59% (917) were African Americans.

Table 15 is the actual number of African American respondents in the 2006 California Board of Behavioral Sciences survey who identified ethnicity and profession. Respondent category included marriage and family therapist (MFT), licensed clinical social worker (LCSW), educational psychologist (LEP), marriage and family therapist intern (IMF), and associate clinical social worker (ASW), *Figure 23.*

Table 15: *Percent of California Board of Behavioral Sciences African American Licensees and Registrants by Professional Category, 2006*

PROFESSIONAL CATEGORY	AFRICAN AMERICAN RESPONDENTS	% IN PROFESSIONAL CATEGORY
Associate Clinical Social Worker (ASW)	168	7.72%
MFT Intern (IMF)	164	6.32%
Licensed Clinical Social Worker (LCSW)	350	4.65%
Licensed Educational Psychologist (LEP)	16	2.89%
Marriage and Family Therapist (MFT)	219	1.71%
TOTAL	**917**	

Note: Respondents are those who answered both the professional category and ethnicity Licensed Clinical Psychologists were not listed by the DCA.
Source: California Board of Behavioral Sciences, Demographic Report on Licensees and Registrants Summary, December 2007.

When considering the goal of PEI is to prevent and/or reduce serious mental illness/ emotional disturbance and early intervention in the emergence of a mental health problem, one must carefully consider **who will be available to carry out this work.** Another obvious critical issue is the lack of ethnic diversity to provide culturally congruent interventions. In California, 75% of the mental health workforce is non-Hispanic Whites, and 60% of the users of mental health services are nonwhite, extremely diverse ethnic populations (see *Table 3: California Population by Race/Ethnicity, 2010*).

> *"I have a big problem. I have a problem especially my, my people that it's not enough Black, truly Black mental health workers or professionals in that field where we aren't getting the necessary help that we need from our culture to understand our culture."*
> **-FG#14: David, 46 year old Black male, National Brotherhood Association member, Bakersfield**

> *"There is not enough information, resources, and people to give directions to help. Whether with a family or individual, you cannot get resources or help. There is nobody to help you with these mental problems when people get in trouble.... I don't know, ah that's bad."*
> **-FG#34: Raechel, 44 year old Black female community advocate, San Bernardino County**

> *"A lot of Black people do not like talking their personal problems with people not of their race. Many people would like to see African Americans mental health workers."*
> **-FG#10: Tommie, 66 year old African American female, The Children of Promise, Sacramento**

Based on the statistics of African Americans currently in the mental and behavioral health workforce, immediate access to a predominance of African American providers isn't an existing reality. Nonetheless, the effort to build upon this workforce is a priority that is essential to changing the status quo. An equally critical element is training the existing mental health and behavioral workforce to meet the needs of the African American population.

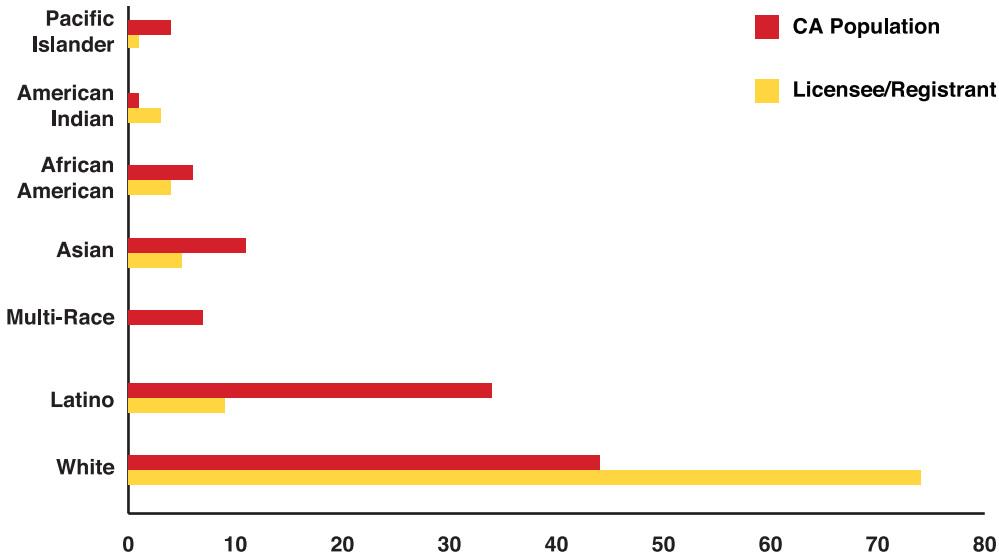
Contracts on state and county levels require a minimum level of cultural related training for mental health providers. Specifically within the MHSA, the priority of relevant, individualized cultural specific services is clearly delineated. This is difficult for service providers to meet this standard due to the very limited number of workshops offered

that focus on cultural issues. A smaller number targets general and/or specific issues of the African American population. Although the Governor of California has made it a priority that disparities relative to African Americans and mental health services remain a focal issue, **missing are enforceable accountability standards**. The long-standing trend has resulted in a repetitious awarding of state and county contracts to agencies who continually fail to meet a minimum level of culturally relevant care to African Americans. Their recruiting of African Americans in all levels of service is far below expectations.

Plans which are outlined in the proposal for funding must be accompanied by a minimum level of funding allocated to achieve outcomes specific to African Americans. The initial step requires assessment of senior-level management training and awareness related to African Americans and disparities within mental health care. These topics ideally cover recruitment of African Americans within all levels of agencies, policy decision-making, and curriculum-training development. To accomplish this objective, a range of activities throughout the life of the funded projects would include larger scale training where open dialogue is facilitated within smaller groups. In order to be effective, the feedback must be accompanied with outcomes and a timeline for follow-up after recommendations are implemented. It would also include inviting experts on African American issues if they do not exist within the organization. If they do, collaboration between African American staff and the experts is a must in order to validate the inclusion of staff most appropriate to assist with developing the training.

The meeting of the minimum standard indicated herein would be contingent upon funding and the continuation of funding. If not achieved, a corrective action process would be implemented with specific timelines to achieve the stated expectations. Funding sources who do not meet this standard would have their funding reduced. Those providers who continue to disregard the expectation would lose the specified funding until compliance is demonstrated and maintained.

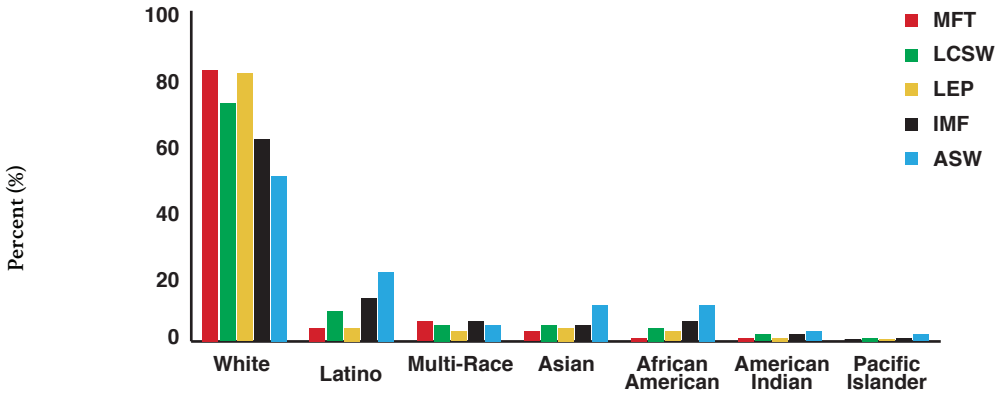
California Mental Health Professional Workforce



Source: California Board of Behavioral Sciences, Demographic Report on Licensees and Registrants Summary, December 2007.

Figure 22: *Percent of California Board of Behavioral Sciences Licensees and Registrants by Ethnicity, Compared to the Population, 2006*

Note: MFT = Marriage and Family Therapist; LCSW = Licensed Clinical Social Worker; LEP = Licensed Educational



Psychologist; IMF = Marriage and Family Therapist Intern; ASW = Associate Clinical Social Worker.
Source: California Board of Behavioral Sciences, Demographic Report on Licensees and Registrants Summary, December 2007.

Figure 23: *Percent of California Board of Behavioral Sciences Licensees and Registrants by Ethnicity and Professional Category, 2006*

African American mental health professionals are critically lacking across all categories. While the perception of service providers may be that they are doing their best within the systems where they work and have the best of intentions, many in this population believe that service providers do not understand the African American culture.

"He diagnosed me and put me on a lot of medications that didn't work for me... what medication you are on and the dosage is a whole 'nother thang because as we talked about before depending upon your genetic makeup and your cultural background, it will determine how well your medication will or will not work."
-FG#9: Mona, 43 year old female client and mental health advocate, Chico

"We do not have African American therapist who are trained to, we don't even have African American therapist who are culturally competent to treat their own people.... The bottom line is we do not have culturally competent therapist in this county who have been trained to treat their own people."
-FG#6: Torclanna, 44 year old Black female, Office Manager, San Diego

"It's like nobody cares. Like you have nothing; like when you wanna talk to somebody, there's nobody there. So when you already in a depressive state, your're thinking man I need somebody but you don't have anybody, so it's just man so you get even more depressed and more depressed as the day goes on, by each day."
-FG#11: 18 year old gay male college student, Sacramento

"Major mental health problem for Blacks is a lack of a culturally competent and appropriate system."
-Consumer, Client, Client Family Member Survey Contra Costa: 63 year old female parent of a son diagnosed with bipolar, depression, and substance abuse

"I'm just going to tell it like it is. It seems nobody understands us Blacks. We have culture too. We are all not the same but, nobody gives-a-damn. They try to treat us all the same. We are not the same. We keep talking. We keep telling them, look, I had a problem. Things weren't clear in my head. I went down to the mental health place to talk to somebody. They put me on this medication and it made me feel 'weird'. I went back down there and told them folks I don't need this medication. I just want to talk to somebody to get my thoughts straight. They told me to keep taking the medication. That is not what I needed."
-FG#20: 40 year old Ethiopian male, mental health client, Oakland

"We keep talking, but it appears nobody is listening, or is it they don't understand us."
-FG#19: 21 year old TAY African American female mental health client, Alameda

This situation is further compounded by the possibility that an individual could have a service provider who operates from unexamined personal biases of sexism, heterosexism, and racism; and also operates within a system of institutional racism and has an ethnocentric perspective. These biases are often not malicious; rather, it is the result of unexamined or entrenched systems operating in American culture. All people need assistance in unlearning racism and systems of oppression and service providers are no different. Engaging in discussions and education in this area will also positively affect individual's views of service providers.

"Prevention and early intervention practices need more people like 'us' (African Americans) who understand. People need to be culturally sensitive, a person who cares, communicates differently, NO stereotypes, and will get to know the person."
-In-depth Interview: 48 year old gay business man and social activist, San Francisco

"I'm a, I'm a father of, of 5 children and so I, in, in remembering how I was brought up you know again everything that's said in the home stays in the home and you don't really talk about it but um but we introduced um another member of our family, our nephew and I'll say this in a safe space Ernest who is with us now and we went to see Ernest a couple of months ago in Las Vegas which is where he was living, I knew at that time he was developing into ah a gay young man. And being a gay young man myself growing up in the hood I know the trials and tribulations that come with that and you learn to suppress a lot of stuff and you can't really be who you are so when I saw Ernest a couple of months ago, my partner and I were driving home and I said my fear is that he is not going to be the man that God has called him to be. He is going to ah he could fall into a sea of depression. He could start running with the wrong crowd so we stepped up to the plate and asked his mom if he could come and live with us. Because by living with us then he does not have to live with a mask on he can be all of who he is going to be. And I can tell you putting a child or a person in a safe environment where they can really blossom and be exactly who they are, you'll see a lot of things lift and the my thing now is I don't even see that same boy that I saw a couple of months ago. Now I see this striving youth who is sure of himself and ready to go so it's amazing of what you can do with your environment by putting people in a safe space where they can blossom. We have a, a saying in our home is that the world is so cruel that once you leave our door, life just have you putting on different masks and pretending to be a person that you are not. But when you healed you get to be all of who you are and so Ernest is now in a place now where he can thrive and he can be the person he is called to be. If he wants to wear his hair pink one day, fine. If you want to wear your hair green one day then we'll go buy green hair color cause I want you to be the person that God has called you to be and you know who that person is. On the other hand I have another son who's 17 and he has ADHD. And Ivan knows he has ADHD and we don't make, um, a secret about it cause in our community everything's a big secret and we don't live in secrets. So in his situation we talk about it openly and that this is not a um a curse against you but because we know what you have now we can deal with it. Okay so you have ADHD so that means you gotta take your meds. I don't like to take my meds. Well why don't you like to take them and then we begin to have that dialog with Ivan around he doesn't like it because it makes him too mellow. He, he doesn't like to be mellow and he's 17 years old he wants to be out there cutting up with the other kids. But when he takes his medicine he becomes very just like this and it makes him very focused. He can get his homework done which is what he supposed to do. That's what the medicine is for. He doesn't like that. So again we, we constantly have that dialog around mental health authenticity ah in the home and it doesn't become this kind of secret, secrecy because again going back to the beginning my family was taught because we had so many people in my family with mental health issues, never talked about it."

-FG#11: 46 year old same gender loving father & partner, with sons and other family members with diagnosed mental illnesses, Sacramento

Another major challenge is the geographical variation of California's population. However, geographical findings present the same dismal outlook. In some rural and isolated areas there are no mental health professionals at all.

REGIONAL BARRIERS TO ACCESSING PROGRAMS AND SERVICES

Central California Region

Regionally, the Central Valley (population over 6 million) experiences greater shortages for all physicians, primary care physicians and specialty physicians than any other region in the state of California (Riordan & Capitman, 2006). Counties in the Central Valley are Shasta, Tehama, Glenn, Butte, Colusa, Sacramento, El Dorado, Sutter, Yuba, Yolo, Placer, San Joaquin, Stanislaus, Merced, Madera, Fresno, Kings, Tulare, and Kern (Umbach, 1997). Further, the shortage of health care providers in the San Joaquin Valley—the heart of the Central Valley—is impacted by several factors: its largely rural nature, the large percentage of uninsured residents, and lower Medi-Cal reimbursement rates compared to other parts of the state (Riordan & Capitman, 2006).

The San Joaquin Valley was notably underserved compared to California and the nation on several indicators involving the health professional workforce. All eight San Joaquin Valley Counties (which are San Joaquin, Stanislaus, Merced, Madera, Fresno, Kings, Tulare, and Kern) have Medically Underserved Areas/Populations designations. These counties experience shortages in dental, mental health and primary care professionals, as determined by the United States Health Resources and Services Administration, Bureau of Health Professionals. These health professional shortages create access challenges for all residents, but those who are uninsured or dependent on public insurance programs are the most impacted (Riordan & Capitman, 2007).

The **most severe provider shortages** in the San Joaquin Valley were in the mental health workforce. The ratio of mental and behavioral personnel is 94 per 100,000 versus 327 per 100,000 in California. Compared to California, the San Joaquin Valley, had 85% fewer psychiatrists, 70% fewer psychologists, 50% fewer licensed clinical social workers, and 65% fewer marriage and family therapists, per 100,000 persons. Only 19 child psychiatrists currently practice in the entire San Joaquin Valley, but the national standard is 14.8 per 100,000 persons. Six out of the eight San Joaquin Valley counties have county-wide mental health professional shortage area designations (Riordan & Capitman, 2007).

San Diego Region

On June 24, 2010, the Breaking Down Barriers Program (Current Change Consulting, August, 2010) assembled a group to discuss the challenges to accessing mental health services for the African-American community in San Diego County. Though there are many organizations that provide mental health services there isn't a comprehensive plan in place that addresses this population's mental health needs. Many regional barriers and recommendations were identified by the Breaking Down Barriers Program and will be presented in the recommendation section of this report. The overarching theme discussed among this assembled group was clarification of service delivery, and providing multi-faceted mental health services to the diverse African American community. The group defined barriers and challenges to mean the following: barriers are the physical challenges to access, policies restrictions etc., where challenges are barriers that are intangible. Table 16 provides a synopsis of barriers and mediators to equitable mental health care. Understanding and accepting regional perspectives will facilitate or hinder mediations to equitable care.

Table 16: *Barriers and Mediators to Equitable Mental Health Care*

Taken from Mapping Progress in Mental Health Disparities in a Transformed California Mental Health System presented by Annelle B. Primm, MD, MPH, Director, Minority and National Affairs American Psychiatric Association, May 22, 2009 at University of California Davis Health System, Sacramento, CA

BARRIERS	USE OF SERVICES	MEDIATORS	OUTCOMES
Personal/Family	Visits	Quality of providers	Health Status
Acceptability	Primary care	Cultural competence	Mortality
Cultural beliefs	Specialty	Communication skills	Morbidity
Language/literacy	Emergency	Medical knowledge	Well-being
Attitudes, beliefs	Procedures	Technical skills	Functioning
Preferences	Preventive	Bias/stereotyping	Equity of Services
Involvement in care	Diagnostic	Appropriateness of care	Patient Views of Care
Health behavior	Therapeutic	Efficacy of treatment	Experiences
Education/income		Patient adherence	Satisfaction
Structural			Effective partnership
Availability			
Appointments			
How organized			
Transportation			
Financial			
Insurance coverage			
Reimbursement levels			
Public support			

Modified from Institute of Medicine (IOM, 1993) *Access to Health Care in America: A Model for Monitoring Access.* Washington, DC: National Academy Press.

B3C. PHARMACEUTICALS/MEDICATIONS

Psychotropic Drugs and Mental Health Disparities in Healthcare of African Americans: A Prospectus

by Douglas Ray-Breaux, M.D., Pharm.D.

Content was taken (with permission of Dr. Ray-Breaux) from Chapter 8 of "Slavery and Its Impact on Today's Healthcare of African Americans" (Ray, 2011). Dr. Ray has been a member of the National Library of Medicine Study Group and conducted disparity research with Historically Black Colleges and Universities (HBCUs). Dr. Ray is the founding director of the Pharmacy Technology Program at Charles R. Drew University of Medicine and Sciences in Los Angeles.

Brief History of Medicine in USA

The history of the practice of medicine began in Africa around 2000 B.C., then Greco-Rome around 1st Century AD (Ergil, 1997). Historical records are both secular and religious. Religious history has greatly influenced secular and scientific practices. Religious practices of medicine are well documented in the Bible (Exodus) by men that believed in God and sought cures for the people's sins and illnesses. For example, Moses, Aaron (a high priest), and Joshua were recognized spiritual leaders or mediators for the people, who were guided by their belief in the spoken word of God to herbal cures for the atonement of the peoples sins and or illness.

It is very important to make known that herbal healing or cures were made effective by the belief/trust of the word spoken by their spiritual leader. This belief/trust relationship exists today between therapist and patient. Furthermore, the treatment outcome of a patient is mainly determined by culture belief/trust relationship between the spoken word (instructions) of his or her therapist.

Therefore, the knowledge of healing process using herbs is based on believing in the "belief/trust language" used or spoken by the healer. During ancient times the knowledge of healing came through the spoken word of spiritual leader, today, healing comes through many ways, such as healers, physicians, pharmacists, herbalists, nurses and others. But, the effect of the healing process still depends on strength or power of the word spoken by the healer or provider. It is also important that the provider have knowledge of the belief/trust value system of a patient/culture. Today, this is becoming an essential in providing healthcare and compliance to patient.

Another biblical example, emphasizing the power of spoken word thru "belief/trust" and compliance, is the leaper Naaman. Naaman believed in the spoken word of Elisha, the prophet, but after rebuttal, obeyed the word or instruction and was healed of leprosy by dipping in the Jordan River (2Kings 5: 10-15, Kings James Bible). The practice of herbal healing or the knowledge of herbs for healing diseases began by spoken word of God thru men who believe/trusted and obeyed as they were instructed. Thus, the belief/trust of words spoken by spiritual leaders lead to a knowledge of herbs for healing. This knowledge of herbal healing began in Africa and eventually it was revealed to the different tribal cultures in African and then became known to other cultures in different parts of the world.

According to Shelley Adler, Ph.D., associate professor of medical anthropology, University of California in San Francisco writing from The Bravewell Collaborative article entitled, *"The Power of Belief and the Importance of Culture"* (2011), "people in

different cultures and different societies have different ways of thinking about medicine, different types of healing modalities, different tools, and even different illnesses." This can literary translate to mean the many different cultures thru out the world each have their different belief in the practice or use of herbal medicine.

Overtime, herbal medicine arrived in this country and gave rise to what is known as western medicine, especially in the area of prescription drugs. The difference between the practice of herbal and western medicine in this country is also a culture belief/trust system. Thus, it can easily be argued that a culture orientation or belief to the use of herbs is one of the most important factors in treating an illness/disease. As the use of herbs became popular in this country, different cultures began different usages based on culture/belief/trust/language system.

During the days of slavery, this different culture beliefs (African Americans and Europeans) were used to explain why the healthcare for both slaves and slave owners was European culture based (double standard of healthcare system) but, was operated and controlled by Europeans. According to Byrd and Clayton (2000), both professors of medicine at Harvard University School of Medicine and authors of *"An American Dilemma: Medical History of African Americans and the Problem of Race"* state, "the healthcare of this country was established on a European culture base system." This system was further described as a double standard of health care system to treat slaves and slave owners. Slaves were allowed to be treated by their culture/tribal root doctors, grannies, and midwives while European physicians treated slave owners.

The Food and Drug Administration (FDA)

The practice of culture/herbal medicine was the standard practice of medicine until the up rise of pharmaceutical companies, which began to peak in the 1900's. Herbal medicine became limited due to the abuse by charlatans improper mixing, labeling of herbal mixtures that lead to deaths and illness. The Food and Drug Act of 1906 was the first law to regulate the mislabeling and adulteration of herbal remedies in the country (Fetrow & Avila, 2000; American Society of Health System Pharmacist, 2006). This law allowed pharmaceutical companies to promote and market drugs to consumers and them medical profession to treat systemic diseases. The requirement for Food and Drug Act approval was that the drug had to be accurately labeled and the drug content in the bottle had to match the label.

Many of these chemicals known as drugs were extracted from herbs and reformulated to become label known by the term "drug." Drugs became recognized by the Food and Drug Administration (FDA) and had to be labeled properly for approval for treating systemic diseases. This law did not stop herbs improper use from being used to treat systemic diseases, today some are in higher demand than prescription drugs for treating systemic diseases. Some of the reasons for the high demand of herbs/pharmaceutical drugs are by the consumers are people living longer today thus the need to maintain independent living is greater. Thus, a greater demand for herbs/new drugs in both areas and consequently accounting for an increase in the number of prescription drugs/herbs consumed by patients.

The increase in the number of prescriptions being filled is associated with an increase incidence of adverse drug reaction secondary to polypharmacy. Polypharmacy by definition refers to a patient taking two or more drugs to treat the same illness thus, increasing the risk of experiencing adverse drug reactions (ADR); a direct result of the number of drugs taken. ADR is the fifth leading cause of death in this country.

One of the main reasons for ADR having such a high mortality rate is due to under reporting or lack of recognition of these drug interactions by the consumer. Moreover, pharmacists spend more time filling the increase number of prescriptions and have less time consulting or educating consumers. This leads to an increase risk of drug induced diseases experience by consumers. Drug induced diseases are extremely dangerous, because their symptoms can mimic the symptoms of other diseases. Drugs used to treat high blood pressure can induce cough that may mimic or increase symptoms of bronchitis. Drugs that induce anemia may worsen the menstrual flow in females who may become anemic due to monthly cycles.

Disparities in Drug Use

According to the Kaiser Family Foundation article, *"Prescription Drug Trends"* (May 2010), spending in the US for prescription drugs in the 1990s was $40.3 billion and has increased to $234.1 billion in 2008 (increase nearly 6 times as much). The average number of retail prescriptions per capita increased from 10.1 in 1999 to 12.6 in 2009. A research study by Han & Liu (2005) found that Blacks (8.3%), Hispanics (6.1%), and Asian-Indians (23.6%) were less likely than Whites to use prescription drugs for specific mental illnesses. Additionally, all three ethnic groups spent less per year for their actual prescription drugs than Whites (actual dollar amount spent by Whites was not reported in the article); Blacks spend $606.53 US dollars, Hispanics spent $9.83 US dollars, and Asian-Indians spent $179.60 US dollars.

Most of the drug-induced diseases occur in the general population but the indigent/minority population suffers the most from not having medical insurance and the lack of understanding their culture/beliefs and its impact on prescription drugs. The lack of understanding the different culture/beliefs is associated with high incidence of experiencing adverse drug reactions (ADRs). Moreover, only recently have pharmaceutical companies given consideration for culture/trait differences in evaluation and formulating drug efficacy and reducing ADR in the general population.

Pharmacogenetics

The old days of "one drug cures all" or, the same drug can be used to treat different diseases, is changing due to an increase in ADR, and a lack of knowledge of culture/genetic traits to drug efficacy. Kirchheiner et al., (2004) in the article *"Pharmacogenetics of Antidepressants and Antipsychotics: The Contribution of Allelic"* presents the position that "pharmacogenetics can improve efficacy and reduce ADRs." Pharmacogenetics is a laboratory test that can be used to diagnose and monitor drug ADF and efficacy before long term regimens of prescription drugs are begun. This is accomplished thru the genetic (DNA) testing of body enzymes that metabolize these drugs while in the body.

Pharmacogenetics mandates that drugs be formulated based on culture/genetic traits differences in evaluating and formulating drug efficacy and reducing ADR in the general population. Pharmacogenetics also involves the testing of patient's genetic material (DNA) and specific enzymes that are made or manufactured by the body to regulate the metabolism (synthesis or breakdown) of any substance including drugs while inside the body. The testing of a patient genetic material can be used to provide specific patient information on identity of drug or drug allergies, drug interaction, or drug efficacy. Thus, the use of Pharmacogenetics can be used to monitor ADRs, and diseases that are culture specific or diseases common to certain cultures.

African American culture unlike any other culture in this country, born in part out of slavery, **is the least understood**. Families and community associated with the lowest quality of health/healthcare, but our contribution to this country has been second to none!!! The lack of understanding of our culture can easily account for the existence of the dual standard of health/healthcare. This dual standard in health/healthcare originated during slavery continues and contributes greatly to the poor state of health and lesser quality of healthcare for African Americans. The root causes of health disparities are numerous and relate to individual behaviors, provider knowledge and attitudes, organization of the healthcare system and societal and culture values, according to Thomas, Fine & Ibrahim (2004). In sum, the knowledge of our culture belief/trust values influences our attitude and behavior toward healthcare and others.

Studies cited supports the fact that healthcare in America operates under a dual system of healthcare delivery based on a European/culture with dual standards. This dual standard (two separate systems) of healthcare continued from slavery through the Jim Crow areas while African American health/healthcare and culture continued to be neglected. Efforts under the Civil Right Bill, 1964, and the introduction of health maintenance organizations (HMOs) like Kaiser Permanente, and others such as Blue Shield, Blue Cross during the 1960's, created standards of healthcare that improved outcomes for African Americans and other minorities. Still a much greater problem was the African American medical workforce.

It is necessary for the reader to understand discriminatory practices in the medical system has greatly impeded the availability of Black physicians and severely hampered qualified cultural practitioners. There are two professional medical organizations, the American Medical Association (AMA) and the National Medical Association (NMA). The AMA when established accepted only White physicians. The NMA was later established for Black physicians because Black physicians were denied membership to the AMA. It was not just belonging to a professional medical organization. It involved not having support to practice medicine, inability to admit patients to certain hospitals, inability to access treatment resources, and a multitude of other support necessary to provide good medical care for African Americans.

This is another example of the existence of double standards within the healthcare delivery system. For more than a century, institutional racial inequality toward African American physicians persisted. Such race-based health disparities have led to a precipitous decline in the health of the African American population. Even thou today, situations are better for Black physicians, it is still extremely challenging to enter the medical field, to establish a viable medical practice and to become a member is a financially secure group practice. In California, Black physicians are less that 3% (USCF Center for California Health Workforce Studies, 2011) of the entire medical profession; White physicians are 78%, Asian physicians are 11%, Hispanic physicians are 5%; Native Americans are less than 1%.

Mental Health and Psychotropic Drugs

Psychotropic agents are used to alter expression of thought/behavior which are used for long term management of psychosis rather than short term or acute behavior problems. The differential diagnosis between a psychosis, personality, or anxiety disorders can be based on age and /or signs and symptoms. Satre et al. (2010) examined ethnic differences in accessing treatment for depression and substance use disorders (SUDs) among men and women in a large integrated health plan, and explored factors potentially contributing to health care disparities. Among women diagnosed with depression,

Latinas and Asian-Americans were less likely than Whites to fill an antidepressant prescription. Among men diagnosed with depression, African Americans were less likely than Whites to do so. Among women diagnosed with an SUD, African Americans were less likely than Whites to have one or more chemical dependency program visits. These results persisted after controlling for education, income, having a regular health care provider and length of health plan enrollment. Results may indicate that Blacks and Latinos do not prefer to take medications as a cultural practice.

Depressed African Americans are medicated at lower frequencies than Whites with the same diagnosis. Even though data (Lawson, 1986; Lawson 1990) suggests that Blacks may metabolize some psychiatric medications more slowly than Whites, they are often given higher doses with the result being higher rates of side effects. This can lead to higher rates of discontinuing medication, and lower functioning than necessary when taking the medications. However, dosing cannot be used as a measure of appropriate pharmacotherapy because an extensive literature has shown that African Americans often receive higher doses of antipsychotics despite evidence of more side effects (Lawson, 2008).

Of critical concern, is the use of psychotropic drugs in children and youth. A typical example is what happens within the foster care system. African American children and youth are 10 times more likely to be taken away by the court from their families than Europeans when allegations are the same (Pope, Smith, Shack & Hargrove, 2011; Shabaka & Smith, 2003; Smith, 2005, 2002, 2001a, 2001b). Many of these children are between the ages of 0 to 12 years old. When separated from their parents will experience some problems in their growth, development, and behaviors. Consequently, these children are placed on psychotropic drugs (major tranquillizers). These agents are considered major tranquillizers because they have the properties to alter though/ behavior patterns in the deep structure of the brain (hypothalamus). The hypothalamus is the area of emotion/behavior expression to internal and external stimuli, such as feelings, love, sadness, etc.

However, it is difficult to justify the prescribing of these agents in this young age group. The inappropriate prescribing of the psychotropic agents may unnecessarily "label" these children for life. Moreover, the exposure of this agents at such an early age increases the risk for suicide, abnormal muscle or body movements known as pseudo parkinsonism (dystonic, involuntary body muscle movements that are initiated as a result of being on the drug) and dyskensia (late onset of abnormal body muscle movements manifested after the drug is discontinued). Such side effects in this age group are unacceptable to their peers causing these kids to be isolated or socially rejected (left to themselves). In addition, the central nervous system is not anatomically developed until the age of 7 years old (Victor and Adams, 2005; Larson, 2009), and does not become functional until the age of 12 or puberty; thus increasing the risk for abnormal growth and development.

Moreover, the coupling of adverse drug reactions (ADRs) with the family separation, at such early age, increases the risk of children entering the cycle of hopelessness, becoming depressed, high school drop outs, homeless and incarcerated and further displacement of disproportionate numbers of African Americans, especially males. Also, the general African American population continues to receive the lowest quality of healthcare than other ethnicities. African Americans continue to have the highest death rates for heart disease, high blood pressure, strokes, cancer, diabetes, suicide, respiratory diseases, to name a few, as a result of the dual standard of healthcare, and a lack, or denial of understanding cultural beliefs and treatment of diseases. This dual standard of healthcare delivery must end.

In addition, expert research conducted by Dr. William Lawson, (professor and chair of the Department of Psychiatry at Howard University College of Medicine, and president of the Washington Psychiatric Society), on racial and ethnic factors in psychiatry (Lawson, 2008; 1986), neuropsychiatric disorders (Lawson, 1990), and pharmacotherapy of African Americans (Lawson, 2000) must be considered. With an increasing ethnically and culturally diverse American population important implication for pharmacotherapy is inferred (Lawson, 2008).

It is now commonly accepted that genetic differences between the various ethnic groups are quite small and probably less than individual differences. Based on clinical trials there is evidence that ethnicity must not be ignored in psychopharmacology. The relationship between culture and illness occurs in persons of all ethnicities (Malik, Lake, Lawson, & Shashank, 2010) and, these differences must help provide guidance for appropriate early intervention of mental issues. Genetic variation in drug metabolism processes, and nongenetic biologic factors such as diet, smoking, and complementary and alternative medicine (CAM) treatments are also critical considerations in providing care for diverse ethnicities (Malik et al., 2010). Related to culturally adapted pharmacotherapy, several descriptors are suggested during the information gathering assessment for developing a treatment plan (Malik, Lake, Lawson, & Shashank, 2010). The descriptors provide a biopsychosocial framework with five domains (Malik et al., p795):

1. **Predisposing Factors:** areas of vulnerability that increase risk for the presenting of problems. Examples- genetic loading for affective illness, ADHD, or prenatal exposure to alcohol, or possessing a poor metabolizer, which could lead to abnormal metabolism of many psychiatric drugs.
2. **Precipitating Factors:** stressors or other events with temporal relationship with the onset of symptoms and may serve as precipitants. Examples - conflicts about identity or separation-individuation that arises at culturally relevant developmental transitions, i.e., puberty onset or graduation from high school.
3. **Perpetuating Factors:** conditions in the patient, family, community, or larger systems that serve to maintain rather than ameliorate the problem. Examples – unaddressed parental conflict, unsafe neighborhood, poor teacher-child fit, or inadequate educational services to meet the child's learning needs.
4. **Protective Factors:** (Strengths) areas of competency, talents, interests, supportive elements in the family or extrafamilial relationships. Examples – a good relationship with a mentor, a talent in sports, music, or video gaming that can be helpful in engaging in treatment and enhancing self-esteem or self-efficacy.
5. **Prognosis and Potential for Change:** identification of areas most amenable to change and potential obstacles. Example – when a youth with school avoidance is rewarded by being allowed to stay home for long periods.

B3D. SYSTEMS ACCESS ISSUES: CONDITIONED FAILURE MODEL

There are various factors that contribute to the disparities in racial mental health. Among these are differences in environmental risk factors, social settings, access to quality preventive care, and genetic inheritance. All of these can affect the differential onset and degree of severity of mental health conditions. Many of these factors are a result of social stratification, which is the process that creates a hierarchy of social positions and concomitant privileges, which are correlated with differences in the unequal distribution of power, property, status, and/or psychic gratification (Tumin, 1967). Of particular concern here is that social stratification which creates unique situations for African American children and families. Such situations have been shown to increase the likelihood of development of poor physical and mental health outcomes (García, Lamberty, & Jenkins, 1996; Lamberty, Pachter, & Crnic, 2000). The effects of social stratification are mediated through other social factors such as racism, discrimination, and oppression, which, in turn, create segregated environments that provide less access to material, social, and psychological capital (García, Lamberty, & Jenkins, 1996).

Educational System

Social stratification is perhaps more evident in American schools than any place else. Schools frequently place students in different 'tracks' that offer academic classes only to those who fit an appropriate prototype (e.g., middle class, Caucasian, "standard English" speaker). Students who do not fit this ideal prototype (e.g., poor, Black, "nonstandard English" speakers) find themselves placed in more general or vocational tracks (Apple, 2004). It has long been known that African American students tend to be over-represented in the lowest tracks (Braddock & Dawkins 1993; Oakes 1990; Oakes, Joseph, & Muir 2004). It is in these lower tracks where students are exposed to a restricted curriculum, generally receiving less stimulating teaching from teachers with less training who see themselves as less effective educators (Oakes, Joseph, & Muir, 2004, Talbert & Ennis 1990). African American youth also bear the brunt of disproportionately high rates of drop out, school violence, and school suspension and correspondingly low rates of per pupil expenditures, and performance test scores. Furthermore, there is mounting evidence that shows the detrimental mental health impact that these practices have on at-risk and disadvantaged students (Joseph, Slovak, & Broussard, 2010).

It should also be noted that, gifted African American children in the public school system are often under-identified due to behaviors related to their culture, as opposed to their level of giftedness; furthermore, such under-identification can lead to detrimental misdiagnosis (Belijan, 2011). Some of the reasons for the detrimental misdiagnosis include: language differences, cultural norm differences, multiple school placements, institutionalized racism, and the prevailing lack of knowledge about giftedness in general (Beljan, 2011). Instead African-American children are often labeled as having psychological disorders (e.g., Attention Deficit Disorder, Attention Deficit Hyperactivity Disorder) that further puts them at risk of being exposed to a deficit curriculum and/or higher degrees of medicated treatment.

Toppo (2001), examining data from the U.S. Department of Education (DOE), found that African American students were 2.9 times more likely to be labeled with a disability than their White counterparts. The disproportionate placement of African Americans in special education has been recognized as a long-standing achievement gap (Ward, 2010). Blanchett (2006) points out that African American children are not only disproportionately placed in education classes for mental retardation, emotional or behavioral disorders, and learning disabilities; once placed they are less likely than

their White counterparts to make achievement gains and return to regular instruction. Furthermore, special education was initially conceived as a mechanism to provide individualized instruction to students who needed special assistance; however, most African American children do not receive adequate resources nor are they exposed to stimulating activities (Blanchett, 2006). Instead, for African American children, special education has become a form of segregation from the mainstream (The Civil Rights Project, 2001). Some scholars have even argued that special education for African American children is a "legalized form of structural segregation and racism" (Blanchett, 2006, p. 25).

Many of these children who have been classified with learning or behavior disorders are prescribed psychotropic medications such as Ritalin, Concerta, Adderall, and other cohorts (Fitzgerald, 2008). These medical interventions, combined with media representations on behalf of the drug companies, have convinced the general public that such treatments could serve as a panacea for school officials and families concerned about their children's behavior, both at home and at school. Several scholars argue that there are racial underpinnings in using psychotropic drugs to control the undesired behavior of Black school-age boys with special education needs or those who have been medically classified with Attention Deficit Disorder, Attention Deficit Hyperactivity Disorder (ADD/ADHD) or some other emotional/behavior disorders (Fitzgerald, 2008). In addition, evidence is mounting that too many African American children are misdiagnosed with ADHD and unnecessarily medicated, thereby causing psychosocial stress which, by the time they enter middle school, results in recommendations for mental health interventions (Perry-Burney, 2007).

A recent large community-based youth study revealed deep-seated concerns about these issues among South Los Angeles high school students (Grills & Anderson, unpublished). The initial phase of the study consisted of an anonymous, self-administered survey soliciting student opinions and concerns about their school (n=5,956). A second phase consisted of a youth summit of focused small group discussions guided by a structured interview protocol and a school bonding and depression symptom survey. In total, 6,008 African American and Latino students across 7 major south Los Angeles high schools representing 9th through 12th grade were surveyed. The survey revealed that students cited concerns that clustered around four domains of unmet needs: environmental, intellectual, emotional, and psychological. In particular, these concerns related to school safety, inadequate CAHSEE and college preparedness, access to ethnic studies, and bouts with depression.

Several studies have investigated the relationship between racism and behavioral, emotional, and mental health; these studies have reported that African American youth who perceived discrimination reported higher levels of depressive symptoms, school stress, behavioral adjustment (Szalacha, 2003), and conduct problems (Brody, et al, 2006). The longitudinal nature of the latter study indicated that perceived racism led to increased depression and conduct disorders, and not the reverse. In addition, other studies have also shown that perceptions of racism was associated with internalizing and externalizing behaviors, anger, and delinquent behavior in both adolescents (Scott & House, 2005) and preadolescents (Gibbons & Gerrard, 2007; Nyborg & Curry, 2003).

While the State Governmental apparatus could offer African American and all students improvements in education as a way to address behavioral problems, school officials have instead used criminal "justice system" as the preferred method to address school discipline problems. The process of criminalizing social problems, policing

communities, and, in general, punishing African American students (Giroux, 2003) has had little success. Specifically, "zero-tolerance" policies in schools have been shown to be an extension of the racial bias that exists in the larger American society.

Criminal "Justice" System

Prior to the mid 70's only about 2% of the US population went to prison at any point in their lives (Boxcar, 2001). A policy shift has recently occurred and this has resulted in the increased use of imprisonment for offenses that were formerly not considered felonies (Western & Wilderman, 2009). Coupled with tougher drug sentences, parole limitations, and sentence enhancement for repeat and violent offenders, increased prison admission rates and time served in prison (Western, 2006) also became more common. This change in policy marked the beginning of a new and more insidious form of racial inequality. The policy was especially used to disenfranchise African Americans, who were demanding that America live up to its creed of "freedom and justice for all". Thirty years later, more than a third of non-college African American males had been or were incarcerated (Western & Wilderman, 2009). This has had a devastating impact on African American families.

This new punitive system of criminal sentencing was fueled by the chronically high unemployment rate in urban areas due to deindustrialization. Young African American males who managed to find employment experienced declining incomes, due to de-unionization, and the shift from manufacturing to service delivery (e.g., restaurants, nursing homes, etc.).

Furthermore, social programs that could have retrained them for technical jobs were dismantled and the few jobs that did remain were frequently out-sourced to countries overseas. At the same time, the welfare system, by design, further diminished the Black man's legitimate role as providers for their families. During the Clinton Administration, the demise of the African American family was further accomplished by requiring that mothers work, taking them from their children even though the wages earned were hardly enough to live on.

During the early to late 80s, without an avenue to legitimately provide for their families and frustrated by the lack of opportunity, a number of African American males turned to petty crimes, especially the sale of drugs, to survive. Competition in this business sphere led to an increase in gang activity and resultant homicides (Pastore & Maguire, 2006). The late 90s saw policies in place to criminalize and incarcerate, especially young African American males, for insignificant infractions that, as indicated above, were previously considered misdemeanors). Small transgressions were addressed with harsh penalties—such as a five-year automatic sentence for a thumbnail of crack cocaine. The arresting officers or the courts often increased misdemeanor infractions of the law for African Americans to felonies, while the felonies committed by Whites were reduced to misdemeanors. Further adding to this picture, was the use of "zero tolerance" parole supervision to re-incarcerate African American males.

The impact of the high incarceration rate on African American families is widespread. Being incarcerated further reduces stable employment, marriage, parenting, and other positive life experiences. It is not surprising that many modern Black observers suggest that these policies are purposely designed for racial genocide.

In April 2011, the Judicial Council of California released the *Task Force for Criminal Justice Collaboration on Mental Illness: Final Report* detailing recommendations for changing the paradigm for persons with mental illness in the Criminal Justice System. Funding in part was provided for this report by the California Department of Mental Health and the MHSA/Proposition 63. The purpose of the task force was to provide improved practices and procedures for adult and juvenile offenders with mental illness, to ensure the fair and expeditious administration of justice, and to promote improved access to treatment for defendants with mental illness in the criminal justice system.

Final recommendations included all facets of the criminal justice system with specific guidance in six major areas for improved responses to people with mental illness:

- Community-based services and early intervention strategies that reduce the number of individuals with mental illness who enter the criminal justice system;
- Court responses that enhance case processing practices for cases of defendants with mental illness and reduce recidivism for this population;
- Policies and procedures of correctional facilities that ensure appropriate mental health treatment for inmates with mental illness;
- Community supervision strategies that support mental health treatment goals and aim to maintain probationers and parolees in the community;
- Practices that prepare incarcerated individuals with mental illness for successful reintegration into the community;
- Practices that improve outcomes for juveniles who are involved in the delinquency court system; and
- Education, training, and research initiatives that support the improvement of criminal justice responses to people with mental illness (Task Force for Criminal Justice Collaboration on Mental Issues: Final Report, 2011, page 290).

Significant to the Judicial Council's recommendations are the continual involvement of the community in working collaboratively with the criminal justice system to appropriately provide wellness interventions for persons entangled in their system.

Testimonies from Within the Criminal Justice System

"...being made to feel 'invisible' during case conference with mental health and medical staff professionals.... Unable to make comments on what I am feeling based on my mental illness. I get the feeling, 'They know what is best for me.'"
-47 year old female, Pittsburg Adult Mental Health Clinic

"Feeling 'insignificant' because I ask questions about the medications and why I am taking them. No explanation given to me by my doctors only says to me that 'It's what you need. Don't worry about it, just take your medications and you'll be fine.'"
-39 year old male, Correctional Facility, Martinez

Now listen to me, I know what I am talking about. The prison system and TAY's, if you do not have a serious mental illness you are on the street. They bring baggage from the prison system into residential. When you go into the prison, the one who has the most serious diagnosis is Blacks. I have two sons in the system. My son has been in prison 24

*years (tears in her eyes). My youngest one (is) in for six years. They have the youngest one on **Thorazine, Seroquel, Paxil, and Haldol**. He is only 30 years old, okay!*

My recommendation is, what about training the ones before they come out. Train them in the prison system. I want to open a "prison without walls." And, train the one's incarcerated. Why, because they are one's incarcerated that can never be housed (pause). These are prisoners like arsons, sex offenders, methamphetamines, cocaine and PCP user. These people can never be housed. They need to be trained as criminal psychologist and forensics peer-specialist. They can revolve the doors in the prison system and train others, and have them come out by life experiences. Not have them trained in schools. 'Cause, all those trained in schools don't know what they are doing. But, if we train them in prison, then they can be helped. That's what I want to do.

-Balenciaga Muldrew, 58 year old female, Survivor, Black Los Angeles County Client Coalition (BLACCC)

Note: All four medications (Thorazine, Haldol, Seroquel, and Paxil) are commonly prescribed psychotropic medications. Thorazine, Haldol and Seroquel are classified as antipsychotics. Thorazine and Haldol are typical antipsychotics and Seroquel is atypical antipsychotics. All three are used in the treatment of schizophrenia and mania. Paxil is classified as a mood stabilizer and is anti-panic agent, anti-obsessive agent, and anti-depressant. Paxil is used in the treatment of bipolar disorder (NAMI, Policy Research Institute, 2011, online at www.NAMI.org).

11-10-2011
CSP Solano State Prison

Dear Dr. Woods,

Thank you for the opportunity. I found your draft (30-day draft CRDP African American Population Report for public review) to be well prepared and very informative. There was a section on prison I found interesting.

I also believe you're right, when you say, when a person receive mental health assistance though the penal system, the treatment won't be administered the same. ***My question to you is what can I do to help?? How can I be part of the solution?***

At 21 years, I forfeited my freedom. For the past 27 years, I have improved my level of consciousness to a position to help my fellow inmates. I have facilitated many self-help groups/workshops. I'm in contact with several non-profit organizations that do positive work in our communities. I have composed letters to at-risk youth covering the importance of (1) a positive sense of self; (2) The ability to control-self; (3) a positive moral belief-system; (4) also, a pro-social connectedness.

Dr. Woods, a lot more brothers than me are of a true social conscious. That want to branch out and help in any way we can with our communities. If you can find a way to utilize our talents, it would be our honor to serve.

I wanted to ask your opinion about, obtaining PTSD from the hood? I have noticed a lot of these young inmates have been through, some very sad experiences. Any information concerning this matter will be helpful.

Dr. Woods, Thank you again for the opportunity to read your draft (report). It was an honor. May God continue to bless you and the work that's being done.

Respectfully,

J. Hegler D23036
P.O. Box-4000/4 226
Vacaville, CA 95696

"What can I do to help? How can I be part of the solution?"

B3E. LACK OF MENTAL HEALTH FUNDS

The system of funding mental and behavioral health services is California directly and indirectly impact population outcomes. During the development of the CRDP Population Report, the constant inquiry was, *"Where is money going to come from to fund the recommendations put forth by the Black population?"* And, *"Should we make recommendation knowing that there will not be money to pay for the implementation?"* Answer: a resounding YES. This CRDP Population Report is a roadmap of meaningful practices that the Black population believes will help them experience better mental and behavioral health with the hope of eliminating disparities. To properly address PEI programs and activities, to provide a culturally appropriate workforce, and to eliminate disparate mental health outcomes, sufficient funds must be appropriated. In addition, PEI is frontline, proactive community level approach to good mental health.

A much larger question related to funding is getting significant funds to Blacks for the community to work with their own population. Based on the information collected during the CRDP process, there is a perception within the community that Blacks have received less than 1% of the MHSA funds to support tailored programs targeting their population. Numerous attempts have ended without discovering a comprehensive report on MHSA funding distributions that were awarded to minority-led organizations. Specifically, we could not find a report on how much MHSA funds have been awarded directly to Black led organizations to work directly with their population on culturally tailored programs. We strongly believe insufficient funding has direct consequences that are displayed in persistent disparities, and extremely poor mental health outcomes.

> *"There are no resources. Your love one has a mental deficiency. There is a great need but no resources in the community to help. You need medication. You need someone to talk to the person who has a mental illness, but there are no resources in our community to help. Then people just get worse, and worse."*
> **-FG San Bernardino County: Charyce, 54 year old Black female advocate/servant**

In 2008, The Greenlining Institute published *Funding The New Majority: Philanthropic Investment in Minority-Led Nonprofits* (Gonzalez-Rivera, Donnell, Briones, & Werblin). The report analyzed funding of national independent foundations and California based foundations and reported by ethnic distribution. According to Greenlining, only 8% of national grants awarded went to minority-led organizations of which African Americans received 2.7%. California awards were higher at 17.7% to minorities; however African Americans only received 1.5% of the awards. In California, multi-cultural nonprofits received the largest percent of grants to minority-led organizations (8.5%). The second highest awards went to Latino (4%), followed by Asian /Pacific Islanders (3.2%). Unfortunately, Native Americans received only .5% of the awards to minority-led nonprofits.

Mental and behavioral health funds have affected the following service provisions: outreach to the Black community; there **aren't any "one-stop" shops for mental health services and/or social services (validate - references)**; need access to a wider pool of services that connect mental health and social services; not enough African American providers and mental health doctors for this community; limited age appropriate services; and not enough support groups. Insufficient funding also affects the cost of mental health services for the consumer. People of lower socio-economic status are financially incapable of accessing mental health services. Medical costs as they stand are unaffordable .

Because of limited or no health insurance, many families' primary method of help-seeking for mental care needs is using primary care or emergency facilities (Grant, Kravitz-Wirtz, Aguilar-Gaxiola, et al., 2010). Sometimes mental illnesses may manifest as physical conditions such as psychosomatic illnesses, chronic pain, and fibromyalgia. These conditions could be confusing for the patients to describe and for professionals to diagnose. Mental illness in children and youth can be displayed in loss of physical control such as bed wetting, mood swings, eating disorders, ringing in the ears, or social isolation. Patients may also attempt to reify or magnify their symptoms if they believe this would help to qualify them for disability benefits.

The evidence is clear, mental healthcare is costly; see Figures 24 and Figure 25.

For over seven years the MHSA (2004) has been in force. From the perspective of the Black population, there is no evidence that **any significant funds** have gone directly to Black lead organizations to assist with mental health issues within their population. There are several Black lead organizations that provide effective direct prevention and early intervention services to the population but, do not receive MHSA funds or any county mental health funds to operate their programs and interventions. During the CRDP process many Black California residents asked the question, *"How much MHSA funds have been awarded to Black organizations?" How much of the MHSA funds have been used on specific outreach and community efforts directly targeting the Black population?"*

Obtaining statewide financial reports on how MHSA funds have been used for specific programs, interventions, and outreach to the African American population is beyond the scope of this project. Reports from the state or local department of mental health were not available. Further investigation and follow-up is needed to determine how MHSA funds have been disbursed directly to Black led community organizations for culturally tailored mental health efforts.

> *"The issue isn't funding itself but the misuse of funding absent corresponding accountability. African American clients remain underserved. Most non profits who hire African Americans as managers exclude them from any form of policy development, decision making, or program implementation. The result is African Americans continue to be used merely as statistical references for non profits to maintain or garner additional funding. To the detriment of African Americans, the focus on their needs remains only within the four corners of a proposal for funding."*
>
> **-Andrea, 48 Marriage and Family Therapist/Community Advocate**
> **San Diego County**

The new California behavioral and mental health system for funding the community needs to be directly from the State to the community. In the California re-design, a mechanism must be put in place that ensures funds go directly to ethnic community-based organizations.

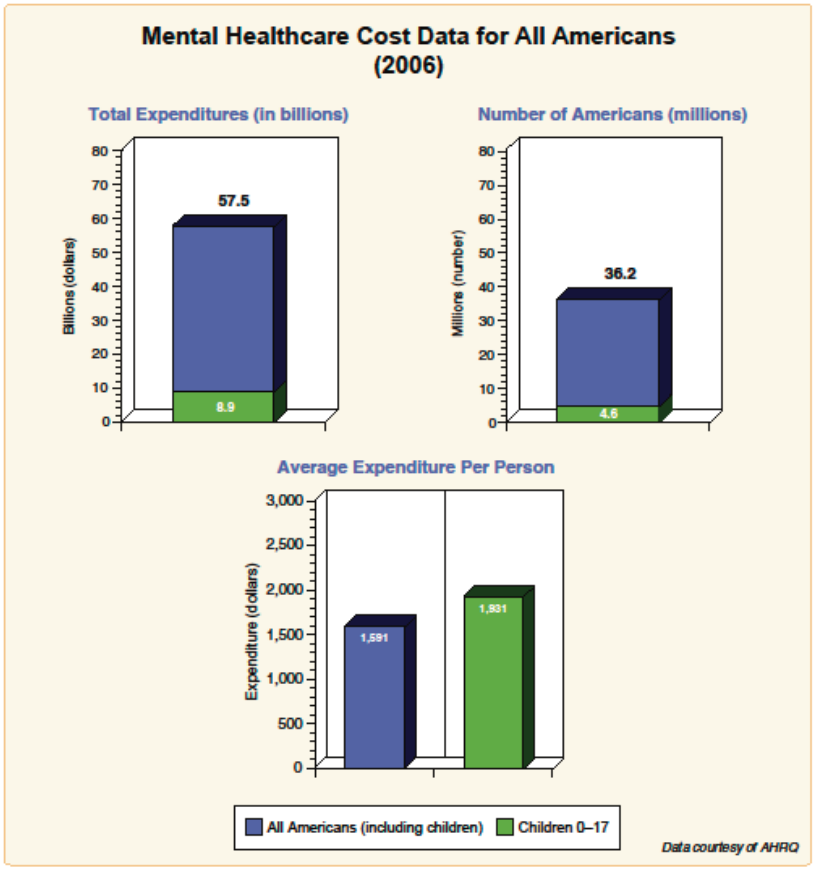


Figure 24: *U.S. Mental healthcare Cost Data*

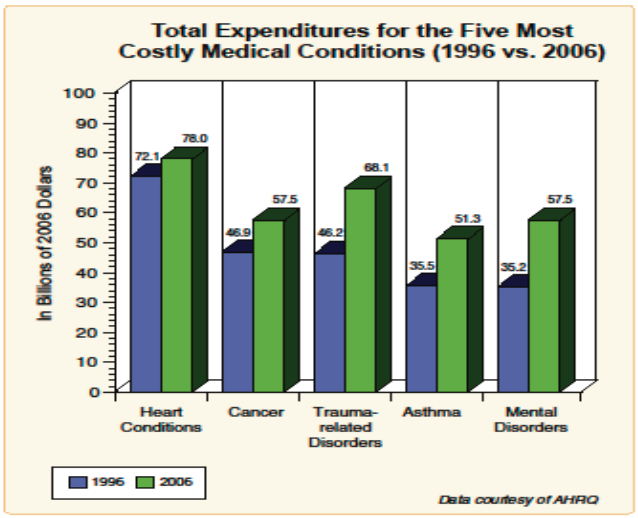


Figure 25: *U.S. Expenditures for Most Costly Medical Conditions*

B4. POPULATIONS OF SPECIAL INTEREST

B4A: AFRICAN AMERICAN OLDER ADULT MENTAL HEALTH ISSUES

"Those who respect the elderly pave their own road toward success.
African Proverb

The Older Americans Act (OAA) [Administration on Aging, 2011] was signed into law in 1965. OAA has provided the opportunity for the development of comprehensive and coordinated service systems for the elderly. In California, the Department of Aging (DOA) and its Area Agencies on Aging (AAA) have achieved tremendous accomplishments in the quality of life for older adults, adults with disabilities, and their families. The Department of Health and Human Services (2011) has established standard age categories for calculating age specific diverse population statistics. Standard adult age categories are: 25 to 34, 35 to 44, 45 to 54, 55 to 64, 65 to 74, 75 to 84 and 85 years and older. Data is usually reported based on this age grouping. Further, distinctions in age groups are also used to identify and qualify for benefits and services. Individuals 55 to 64 are considered older adults; 65 to 74 older, older adults; and 75+ are seniors, elderly, or older, older, older adults.

Population aging is a global phenomenon (Kinsella and He, 2009). According to the National Institute on Aging report, An Aging World (Kinsella and He, 2009), the world's population is aging. *"For the first time in history people age 65 and older will soon outnumber children age 5"* (page 13). In 2012, Americans 50 and older will reach 100 million, and 1 in 5 persons will expect to be 65 or older by 2035. Providing for the care of older adults creates a tremendous challenge and requires understanding of the aging process. Understanding older adults varies across people groups and within groups. One size does not fit all.

Aging is a dynamic process every human will experience. We all will individually experience aging in a different manner, starting at birth. Biological aging certainly does not correlate with chronological age (Kinsella and He, 2009). Variability among and within individuals in rates of change with age is considerable related to physiologic, pathologic, and functional characteristics. For example, consider the classification of age groups. Some now consider the adult group to be individuals age 25 to 64, and older adults to be sub-divided into the *"young old"* (65 to 74), the *"old"* (75 to 84), and the *"oldest old"* (85 and older).

In 2009, according to the Department of Health and Human Services, *A Profile of Older Americans: 2010* (DHHS, 2010), there were 39.6 million older persons 65 years and older. See Table 17for other facts about older Americans. It is projected in the California State Plan on Aging, 2009-2013 (California DHHS, 2010) that by 2020, persons age 60 and older will comprise nearly 20% of California's total population. With the increase of diverse older adults, including the extremely healthy and independent to the extremely poor, frail and very needy, specific care issues must be tailored to the population with the goal of ensuring optimal wellness and respectful quality of life.

All older adults, 65+, will have similar needs to maintain independence, physical activity, respectful living arrangements, reasonable income, and healthcare services (DHHS, 2010). One critical need for all older adults is good mental health and to be in control of personal bodily functions. Mental health of older Americans has been identified as a priority by the Health People 2020 objectives, Health People 2010 objectives, the 2005

White House Conference on Aging, and the 1999 Surgeon General's report on mental health (CDC, 2008).

Table 17: *Facts about Older Americans and Aging, United States Data*

Americans aged 45 to 64, who will reach 65 over the next two decades, increased by 26%
Americans 65 and older are 12% of the population (over one in every eight)
Americans reaching age 65 have an average life expectancy of 83.6 years
In 2009, 19.9% of persons 65+ were minorities:
• 8.3% African Americans
• 7.0% Hispanic origin (any race)
• 3.4% Asian or Pacific Islander
• 1.0% American Indian or Native Alaskan
• 0.6% Two or more races

Source: *A Profile of Older Americans: 2010,* DHHS, 2010

What are mental health issues for African American older adults living in California?

Fear

"And, one thing we have to realize also that a lot of people especially African Americans, they have a fear, inner fear, a hidden fear I should say of even admitting that there might be something wrong."

-FG: Betiye, 68 year old Black female mental health advocate, Contra Costa County

Trauma

"In the case of mental health, my experience was that once when I was ah going through a traumatic situation ... with people.... And stuff like that, and then stuff started happening to me and I was reacting abnormally, but I didn't know at that time that I was abnormal till after I came out of it and then I started getting some help."

-FG: Arthur, 70 year old Black man mental health advocate, Richman

Stigma

"We don't like people into our business. I don't want my sister to come over and say I'm crazy, and why do I need mental health."

-FG: Norma, 59 year old female African American, The Children of Promise, Sacramento

Misdiagnoses

"I was hearing voices you know. I had been through a lot of deaths at that time in my life and you know it was like they were coming to me talking to me... I done went to my doctor and started telling my doctor and he telling me, are you sure. And, I'm telling him yes I'm sure. And, I'm constantly telling you this... I'm trying to explain to him what's going on in my life, what's going on with me and I need it to stop or whatever, ... I was diagnosed with ah schizophrenic. That's what they told me.... To actually look up the word and see what it actually mean and just because I had these dreams, it, it happened for a while, I don't classify myself as schizophrenic."

-FG: Jacquelyn, 81 year old Black female, San Diego

No Appropriate Access

"…. get on the right medication, the right help. You know you can go to like a, ah mental health department and, and state you have a problem and they wanna pass the buck and give you the shuffle and that frustrates you like ah ain't nothing wrong with me. Then, and then I tell them this, and they say no, that's not it. And, they just give you the runaround but they don't wanna believe what you saying about how you feeling inside, or what you're going through. And they send you, like you stuck at downtown mental health. You go there and they wanna send you way to, to um east LA somewhere you don't know how to get there. Don't know the streets, don't know the streets, or nothing and you get lost and frustrated so you just push it to the side, and keep going and it gets worse."

-FG: Brigitte, 50 year old female, African and French descendents, advocate for visually impaired/counselor/legally blind, Oxnard

Not Being Understood

"There is a difference between African Americans and Whites. If I am mentally ill, I want the resources and somebody around to help; somebody who understands about what is going on. I don't want it to be like, sometimes, Blacks get arrested and police do not understand that it is a mental problem. You need people with training and understanding, professional people who are trained to know what to do and can recognize mental illness."

-FG: Marlene, 72 year old African American female, The Children of Promise, Sacramento

Loneliness and Isolation

"People are just lonely. People don't understand when all your folk are gone. You don't have anyone to turn for help. I try to help my daughter, but see doesn't understand. I'm just lonely and don't have anyone to help."

-FG: Gloria, 81 year African American mother of a 60 year old bipolar daughter, member of Black LA County Client Coalition (BLACCC), Compton

B4B. TRANSITION AGE YOUTH (TAY)

The Alameda County Behavioral Health Care Services *African American Utilization Study* (2011) provides valuable insight into county level mental health issues across the life span. Findings were identified based on four specifically defined age groups, birth to 16, TAY 16 to 29, adults 29 to 59, and older adults 59+. The entire report can be downloaded from the Alameda County website at www.acbhcs.org.

Overview of the mental health issues in Alameda County (African American Utilization Study, 2011, pages 16-27):

- 33.1% African American adults 18 to 39 need professional health for mental health issues
- 41% children entering the child welfare system are African American
- Alameda County data suggest African American children and youth may be inappropriately diagnosed with serious emotional disturbances (SED), and serious mental illness (SMI)
- TAY – a story is presented about a typical young African American male living in Alameda County. John's Path represents how the system has not appropriately or effectively served young adult African American males.

John's problems started at an early age resulting in severe drug addiction, violent behaviors, and social isolation, discrimination, and repeated arrests. Throughout his early years until age 18, John was shifted from group home to group home and placed on heavy doses of various antipsychotic medications, producing negative consequences in his young adult life at age 20.

- African American adult consumers in Alameda County live in poverty, many experience traumatic situations, and impaired psychological well-being contribute to depression, PTSD, perceived aggressions, anti-social behavior, and social withdrawal
- Older African American adults: The story is told of Christine. As a biracial African American experienced isolation and discrimination resulting in drug abuse, prostitution, and mental illness starting a vicious downward cycle at age 15. Christine's struggles continued until her early 50's when she began a mental health day program and encountered a spiritual experience.

"Not everyone is able to afford health insurance. You be seeing like more and more people is not just dying from gunshot wounds and stuff like that. People also dying from mental health issues and stuff like that, that's a health problem.... Cause they don't have that insurance to help them out, to provide the uh medicine that they need."
-TAY FG Alameda County: Erica, 20 year old Afro-Latina female

"Alameda County has their own, like um.... outreach programs and stuff... You know, and therapy for people you know ... they want you know, someone that being a victim of something, you know uh... domestic violence ... They don't just have regular mental health programs."
-TAY FG Alameda County: Marcus, 23 year old African American male

"... for my cousin for instance, like he has a mental problem ... And, nobody's trying to help him, like he, let him run wild, so you see.... He just seems like he's, well people will tell us, 'you turn 18, you're grown' and I have to tell him you're not...you're, I don't want to tell him like you're not normal but you're, you're 18 and still people gonna have to care for you and stuff like that; trying to break it down to him.... So I try to help but it's only so much you can do with a person who has mental issue and you know, some of them listen and some of them don't .... Yeah, he knows because of the other family members that say stuff but they say it so rudely, to him, they don't say it like, oh like you have a problem. They just call him retarded.... I think that's wrong. I think that's very wrong for people... I think some services help and some do not.... you can't just get one opinion, to get several opinions because it can be different... They can be bipolar, and then they can have like schizophrenia and all that other stuff like that... like doctors just say anything, just to just say, they can just be like...oh...you okay then two days later, oh we found this and stuff like that...makes people like oh...makes them go crazy, makes them really think that they're sick and there's nothing wrong with them...."
-TAY FG Alameda County: Deliesha, 22 year old African American female

"Yeah, because they had me on Haldol when I was 19... And that's supposed to be a last resort when nothing else is working and they worked, went through me so fast that I had a drug induced like episode where I was hallucinating and I al...when they put me on Haldol um I did some really crazy stuff and my mom called the police on me... And they arrested me and um took me to the hospital but when I was in the um, the police car, my jaw locked because I had been switched around so much, and like I'm still weird. The police didn't do anything. They didn't care.... Yeah, I don't understand why

they would put me on it. And... they diagnosed me as one thing and then changed my diagnosis and when they changed my doctor. He changed my diagnosis, so I felt like they really didn't know what they were doing. Like they really were guessing, and it's hard for me to have trust in my providers now because I feel like they did all this stuff with me since I was 19 and I'm 34 now, and um, I still have to deal with the same facility and I don't really have that much trust for them... And, I feel like they don't really know what my diagnosis is. It's like they're just guessing."

-FG Bonita House Alameda County: Naeema, 34 year old African American female; diagnosed: schizoid effective

As a result of the Alameda County African American Utilization Study (2011), local resident needs were prioritized according to age groups (page 10):

AGE GROUP	IDENTIFIED NEEDS
Children & Youth (Birth to 16):	Accurate and unbiased mental health diagnosis Address ad-hoc and piecemeal services for complex mental health issues
TAY (ages 16 to 29):	Address social isolation & marginalization of TAY at risk for serious mental health issues due to social determinants
Adults (ages 29 to 59):	Culturally responsive, strength-based, and coordinated services to empower adults to recover from serious mental illness and substance abuse
Older Adults (ages 59+):	Accurate diagnosis of mental health issues Link primary care and mental health support

As in Alameda County, African American TAY experiences the same mental health issues throughout the State of California.

"Um, I think part of it too is ... actual recognition that there is a problem... We don't talk ...about family too...like um my dad's brother suffers from mental illness. But, he was just like my weird Uncle Rick because no one ever explained to me anything about him and why he was the way he was. Or, why he had a sort of like childish type of mentality even though he was an adult....When I was little, it was cool 'cause I had somebody older to play with me. But, I mean as you get older you kind of like, you don't understand what's going on. And, having this sort of like shame and a guilt that's around it... I think... that my parents sort of were ashamed of him... So instead of talking about it openly and really trying to get help for him, it was just sort of like, well we'll just kind of like hide him in the back and let him do his own thing...And, not really address the issues that he's dealing with instead of really getting him help. It was more like sort of like push under the rug type thing."

-FG College Student: Brittnee, 22 year old Black female; diagnosed: childhood depression, Riverside

"I wouldn't personally go to a doctor to ah help my mental issues because they don't know me. And, I would have to go through the motions of explaining everything to them and my life to them, when I can just go to someone that already knows me and they would be able to help me a little better than someone who doesn't know me."

-FG College Student: Aaron, 24 year old Black male, Riverside

"Like I've been to people who were straight and White and they look at me different than someone who is Black or gay. And, they don't really, they don't really understand like what I'm going through. They just listen, and like I need someone who really

understands. They've been through it, or they've been through something like it. So like they, when I say it, they know what I'm talking about; not someone just looking."

-FG LGBTQI: Ernest, 17 year old gay student, Sacramento

"Um, well my sister has dealt with mental illness for the last 10 years I think, and so I pretty much my whole life... I was trying to differentiate between um like stigma labels and medical labels because the wrong medical labels even can lead to the wrong drugs. .. So I feel like sometimes the medical terms are not accurate and sometimes they are just as bad as you saying you're crazy or, whatever because sometimes the doctors are still coming up with new labels..."

-FG Chico: Aminesha, 25 year old Black female, client family member

"I don't, I don't know what to say but I do think that it's hard. The stigma coming from Black people is the hardest thing to deal with, the lists, the labels, what people think. People are saying that you are that ... you have to deal with that, but then also being labeled ... for the services that you're getting, that's even more worse."

-FG Chico: Jamilah, 27 year old Black female client; diagnosed: bipolar

"You know what happened to you, happened to me when I was 14 and ah I was doing something...so I was taken in... and they were testing me for all these drugs. At the time when I was 13, or 14 I wasn't messing with anything...I felt like for the fact that you know that wasn't the solution... drug. He was confused on how to treat me, so he just gave me all these things that I didn't like. It didn't work and that ended up pushing me to drinking. By the time I was 15, um between the ages like 15 and 18, you know... doctors could treat me so... it ended up pushing me in self medication and drinking. So I, I think that's interesting you know how they wanted to paint me as somebody who was doing all this stuff and wasn't and it pushes me. They can't treat me. They don't wanna treat me. They don't know how to treat me. So, I might as well drink."

-FG Chico, Jessica, 20 year old Black female; recovering mental illness/ advocate

"I feel speaking from experience that um, I slightly got mental health problems from everything else that I've been through and it lead into drugs, marijuana, and ecstasy pill, whatever. You know what I mean, and it was an escape route for me speaking from experience. And me feeling like as a person, another individual and going to a White lady or a Hispanic lady trying to tell her my business and they put me on paper like I'm crazy. You know, so a lot of the time, it mental health problem do lot of the time drug addiction come from mental health. Majority 99% of the time, you ask me I think that's where drug addictions come from, mental health problems. But instead us being Black African Americans like you said, we so strong we go our own route, make our own decision instead of breaking down and really getting help that we need. And then at the same time, when it comes to the mental health workers, you have to have good mental health workers you can't just have a mental health worker in here to get her paycheck by the end of two weeks. You got to have a good mental health worker that knows what she's doing. That's gone really, really help this person, and know how to talk to this person and know how to guide this person. 'Cause a lot of times when you got a mental health person, you got to be I mean a lot of times you got a mental health problem you have to talk to somebody that's really got experience in dealing with mental health people. .. The first thing ...they gonna ...tell you, you got this depression and here go these pills, try this. I'm gonna prescribe you this and majority of the time that's what they do."

-FG Bakersfield: Brannish, 20 year old Black female, client, National Brotherhood Association

B4C. THE DEAF, HARD OF HEARING, LEGALLY BLIND

Testimony from a mother of a deaf son:

"Thank you for allowing me to comment on the gaps in mental health care for the deaf. I was forced to relocate my son to Washington D. C. in order to get relevant mental health care. While here in California crisis treatment was rendered by writing notes, and I had to interpret, which violated his confidentiality. I am happy to report that he is now doing well and not using drugs but refuse to return to California because of the experiences. Some of the things that California should look at in changing how mental health services are provided are:

- Making sure that the **provider is proficient** in American Sign Language (ASL), not just calling someone in for the appointment.
- Make sure that the persons have been trained in ASL and not just finger spelling. There can be no quality treatment if there is no communication.
- Have therapist that are familiar with deaf culture and respectful of the culture.
- Increase the number of African Americans that provide services to reflect safe space. The barriers to care are the same in the deaf community as in general society, and the "isms" are the same.
- Provide support groups for deaf clients as are available to hearing clients.

  Not just throw them in with everyone else as some of their needs will be different. How is the group supportive if they cannot interact with those participating in the group?
- Do not assume that the African American family support is not there. (I was told many times that "we didn't know you signed, most families don't") If the family does not sign (ASL) there are definitely "home signs" and the support should be utilized.
- **Most importantly, deaf African Americans and their families should be included when developing policy that will determine their success in treatment.**
- Communicate clearly prior to giving out medications that are not needed, **STOP THE BOILER PLATE TREATMENT WITH OUT EVALUATION!!** Take the time to "hear" what they are saying.

These are but a few of the many issues that are faced by the African American deaf community here in California. This is really sad as we have a school for the deaf in the Inland Empire/Riverside California. I hope that some of these issues will be considered in your discussions. Again my thanks for allowing me to share and this wonderful work you are doing for us."
Peace & Blessings,
Nosente A. Uhuti
Moreno Valley, California

"Everything I do is a challenge. I suffer with pain all the time. It's prolonged suffering. I have limited vision and hearing. I am an individual who has suffered trauma for years. I was hit when I was three years old. My mom and dad were fighting. Mental health decision-makers are not willing to take on my problems and do something about this pain. That gives me more pain. ***It makes me think they really do not care.*** *I believe God designed me for a purpose. I am human. I want to be a part of greatness."*

-In-Depth Interview: Sharon Lyle, 51 year old African American female, legally blind and hard of hearing; mental health client; Los Angeles County

"Deaf and hard of hearing do not have priority among law-makers. The State of California programs are woefully in adequate and inaccurate. We live in two worlds and we do not fit."

One-on-one Interview: Ralph and Judy Singleton, White married couple, both deaf, NAMI Client Family Members, Sacramento

"People, who can hear, do not 'give-a-damn.' The State of California has no expertise to work with deaf people. My son is deaf. The system labeled him as mentally ill, and called it bipolar and schizophrenia, then placed him in a mentally ill facility for one year without a diagnosis. First, they locked him up in jail. We could not see him for three months. And, for three months he did not have an evaluation. There was very poor communication with us as his parents. The system has failed us. The equipment is outdated. There are no facilities in California for young adults. There are no good medications. No good communication. Assessment does not use appropriate tools. I am very angry."

One-on-one Interview: Ralph Singleton, White male, Deaf NAMI Client Family Members, Sacramento

"Um what matters most to me as a Black person, okay when I go to these institutions for help ... I'm starting to know something about these people I'm in the group with you know I pass them on the street, a lot of them I don't even recognize now and ***I don't see*** *and I'm learning that they got a lot inside to say. You know, and when I go for help and I go to them, it's like, ah Brigitte I know you. 'Come on in have a seat. What, what's going on with you? ... Instead of treating me as a number or case file. Oh, you just a file, okay, well next. You know what I mean. That's what matters the most,* ***treat me as a person."***

-FG Oxnard Women's Support Group: Brigitte, 50 year old Black-French female, Advocate for visually impaired/Counselor/Legally Blind, Ventura

B5. SUMMARY OF PROBLEM STATEMENT

California specific data about mental health issues and service delivery is severely lacking. Data that is available is distorted and prevents efforts to properly identify disparate outcomes for African Americans. The California data that is available indicate that one third of all Blacks seen in the mental health system have dual or triple diagnoses (data reports do not specify the combination of these diagnoses). The highest reported psychiatric diagnostic group for African Americans is depressive disorders.

According to the limited data on the type of serves received, 26.5% of Blacks receive 5 to 15 days of services. These services could be crises stabilization, day treatment, day rehabilitation, or vocational. For PEI, it may appear from the data that target strategies should address factors that predispose to, or create a risk for depressive disorders.

A retrospective review of information about mental health problems in Blacks indicate that structural and systems problems, such as a through and accurate mental health assessment of individual problems, a sever lack of ethnically matched workforce, the criminal justice system first respondent interaction, and inadequate diagnoses with corresponding treatment that includes high doses of psychotropic medications are major issues.

Irrespective of the age group, the perception of Blacks is that providers **are not listening** to their expressions of mental health problems. Not listening is internalized as a "lack of interest." The impression of the majority of Blacks related to mental health problems is that their people are given medications and then pushed to the side, or forcefully detained in the criminal justice system. The overwhelming perception of the population is that they are "used and abused" and not properly treated for the right mental health problems.

> *"The county people are always asking Black folk to give them information, and they always use the Black statistics to get money for projects, programs and other initiatives. When the report is done and the money comes to help with the 'proposed' projects, it never makes it to the Black community. The county gets money, but it has not made any difference in the health of our people. We are always being used for somebody else to get the benefits."*
>
> **-Reverend Dr. Pastor Raymond Turner, Inland Empire Concerned African American Churches (IECAAC)**

Disparity outcome reports are pervasive. Poor health and mental health outcomes are not a new issue for African Americans. In fact, W.E.B. Du Bois (1899, 1906) documented disparate overall health outcomes for Black Americans over 100 years ago. In 1906, he reported in *The Health and Physique of the Negro American* that Negroes exceed the White death rate across several health outcomes including still births, heart disease, pneumonia, and diseases of the nervous system, to name a few. Since this original research by Du Bois, others have documented the same including the landmark *Report of the Secretary's Task Force on Black and Minority Health* from the U. S. Department of Health and Human Services (Heckler, 1985).

In sum, complex problems are associated with mental illness in African Americans, such as:

- Being ignored
- Dehumanizing societal encounters
- Mischaracterization
- Oppression
- Intergenerational traumatic experiences
- Ongoing micro-aggressions
- Perpetual societal imposed negative marginalization
- Ongoing abuse and stress
- Overt and covert racism
- Benign neglect
- Personal unresolved identity issues
- Lack of accurate mental health assessment
- Over prescribed medications
- Lack of follow-up
- Timely access to meaningful interventions
- Misdiagnosis and incorrect treatment
- Lack of understanding mental problems, signs and symptoms
- Missed opportunities for early detection and intervention
- Severe lack of "good mental health" promotion based on cultural beliefs
- NO cultural programs to support "good mental health"
- •Lack of community resources to address mental health issues
- Lack of properly trained community individuals
- Lack of properly trained professionals available to help with mental issues
- Invisible mental health outreach in the community
- Fear
- Isolation
- Shame
- Do not have a safe caring place to go for help
- Lack of respect
- Lack of caring for the mental health of the population

As recommended in the Institute of Medicine [IOM] (Smedley et al., 2003) report and other reports from DHHS (2004), in the face of overwhelming evidence of the existence of complex contributing factors for persistent disparities between Blacks and other groups, the most effective way to eliminate them is to engage the Black population in the process of identifying the problems and recommending the solutions based on their experiences.

A sensitive, but humbling task has been to clearly articulate the expressed relevant problems of the population **from their perspective**. Participants repeated over and over that they have shared problems and concerns before, but there is no evidence that decision-makers understand. There is no evidence that what has been expressed resulted in meaningful interventions. With this CRDP Population Report hope has been ignited. The challenge is to ensure the trust of the people that this time their voices will be heard and acted upon.

“WE ALL HURT.”



C

nityrespecthopecompassiondignityfamilycouragepeacetogethernessculturefaithloveu

SECTION C

MENTAL & BEHAVIORAL HEALTH SERVICE DELIVERY TO BLACK PEOPLE IN CALIFORNIA

C1. CALIFORNIA MENTAL HEALTH SERVICE ACT (MHSA)

C2. COUNTY CULTURAL COMPETENCE PLANS

C3. APPROVED COUNTY MHSA PEI PLANS



C. MENTAL & BEHAVIORAL HEALTH SERVICE DELIVERY TO BLACK PEOPLE IN CALIFORNIA

C1. CALIFORNIA MENTAL HEALTH SERVICE ACT (MHSA)

The California MHSA of 2004 was designed to transform the public mental health system into one that focuses on consumer wellness, recovery, and resilience. The intent of the MHSA was the creation of a broad spectrum of prevention, early intervention and other programs, as well as infrastructure support, to engage underserved populations and promote the recovery of individuals with mental illness (MHSOAC, 2011). According to the MHSA Oversight and Accountability Commission (MHSOAC), "by implementing the principles and values of the MHSA, enhancing funding for effective treatment for people with serious mental illness, and initiating new prevention, early intervention and innovative services, California is moving its public mental health system to a *'help first'* system with a commitment to service, support and assistance when needed" *(MHSOAC, June 2011 online website)*.

The five core components of the MHSA (2011) are:

- **Community Services and Supports (CSS):** provides funds for direct services to individuals with severe mental illness.
- **Capital Facilities and Technological Needs (CFTN):** provides funding for building projects and increasing technological capacity to improve mental illness service delivery.
- **Workforce, Education and Training (WET):** provides funding to improve the capacity of the mental health workforce.
- **Prevention and Early Intervention (PEI):** provides historic investment of 20% of the MHSA funding for outreach programs for families, providers, and others to recognize early signs of mental illness and improve early access to services and programs to reduce stigma and discrimination.
- **Innovation (INN):** funds and evaluates new approaches that increase access to the unserved and underserved communities, promote interagency collaboration and increase the quality of services.

California MHSA funds are dedicated to directly addressing risk factors through outreach programs for families and communities to recognize early signs of mental illness, deteriorating emotional and physical health, and to improve early access to services, increase prevention activities, and to reduce stigma and discrimination.

C2: COUNTY CULTURAL COMPETENCE PLANS

The California DMH under the Office of Multicultural Services (OMS) promotes culturally and linguistically competent mental health services within the public mental health system. Operations are implemented at multiple levels with a special emphasis on community partners to eliminate racial, ethnic, cultural, and language disparities in access and quality of care within mental health programs and services.

To facilitate cultural competence at the county level, each County DMH is mandated to develop a Cultural Competence Plan. The Office of Multicultural Services provides technical assistance to counties in the development of their plan. The goal of a Cultural Competence Plan is to ensure that staff receives ongoing cultural competency education and training in culturally and linguistically appropriate service delivery. For the discussion of this section, by definition, cultural competence is a set of congruent practice skill knowledge, behaviors, attitudes, and policies that come together in a system, agency, or among consumer providers, family members and professionals that enables that system, agency, or those professionals and consumers, and family member providers to work effectively in cross-cultural situation.

A major commitment by the California DMH was the implementation of statewide cultural competency training during 2010 and 2011 called the California Brief Multicultural Competence Scale (CBMCS) Multicultural Training Program. The master trainers were Dr. Gloria Morrow and Dr. Robbin Huff-Musgrove. Both Dr. Morrow and Dr. Huff-Musgrove are members of the CRDP African American Strategic Planning Workgroup. The intent of the CBMCS Multicultural Training Program is to provide mental health workforce with skills and knowledge through interactive training sessions, handouts and visual materials. The CBMCS Multicultural Training Program is designed to be applicable across mental health settings and providers with different professional backgrounds and affiliations.

C3. APPROVED COUNTY MHSA PEI PLANS

The MHSOAC Prevention and Early Intervention Trends Report 2009 (Dec 30, 2009), by Dr. Deborah Lee, Psychologist, Oversight and Accountability Commission, reported on the analysis of 32 counties' 223 approved programs in their approved PEI plans. The intent of the Trends Report was to address: (1) intended focus areas; (2) ages intended to be served and programs directed toward specific racial/ethnic communities; and (3) key program features. In the initial county planning stages, the following were reported as planned targeted interventions for the African American population for their PEI Plans:

African American Population

- Berkeley PEI Community Education Supports
- Butte African American Cultural Center (listed as a priority intervention in PEI plan)
- Contra Costa Building Community in Underserved Cultural Communities
- Fresno Integration of Primary Care and Mental Health
- Fresno Cultural-Based Access Navigation Specialists
- Fresno Peri-natal PEI

- Fresno School-Based PEI
- Fresno Horticultural Therapeutic Community Center
- Fresno Team Decision-making
- Fresno Functional Family Therapy
- Kern Integrated Physical and Behavioral Healthcare
- Madera Community and Family Education
- Marin Student Assistance Program
- Merced Public Awareness and Education
- Monterey African American Community Partnership/Village Project and Screening Services (listed in final PEI Plan)
- Riverside Mental Health Outreach, Awareness, and Stigma Reduction
- Riverside Effective Black Parenting (listed in final PEI plan)
- Riverside Africentric Youth and Family Rites of Passage Program (listed in final PEI plan)
- San Diego Elder Multi-cultural Access and Support Services
- Stanislaus Community Capacity Building
- Stanislaus Health/Behavioral Health Integration
- Ventura Community Coalitions (listed in PEI plan)

SPW members contacted the above counties to identify progress toward PEI activities tailored to the African American population. In addition, we reviewed all 58 approved PEI plans to identify language indicating specific outreach efforts to African Americans. Some counties recorded intentions to have multicultural programs and interventions, but they were not specifically tailored to one population. Based on the approved MHSA PEI plans, a number of counties prioritized programs focusing explicitly on racial and ethnic groups: Latinos, African Americans, Asian/Pacific Islanders, and Native Americans; and others. Careful review of the County PEI plans revealed that only two counties have identified African Americans as a priority population **with** carefully designed tailored programs – Butte County and San Bernardino County. Two counties, Monterey and Riverside funded tailored programs and projects for Blacks. Riverside County did not list African Americans as a **priority population but funded three carefully designed tailored programs** in three different county locations. Two counties (Los Angeles and Alameda) funded **studies with the Black population**, the *African and African American Mapping Project* in Los Angeles County, and the *Alameda County African American Utilization Study.*

All approved MHSA PEI plans are posted on the Oversight and Accountability Commission (OAC) website at **http://mhsoac.ca.gov/PEI/Prevention-and-Early-Intervention.aspx**.

Those counties and specific designed PEI tailored African American programs are:

Butte County:

- African American Family Cultural Center

San Bernardino County:

- Resiliency Promotion in African American Children
- African American Family Resource Center

Riverside County:

- Effective Black Parenting Programs
- Africentric Family and Youth Rites of Passage Program
- Cognitive-behavioral Interventions

Monterey County:

- The Village Project

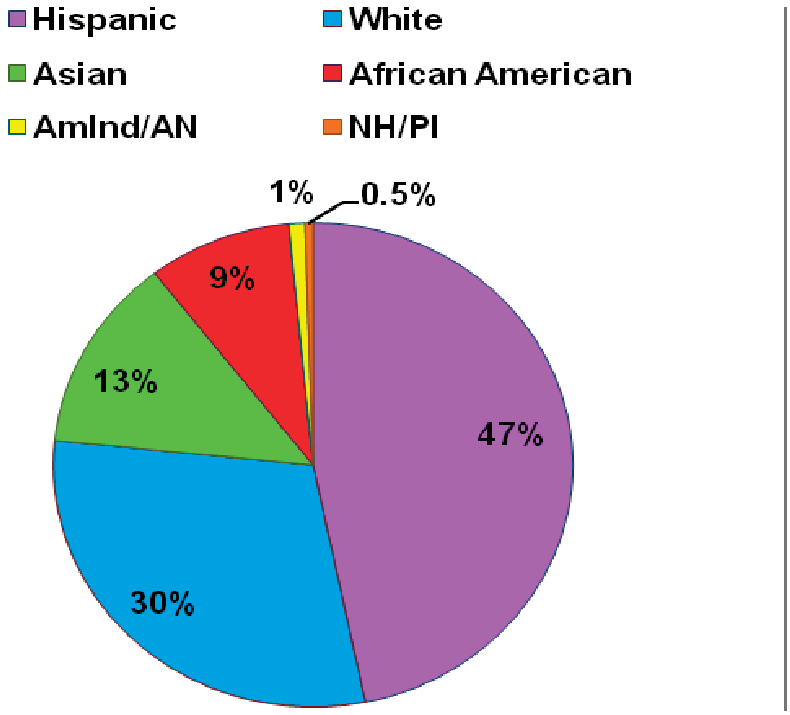
NOTE: Information in this section was taken directly from the approved MHSA PEI plans as posted on the OAC web site. If the information was in the approved plan it was included in this section of the report.

Of the **six counties** (Los Angeles, Alameda, San Bernardino, San Diego, Sacramento, and Riverside), with the highest population of African Americans in the **State of California**, at the time of this report, only two (San Bernardino and Riverside) were proactive to design and fund tailored African American PEI programs under the MHSA as listed in the county approved MHSA Plans. To be clear, *tailored African American programs are designed specifically for the population utilizing principles and concepts tested in scientific research and presented in peer-reviewed literature.* Please see *Table 47* for research studies on tailored African American mental health prevention and early intervention programs; also see the compendium created by this CRDP of African American Mental Health Scholars and their Scholarly work.

According to the CSI data, (see *Table 19*) during fiscal year 2007-2008 compared to the state's overall population, less than 1% of African Americans used the DMH services. In 2009, African Americans were 5.8% (2,159,978) of California's total population. It is unconscionable to think that a population with so many high-risk factors for mental illness, premature deaths from co-morbid conditions, high inter-generational poverty and unresolved trauma, do not use mental health services. It was critical therefore during this CRDP to obtain from the population their perception of low access to mental health services while existing in a crisis level mode.

Figures 26-31 are graphic displays of California's population distribution by ethnicity and county related to number of clients in the DMH system and the actual number of mental health professionals in the county, in each of the six counties where 73% of the statewide African American population lives. Even with the current usage pattern of African Americans, in each of these counties there is a critical shortage in the mental health workforce to address the current needs. Data in *Figures 26-31* and *Table 19* have been updated with CSI data reported as of March 17, 2011.

Los Angeles County



Source: California MHSA Approved PEI Plan as posted on the OAC website, 2011

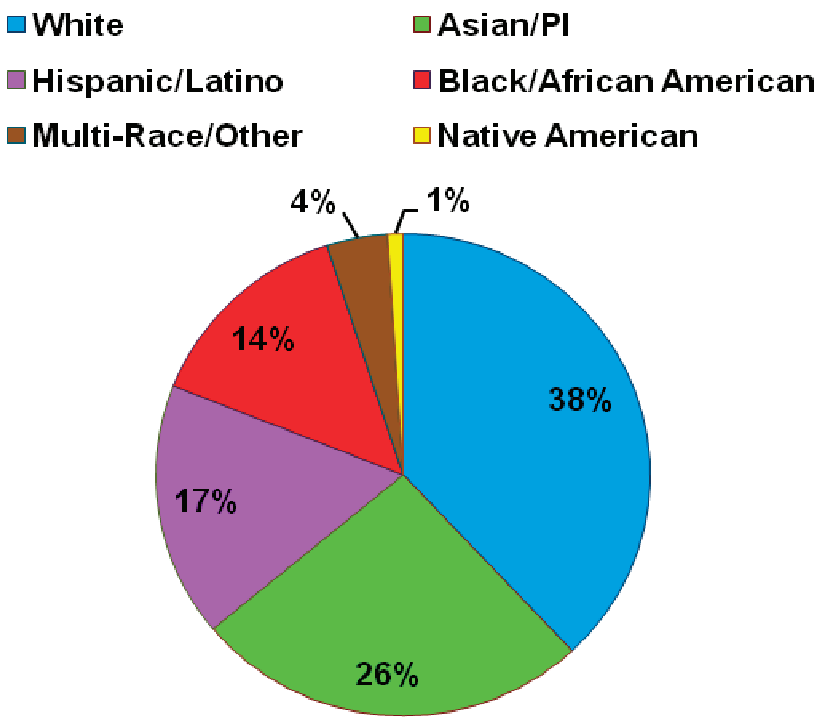
Figure 26: *California Population Distribution by Ethnicity, Los Angeles County as Reported in the MHSA Approved PEI Plan*

NOTE: A profile of African American clients served and the number of properly trained California mental health workforce.

LA COUNTY AFRICAN AMERICAN POPULATION, 2009[1]	DMH AFRICAN AMERICANS SERVED 2007-2008[2]	COUNTYWIDE TRAINED MENTAL HEALTH PROFESSIONAL WORKFORCE, ALL ETHNCITIES[3]	
817,273	**51,308**	Psychiatrist	1,852
		Psychiatric MH Nurse Practitioner	100
		Licensed Clinical Psychologist	4,038
		Licensed Clinical Social Worker	3,907
		Marriage & Family Therapist	5,844
		Associate Clinical Social Worker	2,419
		Marriage & Family Therapist Intern	3,162

Source: 1. U.S. Census Bureau, 2009 American Community Survey (no significant change from 2008 population)
2. California Department of Mental Health (DMH) CSI, total unduplicated clients served in 2007-2008, as of March 17, 2011
3. California Board of Behavioral Sciences, Demographic Report, 2007

Alameda County



Source: California MHSA Approved PEI Plan as posted on the OAC website, 2011

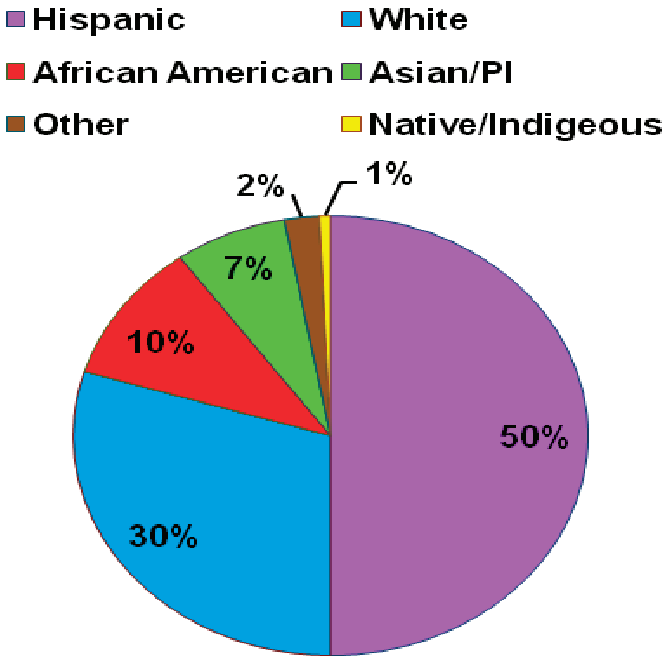
Figure 27: *California Population Distribution by Ethnicity, Alameda County as Reported in the MHSA Approved PEI Plan*

NOTE: A profile of African American clients served and the number of properly trained California mental health workforce.

ALAMEDA COUNTY AFRICAN AMERICAN POPULATION, 2009[1]	DMH AFRICAN AMERICANS SERVED 2007-2008[2]	COUNTYWIDE TRAINED MENTAL HEALTH ROFESSIONAL WORKFORCE, ALL ETHNICITIES[3]	
183,778	**11,890**	Psychiatrist	314
		Psychiatric MH Nurse Practitioner	13
		Licensed Clinical Psychologist	1,128
		Licensed Clinical Social Worker	1,013
		Marriage & Family Therapist	1,428
		Associate Clinical Social Worker	493
		Marriage & Family Therapist Intern	658

Source: 1. U.S. Census Bureau, 2009 American Community Survey (no significant change from 2008 population)
2. California Department of Mental Health (DMH) CSI, total unduplicated clients served in 2007-2008, as of March 17, 2011
3. California Board of Behavioral Sciences, Demographic Report, 2007

San Bernardino County



Source: California MHSA Approved PEI Plan as posted on the OAC website, 2011

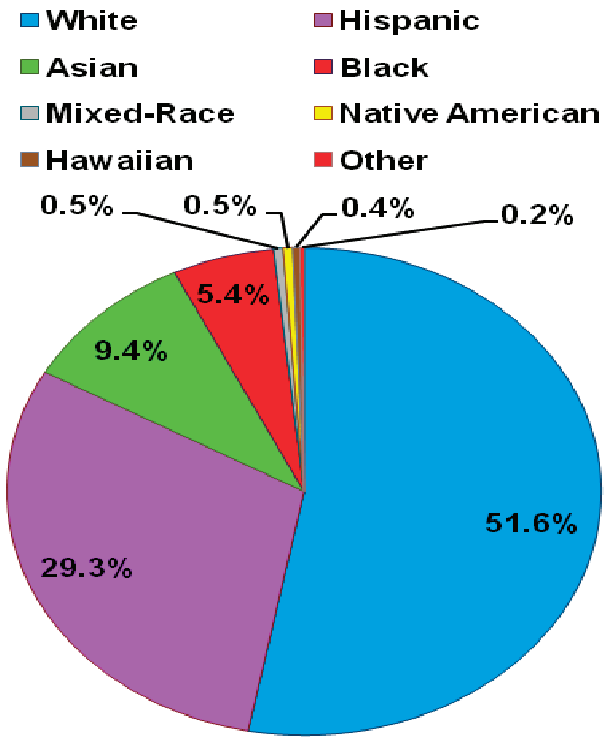
Figure 28: *California Population Distribution by Ethnicity, San Bernardino County as Reported in the MHSA Approved PEI Plan*

NOTE: A profile of African American clients served and the number of properly trained California mental health workforce.

SAN BERNARDINO COUNTY AFRICAN AMERICAN POPULATION, 2009[1]	DMH AFRICAN AMERICANS SERVED 2007-2008[2]	COUNTYWIDE TRAINED MENTAL HEALTH PROFESSIONAL WORKFORCE, ALL ETHNITICIES[3]	
166,671	**5,916**	Psychiatrist	202
		Psychiatric MH Nurse Practitioner	10
		Licensed Clinical Psychologist	319
		Licensed Clinical Social Worker	452
		Marriage & Family Therapist	562
		Associate Clinical Social Worker	372
		Marriage & Family Therapist Intern	409

Source: 1. U.S. Census Bureau, 2009 American Community Survey (no significant change from 2008 population)
2. California Department of Mental Health (DMH) CSI, total unduplicated clients served in 2007-2008, as of March 17, 2011
3. California Board of Behavioral Sciences, Demographic Report, 2007

San DIEGO County



Source: California MHSA Approved PEI Plan as posted on the OAC website, 2011

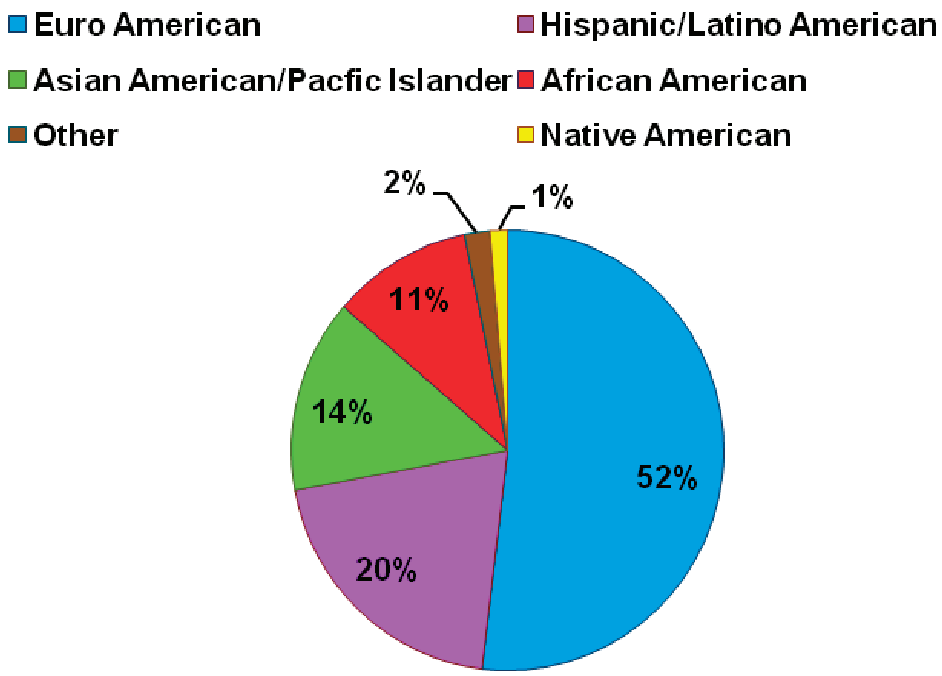
Figure 29: *California Population Distribution by Ethnicity, San Diego County as Reported in the MHSA Approved PEI Plan*

NOTE: A profile of African American clients served and the number of properly trained California mental health workforce.

SAN DIEGO COUNTY AFRICAN AMERICAN POPULATION, 2009[1]	DMH AFRICAN AMERICANS SERVED 2007-2008[2]	COUNTYWIDE TRAINED MENTAL HEALTH PROFESSIONAL WORKFORCE, ALL ETHNICITIES[3]	
148,147	**5,653**	Psychiatrist	629
		Psychiatric MH Nurse Practitioner	39
		Licensed Clinical Psychologist	1,558
		Licensed Clinical Social Worker	1,327
		Marriage & Family Therapist	1,599
		Associate Clinical Social Worker	553
		Marriage & Family Therapist Intern	893

Source: 1. U.S. Census Bureau, 2009 American Community Survey (no significant change from 2008 population)
2. California Department of Mental Health (DMH) CSI, total unduplicated clients served in 2007-2008, as of March 17, 2011
3. California Board of Behavioral Sciences, Demographic Report, 2007

Sacramento County



Source: California MHSA Approved PEI Plan as posted on the OAC website, 2011

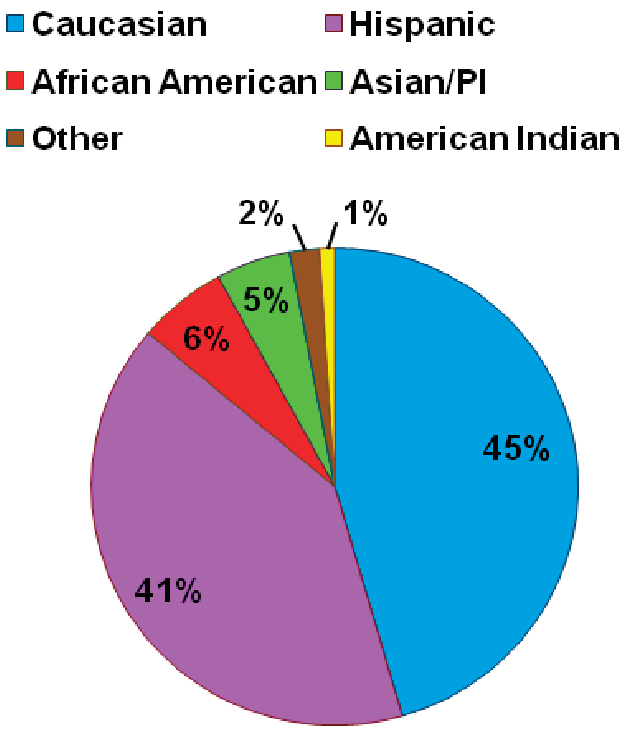
Figure 30: *California Population Distribution by Ethnicity, Sacramento County as Reported in the MHSA Approved PEI Plan*

NOTE: A profile of African American clients served and the number of properly trained California mental health workforce.

SACRAMENTO COUNTY AFRICAN AMERICAN POPULATION, 2009[1]	DMH AFRICAN AMERICANS SERVED 2007-2008[2]	COUNTYWIDE TRAINED MENTAL HEALTH PROFESSIONAL WORKFORCE, ALL ETHNICITIES[3]	
135,243	7,714	Psychiatrist	219
		Psychiatric MH Nurse Practitioner	4
		Licensed Clinical Psychologist	407
		Licensed Clinical Social Worker	677
		Marriage & Family Therapist	685
		Associate Clinical Social Worker	378
		Marriage & Family Therapist Intern	433

Source: 1. U.S. Census Bureau, 2009 American Community Survey (no significant change from 2008 population)
2. California Department of Mental Health (DMH) CSI, total unduplicated clients served in 2007-2008, as of March 17, 2011
3. California Board of Behavioral Sciences, Demographic Report, 2007

Riverside County



Source: California MHSA Approved PEI Plan as posted on the OAC website, 2011

Figure 31: *California Population Distribution by Ethnicity, Riverside County as Reported in the MHSA Approved PEI Plan*

NOTE: A profile of African American clients served and the number of properly trained California mental health workforce.

RIVERSIDE COUNTY AFRICAN AMERICAN POPULATION, 2009[1]	DMH AFRICAN AMERICANS SERVED 2007-2008[2]	COUNTYWIDE TRAINED MENTAL HEALTH PROFESSIONAL WORKFORCE, ALL ETHNICITIES[3]	
125,487	**4,430**	Psychiatrist	120
		Psychiatric MH Nurse Practitioner	7
		Licensed Clinical Psychologist	276
		Licensed Clinical Social Worker	379
		Marriage & Family Therapist	636
		Associate Clinical Social Worker	223
		Marriage & Family Therapist Intern	399

Source:
1. U.S. Census Bureau, 2009 American Community Survey (no significant change from 2008 population)
2. California Department of Mental Health (DMH) CSI, total unduplicated clients served in 2007-2008, as of March 17, 2011
3. California Board of Behavioral Sciences, Demographic Report, 2007

Table 19: *Rank Order by Counties with Highest Number of Blacks/African Americans by those Receiving Unduplicated Services in California Department of Mental Health (DMH), FY 2007-2008*

County[1]	Total African American Residents by County, 2009[2]	Total California Residents by County, 2009[2]	% Total African American Residents	Total African Americans Receiving Unduplicated Serves in DMH FY 2007-2008[1]	% Total California Residents in DMH by County	% Total African American Residents in DMH by County
Los Angeles	**817,273**	**9,848,011**	**8.3%**	**51,308**	**0.52%**	**6.3%**
Alameda	183,778	1,491,482	12.3%	11,890	0.80%	6.5%
San Bernardino	166,671	2,017,673	8.3%	5,916	0.29%	3.6%
San Diego	148,147	3,053,793	4.9%	5,653	0.19%	3.8%
Sacramento	135,243	1,400,949	9.7%	7,714	0.55%	5.7%
Riverside	125,487	2,125,440	5.9%	4,430	0.21%	3.5%
Contra Costa	93,901	1,041,274	9.0%	3,610	0.35%	3.4%
Solano	54,425	407,234	13.4%	1,360	0.33%	2.5%
San Francisco	47,596	815,358	5.8%	5,384	0.66%	11.3%
Orange	47,464	3,026, 786	1.6%	1,753	0.06%	3.7%
San Joaquin	46,520	674,860	6.9%	2,005	0.30%	4.3%
Fresno	45,587	915,267	5.0%	2,560	0.30%	5.6%
Kern	44,334	807,407	5.5%	1,602	0.20%	3.6%
Santa Clara	41,949	1,784,642	2.4%	676	0.04%	1.6%
San Mateo	20,987	718,989	2.9%	1,131	0.16%	5.4%
Stanislaus	13,596	510,385	2.7%	414	0.08%	3.1%
Ventura	13,220	802,983	1.6%	373	0.05%	2.8%
Monterey	11,721	410,370	2.9%	315	0.08%	2.7%
Kings	10,943	148,764	7.4%	320	0.22%	2.9%
Merced	9,051	245,321	3.7%	429	0.17%	4.7%
Santa Barbara	7,818	407,057	1.9%	283	0.07%	3.6%
Sonoma	7,655	472,102	1.6%	133	0.03%	1.7%
Marin	6,943	250,750	2.8%	251	0.10%	3.6%
Tulare	5,955	429,668	1.4%	283	0.07%	4.8%
San Luis Obispo	5,352	266,971	2.0%	99	0.04%	1.8%
Imperial	5,333	166,874	3.2%	88	0.05%	1.7%
Madera	5,153	148,632	3.5%	148	0.10%	2.9%
Placer	4,885	348,552	1.4%	64	0.02%	1.3%
Yolo	4,669	199,407	2.3%	177	0.09%	3.8%
Sutter/Yuba	3,325	165,539	2.1%	90	0.05%	2.7%
Butte	2,967	220,577	1.3%	171	0.08%	5.8%
Napa	2,848	134,650	2.1%	28	0.02%	.98%
Santa Cruz	2,693	256,218	1.1%	110	0.04%	4.1%
Shasta	1,911	181,099	1.1%	79	0.04%	4.1%
Humboldt	1,410	129,623	1.1%	61	0.05%	4.3%
El Dorado	1,328	178,447	.70%	46	0.03%	3.5%
Other Counties[1]	11,840	3,785,296	.31%	419	0.001%	3.5%
Statewide Totals	2,159,978	36,961,664	5.8%	111,373	.301%	5.16%

Source: 1. Counties not listed, have no 2009 individual county data available on the African American population as provided by the California Department of Mental Health (DMH) CSI; total unduplicated clients served in 2007-2008 as reported March 17, 2011
2. U.S. Census Bureau, 2009 American Community Survey (no significant change from 2008 population)

It appears to be a serious oversight when all major reports (e.g. *Mental Health: Culture, Race, and Ethnicity: A Supplement to Mental Health: A Report of the Surgeon General* (DHHS, 2001)) on health and mental health display the African American population as exhibiting extremely poor health and mental health outcomes that lead to premature death and disability, excessive risk factors for developing mental illness, and "high" utilization of mental health services, and **only three counties designed and funded "tailored" PEI programs for African Americans (who are in the extreme high risk category).** This observation is made based on the fact that there are numerous research studies that have documented positive prevention results of tailored PEI efforts and programs for African Americans. These programs could have been identified and funded in the county PEI plans, but African American tailored programs were missing in county plans.

This is extremely disconcerting. Troublesome to say the least, given the high level of mental health disease (mostly undiagnosed, and highly probably inappropriately treated as reported by the African American population), poverty, ongoing intergenerational stress, and other chronic health condition in the population. And, given that there are proven programs that work, but are not funded for implementation so that people can get the help they need. There is overwhelming evidence that certain types of interventions work in the African American population that produce good and balanced outcomes for people with mental health issues.

In California, rural and isolated counties face severe limitations related to resources, properly trained care providers, and services. Rural and isolated counties are identified in *Figure 2a* (GIS Map, page 18) as those counties coded in blue and or white. The African American populations in rural, costal and isolated counties report the same issues as the large urban areas.

How are mental health needs of African Americans determined?

A series of questions that continued to be asked during the development of this Population Report were: *What are the mental health needs of African Americans in California? How has it been determined how many African Americans need to reached for PEI efforts? What mental health conditions do we need to prevent? Where do we target our PEI efforts?*

Understanding and Estimating the Need for Mental Health Services

The National Institutes of Mental Health (NIMH) has few official statistics that estimate the prevalence of serious mental illness by race. The few statistics cited suggest that overall about 4.3% of the African American population had a serious mental health disorder in 2008. This compares with 5% of the population overall (NIMH, 2011; http://www.nimh.nih.gov/statistics/index.shtml). However, this data is somewhat contradictory, because the site reports that 4.3% of the US population had a bipolar or depression disorder in 2008, 4.1% had an anxiety disorder, 9.1% had a personality disorder, and 1.1% were schizophrenic. Even allowing for multiple diagnoses for any one individual, one must assume that the rate of serious mental illness must be considerably higher than the "official" estimates.

Official DMH projections of need have been calculated, and are available on: http://www.dmh.ca.gov/Statistics_and_Data_Analysis/Total_Population_by_County.asp
These projections were derived from a formula developed by Dr. Charles Holzer, at the University of Texas Medical Branch, but there is reason to believe the estimates are not accurate for California. *Table 20,* below illustrates the percentages of the African

American population being served in 2007-2008, using Holzer's formula to estimate numbers of those in need. For the sake of conciseness, we have only included most of those California counties where we held focus groups or interviews.

Table 20: *Percent of Projected Need for County Mental Health Services among African Americans met by Sampled Counties, 2007-2008*

COUNTY	NUMBER IN NEED OF DMH SERVICES 2007[1]	NUMBER OF UNDUPLICATED SERVICES BY COUNTY FY 2007-2008	PERCENT OF PROJECTED POPULATION SERVED FY 2007-08
Alameda	11,615	11,890	102%
Butte	265	171	**64%**
Fresno	3567	2,560	**72%**
Kern	4019	1,602	**40%**
Los Angeles	55,171	51,308	**93%**
Orange	2449	1,753	**71%**
Sacramento	9249	7,714	**83%**
San Bernardino	11,657	5,916	**51%**
San Diego	9028	5,653	**63%**
San Joaquin	3540	2,005	**57%**
Ventura	657	373	**57%**

[1]Numbers reported by DMH on above website as having been calculated using Holzer's formula

There are several reasons why the numbers reported may not reflect an accurate count of individuals served in each county. First, consumers might receive services from more than one mental health facility, using more than one version of their name. This is especially true for counties with high rates of transient or homeless consumers, many of whom are indigent and who may not have appropriate identification. In these cases, individual consumers may well show up as new clients each time they receive services. Another reason why the numbers reported may not match the demand estimates generated by Holzer's formula is that the estimates are calculated by household, institution or group home, it is unlikely to have captured the number of homeless mentally ill who would be eligible for county mental health services. In addition, the Holzer formula does not appear to take into account local rates of incarceration, which in many instances account for as much as 40% of males needing mental health services. There is, however, another way to look at equity of service, and to provide another check on the accuracy of the data projection calculations, which would be to compare the rate at which the projected African American population is being served with the rate at which the projected Caucasian population is being served. *Table 21*, below, provides this comparison.

Table 21: *Comparison of the Percent of Need Met for Caucasians and African Americans, 2007-2008*

COUNTY	PERCENT OF PROJECTED CAUCASIAN POPULATION SERVED FY 2007-08	PERCENT OF PROJECTED AFRICAN AMERICAN POPULATION SERVED FY 2007-08	DIFFERENCE BETWEEN CAUCASIAN/ AFRICAN AMERICAN S ERVICE RATES
Alameda	81%	102%	+21%
Butte	85%	64%	**-21%**
Fresno	86%	72%	**-14%**
Kern	71%	40%	**-31%**
Los Angeles	30%	47%	+17%
Orange	116%	71%	**-45%**
Sacramento	87%	83%	**-4%**
San Bernardino	74%	51%	**-23%**
San Diego	67%	63%	**-4%**
San Joaquin	87%	57%	**-30%**
Ventura	103%	57%	**-46%**

As the data above illustrates, African Americans received service at more than their projected rate in only one county, Alameda (*Table 20*). They received service from DMH facilities at greater rates than Caucasians in only two counties, Alameda and Los Angeles (*Table 21*), despite their much lower incomes and their relatively higher rates of need for public services.

As *Table 18* illustrates, it appears that the rates at which African Americans receive County mental health services reflect under-service. Statewide, African American consumers represent 16.4% of County mental health clients, although African Americans comprise 6.2% of California's population (http://www.dof.ca.gov/research/demographic/state_census_data_center/census_2010/).

Some of this apparent disparity in service is probably due to the relatively low income of California's African American population, and to the higher rates at which they receive other public services. However, it is also likely that these high rates of service reflect real differences in the incidence of mental illness among African Americans, and provide additional evidence that the estimates of mental health illness provided by formulas such as Holzers' are inadequate. According to the DMH CSI database, incidence of mental illness information is not available.

These **caseload figures** do not, however, reflect whether the services provided by CDMH are adequate to the needs of the population, and our focus groups suggest that they are not.

“HARAMBEE (HA-RAM-BEE)”

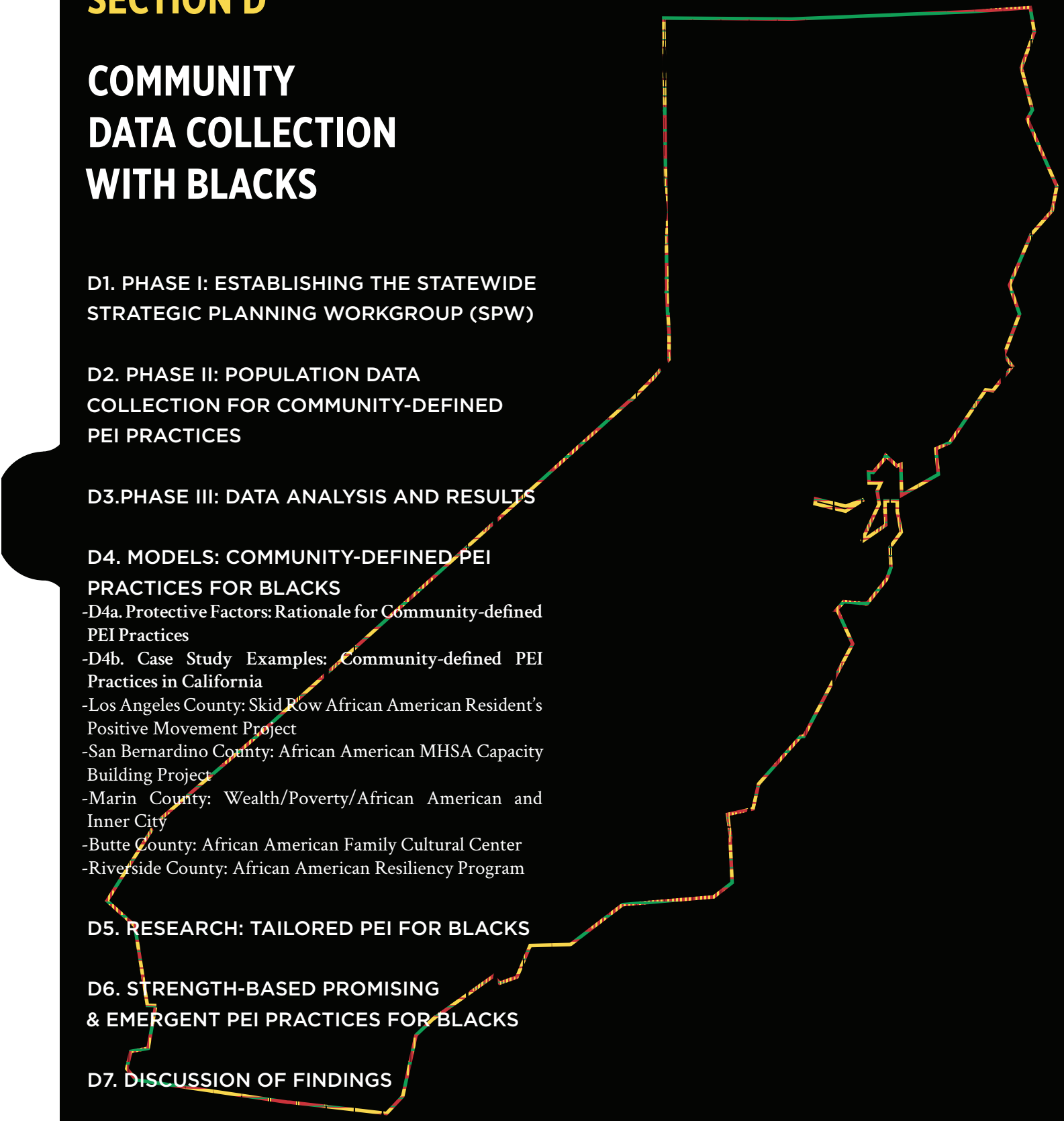


D

nityrespecthopecompassiondignityfamilycouragepeacetogetherneссculturefaithloveu

SECTION D

COMMUNITY DATA COLLECTION WITH BLACKS



D1. PHASE I: ESTABLISHING THE STATEWIDE STRATEGIC PLANNING WORKGROUP (SPW)

D2. PHASE II: POPULATION DATA COLLECTION FOR COMMUNITY-DEFINED PEI PRACTICES

D3.PHASE III: DATA ANALYSIS AND RESULTS

D4. MODELS: COMMUNITY-DEFINED PEI PRACTICES FOR BLACKS

-D4a. Protective Factors: Rationale for Community-defined PEI Practices

-D4b. Case Study Examples: Community-defined PEI Practices in California

-Los Angeles County: Skid Row African American Resident's Positive Movement Project

-San Bernardino County: African American MHSA Capacity Building Project

-Marin County: Wealth/Poverty/African American and Inner City

-Butte County: African American Family Cultural Center

-Riverside County: African American Resiliency Program

D5. RESEARCH: TAILORED PEI FOR BLACKS

D6. STRENGTH-BASED PROMISING & EMERGENT PEI PRACTICES FOR BLACKS

D7. DISCUSSION OF FINDINGS

D. COMMUNITY DATA COLLECTION WITH BLACKS

As we approach this work of identifying community-defined evidence, promising and emergent practices for people of African ancestry, there must be an acknowledgement of the great diversity that exists within African American communities. We must avoid the temptation to use "etic" (cultural general) approaches when providing services. Rather, we must be willing to **consider the within group differences** in our community and to adopt "emic" (cultural specific) approaches after allowing people of African ancestry to teach us about his or her cultural world.

After review of the literature and initial discussions with key population informants, there were many un-answered questions about African American mental health that we were compelled to investigate before we identify practices that are "meaningful." It became very clear in order to engage the African American population around defining practices that were meaningful, valued, and critical to mental health the following questions needed to be answered.

1. What is good mental health for African Americans?
2. How are mental health needs of African Americans identified?
3. What assessment tools are used to diagnose mental health problems in African Americans?
4. Exactly what mental health issues are we trying to identify?
5. What mental health issues are we trying to prevent, and to provide early intervention for?
6. What are the mental health wellness indicators for African Americans?
7. What do African American people say they need in order to experience good mental health?

To understand the world view of African people living in California, we organized our strategic planning workgroup to include as much group perspective as possible. We designed our project into three stages, **Phase 1, 2 and 3. Phase I: Establishing the Workgroup** and CRDP Report Background Information Gathering on Mental and Behavioral Health among People of African Ancestry; **Phase 2:** Target Population Qualitative and Quantitative **Data Collection and Data Analyses**; and **Phase 3:** Crafting Recommendations, **Final Report Writing, and Developing and promoting the State Strategic Plan.**

D1. PHASE I: ESTABLISHING THE STATEWIDE STRATEGIC PLANNING WORKGROUP (SPW)

Diversity and inclusion were two factors needed in order to understand the complexity of problems associated with mental and behavioral health prevention and early interventions (PEI) for African Americans. Conceptual and theoretical underpinnings for the project design were based on a social ecological framework. A diversity of stakeholders, approaches, and data collection methods were paramount in identifying meaningful values, beliefs, practices, traditions and a cultural worldview of the population. One major undertaking was to engage affected people in the CRDP process from beginning to the end and to ensure active participation and representation from each of the five California regions. The intent was to ensure inclusion of regional ecological variations.

Selecting the Statewide Strategic Planning Workgroup (SPW) Members: The AAHI-SBC project core collaborators included 12 individuals (listed in the proposal and DMH contract); five regional consultants, and seven subject matter consultants. Many were consumers and client family members, see page 14. Pre-planning involved developing the project work plan, developing the selection criteria for the statewide workgroup membership and identifying appropriate workgroup recruitment strategies. The 12 individuals became key informants and consultants, and assisted with the identification of potential members for the statewide Strategic Planning Workgroup (SPW). Each of the 12 individuals submitted names to be considered for membership selection to the SPW. There were 165 individuals recommended for workgroup membership. A telephone screening process (see Appendix H Screening Tool A, B, & C) was conducted with the 165 individuals to determine interest, availability, level of subject matter experience and contribution to meeting the project contract deliverables, and ability to make a commitment for at least 12 months to work on the SPW. Final selection was based on participant availability to meet workgroup requirements; regional representation; **lived, worked or professional experiences** with mental and behavior health issues; project funding to support workgroup activities; and subject matter expertise as defined by project outcome expectations.

Statewide SPW member categories included self-identified people of African ancestry clients, client family members, consumers, stakeholders, mental health providers, psychologists, sociologists, anthropologists, marriage and family therapists, social workers, faith and community-based organizations, in addition to youth, older adults, LGBTQI individuals, and representation of sub-target group populations (African American, African, Afro-Caribbean, Afro-Latino, and African other nationalities).

The selected SPW included 42 members, as of June 1, 2010 (see *Table 22*). All individuals signed a Membership Agreement with specific individual expectations and deliverables. A $1,000 honorarium was given each member for services rendered based on personal project deliverables submitted. Those unable to meet workgroup deadlines and due dates were invited to serve as Project Special Advisors, see Table 23 (listed individuals volunteered to serve as project advisors). As the project continued to develop additional consultants and contractors were added.

Table 22: *CRDP African American SPW Members, June 1, 2010*

MEMBER	AREA OF INVOLVEMENT	PRIMARY COMMUNITY AFFILIATION
V. Diane Woods, DrPH, MSN	Project Director	AAHI-SBC President /CEO; UCR Department of Psychology
Nacole Smith, MPH	Project Associate	AAHI-SBC Staff
Denise Hinds, DrPH	Prevention Specialist	AAHI-SBC Staff
Linda Williams	Office Assistant	AAHI-SBC Staff
Valerie Edwards, LCSW	Consultant, Northern CA Region	Berkeley, University of California, School of Social Welfare
Stephanie Edwards, MPA	Consultant, Southern CA Region	San Diego, Mental Health Services Response Team
Edward T. Lewis, MSW	Consultant, Central CA Region	Sacramento, Association of Black Social Workers
Wilma L. Shepard, LCSW	Consultant, Inland Empire Region	San Bernardino, African American Mental Health Coalition
Reverend James C. Gilmer, MA	Consultant, Los Angeles Region	Oxnard, MHSAOAC Services Committee
Daramöla Cabral, DrPH, PA	Consultant, Utilization & Culture	Contra Costa, John F. Kennedy University, Research Scientist
Suzanne Midori Hanna, PhD, MFT	Consultant, Adolescent /Adult MH	Riverside, Private Practice Marriage & Family Therapy
Richard Kotomori, MD	Consultant, Psychiatric Medicine	Riverside, Private Practice; JW Vines Medical Society (NMA)
Walter Lam	African Immigrant Health Services	San Diego, Alliance for African Assistance
Temetry Lindsey, DrPA	Behavioral Health Provider Services	San Bernardino, Inland Behavioral Health Services
Erylene Piper-Mandy, PhD	Consultant, Psycho-Anthropology	Long Beach, University of California, Department of Psychology
Carolyn B. Murray, PhD	Consultant Psychology/Academia	Riverside, UCR, Department of Psychology
Maceo Barber, MFT Intern	Stakeholder /Provider TAY	San Francisco County Department of Public Health, TAY
Yewoubdar Beyene, PhD	Mental Illness in African People	San Francisco, UCSF, Department of Social & Behavioral Sciences
Marva M. Bourne, DMFT	Marriage and Family Therapy	Colton, Private Practice/American Association of MFT
Gregory C. Canady	Client/Consumer/Stakeholder	Oroville, African American Culture & Family Center
Nancy Carter	Client/Consumer/Provider	Los Angeles, National Alliance on Mental Illness (NAMI)
Gigi Crowder	Provider/Ethnic Services Manager	Alameda County, Behavioral Health Care Services
Alemi Daba	Ethiopian Consumer/Provider	San Diego, Alliance for African Assistance
Terri Davis, PhD	Counseling Psychology	Contra Costa, John F. Kennedy University, Psychology Department
Don Edmondson	Consumer	Black L.A. County Client Coalition/ MHSAOAC Committee
C Freeman, MD	Psychiatry & Neurology	Los Angeles, Psychiatrist
Sabrina L. Friedman, EdD, NP-C	Nurse Psychotherapy	Riverside, Private Practice; Azusa Pacific University
Lawford L. Goddard, PhD	African-Centered Sociology	Oakland, Institute for the Advanced Study of Black Family Life
Tracie Hall-Burks, LCSW	Clinical Social Work	Sacramento, African American MH Providers Association
Melvora (Mickie) Jackson, MPA	Forensics/ Client Family Member	Contra Costa, Forensic Mental Health Clinical Services
Phyllis Jackson	CBO/Client Family Member LGBTQ	San Diego, Karibu Center for Social Support & Education
Luvenia Jones	Client/Client Family Member	Emeryville, POOL of Consumer Champions
R. B. Jones	Consumer/Client Family Member	East Palo Alto, Mental Health Community Advocate
Bishop Ikenna Kokayi, MA	Stakeholder /Minister	San Diego, United African American Ministerial Action Council
Lana McGuire, ACSW	Social Work/Client Family Member	Chico, Senior Social Worker Butte County
Gloria Morrow, PhD	Licensed Clinical Psychology	Upland, Private Practice Clinical Psychology
Musa Ramen	Consumer	Oxnard, Life Skills Education & Vocational, Inc.
Linda Redford, LVN	Consumer	San Bernardino, Caretaker/Elderly/ Foster parent
Daryl M. Rowe, PhD	African-Centered Psychology	Los Angeles, Pepperdine University, Department of Psychology
Madalynn Rucker, MA	Provider/Client Family Member	Sacramento, OnTRACK Program Resources
Essence Webb, ACSW	Clinical Social Work	Sacramento Association of Black Social Workers
Doretha Williams-Flournoy, MS	Provider	Sacramento, California Institute of Mental Health

Table 23: *CRDP African American SPW Special Advisors*

Member	Area of Involvement	Community Affiliation
Wade Nobles, PhD	African-Centered Psychology	Executive Director, Institute for the Advanced Study of Black Family Life and Culture, Inc., Oakland The Association of Black Psychologists *Alameda County*
Marye Thomas, MD	Psychiatric Medicine	Director, Alameda County Behavioral Health Care Services Agency *Alameda County*
Robbin Huff-Musgrove, PhD	Clinical Psychology	San Bernardino County Private Practice *San Bernardino County*
Tondra L. Lolin	African American Mental Health Outreach	Mental Health Association of San Diego *San Diego County*
Nancy Carter Sharon Yates	Consumer/ Client & Client Family Member	National Alliance for Mental Illness (NAMI) The Carter Group *Los Angeles County*
Nicelma King, PhD	Cultural Competent Focus Group Facilitator, Social Scientist, Policy Analyst, and Primary Client Family Member Caregiver x 30years	University of California, Davis *Yolo County*
Gislene Mariette, PhD	African-Centered Focus Group Facilitator	The Association of Black Psychologists Private Practice Licensed Clinical Psychology Marriage & Family Therapy African-Centered Psychology *Los Angeles County*
Gwen Wilson, LCSW	Mental and Behavioral Health Resources	G.O.A.L.S. for Women, Oakland *Alameda County*
Hannah L. Head, MSN, PHN, RN	Stakeholder/Provider Forensic Mental and Behavioral Health	Pediatric/Adolescent & Older Adult Forensic Systems *Contra Costa County*
Linda Tyson	Consumer	The Kiamsha Group, Inc. *Los Angeles County*
Cheryl T. Grills, PhD	Clinical Psychologist Development of Empowerment Participatory Models of Evaluation and Cultural Competency African Psychology Research Community-based Research	Loyola Marymount University *Los Angeles County*

Strategic Planning Workgroup (SPW) Structure

The African American Strategic Planning Workgroup (SPW) was organized into three levels of participation:

- **Level 1:** African American Health Institute of San Bernardino County (AAHI-SBC) staff
- **Level 2:** AAHI-SBC project consultants
- **Level 3:** Statewide workgroup regional members

Level 1: The administrative team; day-to-day management of the project, ensure the contract deliverables are on time, and the project is successful. **AAHI-SBC staff** interacted in every aspect of the project. Office staff, expert consultants and select representatives of the workgroup membership were responsible for completing the CRDP Report for submission to the DMH. Participation in refining the final report was based on "efficient" and "effective" utilization of project resources to meet deliverable deadlines.

Level 2: The AAHI-SBC consultants provide input regarding project development and implementation according to mental health best practice models. The AAHI-SBC staff and consultants worked together to submit the application to the DMH, and worked on the project according to identified and approved roles as stated in the executed contract from the DMH. There were two types of consultants: *Regional Consultants and Subject Matter Expert Consultants. Regional Consultants* were responsible for regional project recruitment, informing the region related to the project, and to maintain regional input into the project. *Subject Matter Expert Consultants* provided specific input related to mental health expertise (i.e., psychiatric medicine, psychology, social work, anthropology, epidemiology, behavioral health provider services, African immigrant & refugee care, utilization, culture, adolescent and adult mental health). Each consultant worked with the workgroup members on specific assignments for successfull creation of the CRDP Report.

Level 3: Statewide Regional Workgroup members were volunteers. All individuals signed a Workgroup Agreement to voluntarily serve on the CRDP to develop a population report. Each member identified personal priority areas for working on the CRDP Report, specific assignments and products to deliver according to pre-establish times and due dates. Members represented the diversity of expertise from the mental and behavioral health.

SPW members provide a wealth of lived experiences as well as personal and professional affiliations, all combined to create a well rounded group. See Appendix K SPW structure which include expectations for meetings, timelines, and work assignments. As the CRDP process moved forward, emergent population needs required modifying the SPW structure and workgroup assignments to efficiently meet contract deliverables.

CRDP Population Report Background Information Gathering: The first statewide meeting convened on June 1, 2010. The following were topics to be included in the Population Report as identified in the DMH contract; each topic formed a section group, each members choose a section to work on:

- Section 1: Documenting Disparities
- Section 2: Accessing Programs and Services
- Section 3: Identifying Focused Areas of Improved Mental Health Outcomes
- Section 4: Promoting Effective Relevant Approaches and Solutions
- Section 5: Supporting Community Participatory Evaluation Approaches

A critical first step was organizing to obtain background information for the report. We divided the SPW into small section groups to (1) fully engage each workgroup member in the process of assisting in writing the CRDP Population Report, since small groups facilitate more active participation. The goal was to decrease the possibility of members becoming overwhelmed with the mammoth task, and to enhance broader participation to ensure regional input. (2) The SPW members were selected from diverse backgrounds to ensure that different perspectives of the problem were articulated, identified, and investigated. To maintain diversity of input, each section group consisted of at least a client or a family member, or consumer; a stakeholder; a provider; a psychologist; a social worker; and a community organization representative. There were seven to eight individuals in each section group.

Each section group created a report outline of issues they felt should be included in their topic of interest, and proceeded to obtain background information related to the outline. After the first statewide workgroup meeting, section groups worked from June 2010 to December 2010 to obtain relevant information on their topic of interest. Individuals used **multiple sources to obtain information including literature reviews, on-line computer searches, statistical reports, and word-of-mouth through personal social and professional networks.** Information collected was submitted to the CRDP African American SPW director to synthesize, organize and merge into one document to create the report background. Ongoing telephone conference calls, in-person statewide group meetings, and online meetings at a 24 hour project designed computer meeting center (*SharePoint©*) were used for organizing, archiving, sharing and refining information before submissions by due dates. A communication plan was developed to standardize the exchange of information (see CRDP page at www.AAHI-SBC.org).

In addition to small section groups, we created five other teams, i.e., research design team (for data collection protocols and the development of the focus group guide); data collection team (facilitators & co-facilitators); data analysis team; data interpretation team; and the writing team. After the background draft of the CRDP report was developed and merged into one document, it was sent to the writing team. The writing team was responsible for reviewing the document for missing information, formatting, including the qualitative and quantitative data, and finalizing the report for publication.

Planning Meetings

Over the two year contract period, there were over 45 workgroup planning meetings among SPW members that were conducted either in-person or by telephone conference calls. Statewide meetings by project director included:

- Quarter #1 – Convened Statewide Pre-planning Mt, April 27, 2010 (in-person), San Bernardino
- Quarter #2 – Convened Statewide Mt – June 1, 2010 (in-person), Sacramento
- Quarter #2 – Convened Statewide Planning Retreat, Aug 13-15, 2010 (in-person), Oakland
- Quarter #3 – Convened Statewide Mt– Sept 26, 2010 (in-person), Riverside (UCR)
- Quarter #4 – Convened Statewide Mt – Jan 6, 2011 (telephone conference)
- Quarter #5 – Convened Statewide Mt, Mar 24, 2011 (in-person), San Bernardino
- Quarter #5 – Convened Writing Team Mt, April 8, 2011 (in-person), San Bernardino
- Quarter #5 – Convened Data Analyst Mt, May 17 & 18, 2011(in-person), San Bernardino
- Quarter #6 – Convened Statewide Writing Team Mt, June 9, 2011 (in-person), San Bernardino
- Quarter #6 – Convened Statewide Writing Team and Data Analyst Team Mt, August 31, 2011 (tele-conf)
- Quarter #7 – Convened Statewide Writing Team combined Data Analysis Team telephone conference call meetings: September 8, 2011; September 12, 2011 (continuation meeting); November 18, 2011
- Quarter #8 – Convened Statewide Data Interpretation Team Mt with consumers, client & client family members, writing team and data analysts, December 2, 2011 (in-person), Davis (UC Davis)

Other meetings included attending the County Director's meetings, Ethnic Services Managers meetings, workgroup meetings, MHS Oversight and Accountability meetings, cultural competency summits, and collaborative meetings with the other CRDP SPW contractors, Racial and Ethnic Mental Health Disparities Coalition (REMHDCO), and contractors meeting with CPEHN (facilitator/writer for the Statewide Strategic Plan).

DMH collaborative meetings with State and County, attended by the African American SPW project director (Dr. Woods), included:

September 24, 2009: MHSA OAC meeting, followed by the REMHDCO mt, Santa Ana

October 20, 2009: Statewide DMH CRDP Project contractors meeting, Sacramento

October 27, 2009: Contractors meeting with Rachel Gurrero & Autumn Valerio, Sacramento

November 17-18, 2009: Cultural Competence Mental Health Summit XVI: Embracing Social Justice and Equity to Build Healthier Communities, DMH Directors Association meeting, Hyatt Regency San Francisco

December 1-2, 2009: Older Adult System of Care Conference, DMH Directors Association meeting, Convention Center, Riverside

February 10, 2010: 2010 California Mental Health Policy Forum, DMH Directors Association & County Ethnic Services Managers meeting (in person) reported on African American SPW proposal; Convention Center, Riverside

June 22, 2010: Statewide DMH CRDP contractors meeting, Sacramento

September 27, 2010: DMH Ethnic Services Managers meeting (in-person), Sacramento; distributed a package that included project timeline, structure of SPW, Communication Plan, dedicated website (www.AAHI-SBC.org) for SPW activities, project status report and a draft copy of focus group schedule

February 8, 2011: Statewide Ethnic Services Managers meeting (in-person), Sacramento

June 27, 2011: Panel presentation with SPWs to discuss the CRDP at the Northern CA Mental Health Cultural Competence Summit, San Jose

June 28, 2011: Conducted workshop on community practices that work by presenting three community leaders, advocates, and activists who shared positive work by the Black community on mental health at the Northern CA Mental Health Cultural Competence Summit, San Jose

August 2011: Panel presentation with SPWs to discuss CRDP at the Statewide NAMI Conference, Sacramento

September 30, 2011 & October 1, 2011: Attended California Legislative Black Caucus Policy Conference, Westin LAX, presented information about the CRDP and State Strategic Plan; interest expressed by Senator Curren Price (Chair, Leg Black Caucus), Assembly Member Mike Davis (Vice Chair), and Assembly Member Holly Mitchell; Senator Price and Assembly Member Bradford sent representatives to the public forums (October 11, 2011). Individual 30-day public review DRAFT copies of the CRDP African American Population Report was shared with each caucus member.

November 1, 2011: Two presentations on the CRDP African American Population Report were made at the 139th American Public Health Association Annual Meeting and Exposition, Washington, DC, entitled: Session 4015.0 Community-based Participatory Research and African Americans – *"Analyzing Qualitative Data Using Four Theoretical Perspectives to Understand Community-defined Evidence for Improved Mental Health Outcomes in Black"* – California Reducing Disparities Project (CRDP) African American Strategic Planning Workgroup (SPW) Department of Mental Health by V. Diane Woods, Dr.P.H., M.S.N., RN

November 1, 2011: Session 4160.01 – Community-based Participatory Research - ***In Our Voices:*** *Engaging People of African Ancestry in Defining Community Evidence for Improved Mental Health Outcomes* - California Reducing Disparities Project (CRDP) African American Strategic Planning Workgroup (SPW) Department of Mental Health by V. Diane Woods, Dr.P.H., M.S.N., RN

November 3, 2011: Presentation on the CRDP at the Cultural Competence Mental Health Southern Region Summit XVII, Ontario Convention Center, Ontario, CA

D2. PHASE II: POPULATION DATA COLLECTION FOR COMMUNITY-DEFINED PEI PRACTICES

Data Sources: Data was collected from 10 sources.

Qualitative Sources
1. Key Informant Pre-Project Interviews
2. Focus Groups
3. Small Group Discussions
4. In-depth Interviews
5. Case Studies
6. Public Forums

Quantitative Sources
1. Telephone Surveys
2. Email Surveys
3. Focus Group Participant Surveys
4. Consumer, Client and Client Family Member Solutions and Practices Survey

METHODS

Quantitative Data: Surveying

Survey design was created by SPW members and approved by the CRDP African American SPW project director. Statewide and regional convenient and targeted sampling methods were employed. To capture a broader worldview of current mental and behavioral health services delivered to the African American population in California, SPW members conducted four brief surveys, e.g., telephone survey, email survey, focus group participant survey, and consumer, client, and client family member survey. The primary question asked was, *"What current community programs are you aware of that are designed specifically for African Americans that you believe are truly helping the population get good mental and behavioral health, which may or may not necessarily be funded by the DMH?"* Each survey however, investigated different aspects of the basic question. Survey questions are discussed in each section below.

Survey #1: Telephone Survey: Initial inquiry started in November 2010 with regional telephone calls to the six counties with the highest concentration of the African American population (Los Angeles, Alameda, San Bernardino, San Diego, Sacramento, and Riverside), followed by the next highest, and lastly the less populated counties. Calls were made to key informants, stakeholders, County Ethnic Services Managers, community leaders, providers and regional workgroup members. Four simple questions were asked:

(1) *In your opinion, are you aware of current programs or interventions in your region that are tailored to the African American population for PEI?*

(2) *What is the name of the program or intervention?*

(3) *What is the contact information for the program?*

(4) *What is the focus of the program or intervention?*

A follow-up call was made to the contact person identified during the call, and additional questions were asked about the program, such as, how long the program or intervention has been in operations? Has there been a formal evaluation of the program/intervention? What are the program or intervention outcomes? SPW members also attended diverse coalition, community, and professional meetings to obtain additional information, such as the MHSA Oversight and Accountability Commission, Ethnic Services Managers, Association of Black Social Workers, African American Mental Health Providers, and others.

Survey #2: Email Survey (Appendix B): In mid January 2011, we administered an online survey, and repeated administration in February 2011 and March 2011. In our efforts to identify emergent and promising practices, workgroup members chose selection criteria based on group input and what African American scholars determine are factors contributing to good mental and behavioral health for our population. Our workgroup called their selection criteria *PERAS*, which means *promoting effective relevant approaches and solutions.*

The *PERAS Index* is a list of specific community defined promising practices, with strength-based, culturally competent approaches that support improved services for people of African heritage living in America, irrespective of nationality. Identification of both traditional and non-traditional, effective mental health service models contributing to the overall health and wellness of individuals in the population are listed in the index. The *PERAS Index* consists of four levels or pillars: **Pillar 1:** African-Centered, **Pillar 2:** Faith or Spirit Based, **Pillar 3:** Ecological/Community, and **Pillar 4:** Wellness, Resiliency and Recovery. PERAS Pillars represent the following:

PERAS Pillar 1: African-Centered
African-Centered: Using African values, traditions, and world view as the lens through which perceptions of reality are shaped and colored.

African-Centered Psychology: Examines the processes which allow for the illumination and liberation of the spirit (one's spiritual essence).

PERAS Pillar 2: Faith or Spirit Based
A faith-based organization (FBO) is either a religious organization or a group with administrative or financial ties to a religious organization(s). Faith perspective, however, must be rooted within an established and recognized religious tradition (Christianity, Judaism, Islam, Hinduism, Buddhism, etc). FBOs should be distinguished from secular organizations that provide health services sensitive to the religion of clients or that utilize the religious beliefs of patients as part of the treatment they offer, although their primary mission is not faith based (Spirit-Health Connections, Templeton Press, 2008)

PERAS Pillar 3: Ecological/Community
"**Community Psychology**" has fast become a science of prevention, community intervention and social epidemiology, and its original focus was on social and cultural influences on mental health. Today, "Community Psychology" examines ecological issues beyond the individual level, explores the value of diversity, and challenges narrow uni-dimensional measures of health, and views psychologists and providers of care as agents of social change. While the research continues to be limited as it relates to who the African American consumer really is and the identification of best practices for treating our community, "Community Psychology" promotes the following themes which tend to be promising as an effective approach for working more effectively with the African/

African American community: (1) ecological perspectives; (2) cultural relevance and diversity; and (3) empowerment. "Community Psychology" takes into consideration social relationships, involves diverse community members, and studies factors outside the individual when looking at the problems of individuals, so as to avoid blaming individuals solely for their problems. This model promotes the inclusion of community members in identifying mental health needs and relevant solutions for meeting those needs in a given community. Once the needs have been appropriately assessed by those who are in need, specific programs are developed and implemented. After implementation, the programs are evaluated to determine outcomes and effectiveness. "Community Psychology" stresses prevention, empowerment, promotion of healthy behaviors and contexts, and the creation of settings for community involvement and improvement.

PERAS Pillar 4: Wellness, Resiliency and Recovery
General definition of wellness, resilience and recovery must be developed and customized at the African American individual, family and community level to align with individual, family and community goals and values

The survey was administered electronically by email, or by fax, or in-person with a one-on-one interview. E-mails were sent to over 690 including: community and faith-based organizations, County Ethnic Services Managers, fraternities and sororities, various community stakeholders and coalitions such as NAMI, African American Underrepresented Ethnic Populations Group in Los Angeles, African American Mental Health Coalition in San Bernardino, Los Angeles Black Health/Mental Health Task Force, Kappa Alpha Psi Fraternity, California Alliance of African American Educators, California Black Social Workers, African American Mental Health Providers, Southside Community Center Butte County, 100 Black men of America, Association of Black Correction Workers, and the AAHI-SBC community mass email list (which includes over 500 addresses).

Survey #3: Focus Group Participant Survey (Appendix C): Regional focus groups were conducted from August 2010 to November 2010. At the beginning of each focus group meeting participants were asked to complete a brief survey with demographic information and six thought provoking questions about services, preferences, mental health issues, and identification of self. The six questions were intended to be an ice breaker, and to help participants become relaxed and to be more comfortable in engaging the focus group discussion. The six questions were:

1. *Have you sought mental health services in the last 2 years?*
2. *What is your preferred ethnicity of a mental health provider?*
3. *Are African Americans more prone to mental health issues/problems than others?*
4. *Who is most likely to have mental health problems, males or females?*
5. *When you have mental health troubles who do you want to go to?*
6. *Where do your people come from?*

Survey #4: Consumer, Client and Client Family Member Survey (Appendix G): After statewide focus groups were conducted, there was a heighten interest from consumers, clients and client family members in giving their input on what mental health practices were meaningful to them. A brief one page survey was created with demographic information and three primary questions. A convenient sampling method was employed to collect the data based on the limited available project funds. There were several large meetings taking place throughout the State of California during 2011 that would provide access to Blacks and those with mental issues. Meetings included: a statewide CRDP African American Strategic Planning Workgroup session where each member was expected to bring a consumer, or client or client family member; statewide DMH regional stakeholder meetings, National Alliance for Mental Illness (NAMI) regional meetings and a statewide conference, CRDP African American Strategic Planning Workgroup public forums, as well as other gatherings where the target population may be in attendance. At each meeting participants completed the survey onsite, which took less than 10 minutes. Consumer, Client and Client Family Member survey was on-going during the 30-day public review period. Primary questions asked were:

1. *Identify at least three major mental health problems for Blacks.*

2. *List three solutions to major mental health problems for Blacks.*

3. *List critical community practices for mental health PEI for Blacks.*

Qualitative Data: Interviews

Qualitative data collection and background information development were sequential processes. We initially started our data collection process by interviewing regional key informants, focus groups, small group meetings and followed with in-depth interviews to probe specifics related to practices and recommendations, followed by a series of statewide public meetings to validate the Population Report content. The primary questions centered around *(1) understanding what good mental health is for Blacks, (2) determining perspectives related to the CRDP, (3) a worldview of mental health issues and solutions for Blacks living in California, and (4) areas of mental health concerns for the targeted community.*

- Interviews #1: Key Informants
- Interviews #2: Focus Groups
- Interviews #3: Small Group Meetings
- Interviews #4: In-depth/One-on-One/Case Studies
- Interviews #5: Public Forums

Procedures: Workgroup members were assigned to a research design team, or data collection team, or data analysis team. Standard procedures were developed and implemented. Each team was expected to clearly document their qualitative procedure, and data analysis process. The CDRP African American SPW project director was a part of the decision-making for all data collection procedures.

Interviews #1: Key Informants

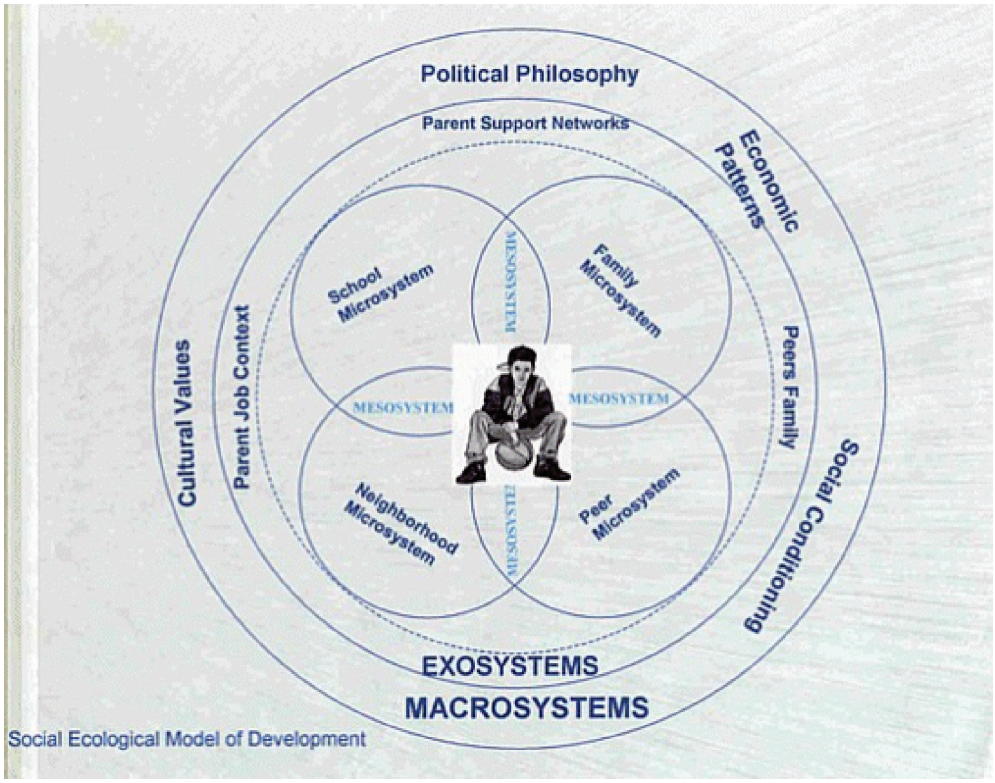
At the beginning of the project development, 15 individuals were identified from each region by word-of mouth, that included consumers, clients, client family members, psychologists, marriage and family therapists, community advocates, special interest groups such as youth, older adults and LGBTQ individuals with representation of Blacks born in Africa, the Caribbean, and America, mental health providers, and county mental health staff. Key informants included the five regional consultants (Valerie Edwards, LCSW; Stephanie Edwards, MPA and client family member; Edward T. Lewis, MSW, Association of Black Social Workers; Wilma L. Shepard, LCSW; and Reverend James C. Gilmer, MA, consumer and advocate); seven subject matter experts (Walter Lam, African Immigrant Health and consumer; Temetry Lindsey, DrPA, Behavioral Health and California Association of Primary Care Providers; Richard Kotomori, MD, Psychiatric Medicine; Daramöla Cabral, DrPH, PA, Epidemiologist; Suzanne Midori Hanna, PhD, MFT, Adult and Adolescent Behavioral Health; Erylene Piper-Mandy, PhD, Psychological Medical Anthropology; Carolyn B. Murray, PhD, Association of Black Psychologists) and three SPW members (Gloria Morrow, PhD., Psychologist and Cultural Competence Master Trainer; Phyllis Jackson, CBO Executive, client family member, LGBTQ; and Terri Davis, PhD, Counseling Psychology). Information obtained from key informants was fundamental to developing the CRDP pre-planning, identifying potential statewide SPW members from each region, and providing insight on African and African American mental health issues for guiding the project process. Key informants were interviewed by the CRDP African American SPW project director, and the epidemiologist.

Interviews #2: Focus Groups

Focus Group Ecological Research Design

Focus Group Guide (Appendix D): A Focus Group Guide was developed using principles of African-Centered psychology, sociology, anthropology, and a public health ecological perspective. The overall question to be explored was, *"What do Black people living in California need in order to get appropriate help for mental and behavioral issues?"* Research questions centered on the perspectives of the population related to prevention and early intervention (PEI), the mental health system, care received, and what characterized "good mental and behavioral health." A social ecological conceptual model was utilized to design the focus group guide.

Social Ecological Model (Stokols, 1996): The Social Ecological Model considers the complex interactions (mesosystems) between macro and micro-level factors (including individual, family, community, policy, and societal factors), see *Figure 32.* Conceptually, the model allows consideration of the interplay between factors and to critically address the potential for additive and multiplicative interactions among contributing factors in elucidating mediators of mental health disparities among Africans in America. Dr. Woods has successfully applied a social ecological model construct to countywide strategic health planning in the African American Health Initiative (Woods, 2004c); with Black men and prostate cancer prevention and early detection (Woods et al., 2006); policy analysis with HIV/AIDS (Woods et al., 2008); with the development of a community-based prevention system for African American and other people of African descent (Woods, 2009), and with statewide African American Initiative for access to care with the CA Department of Managed-Care Office of the Patient Advocate (OPA) (2009-2011).

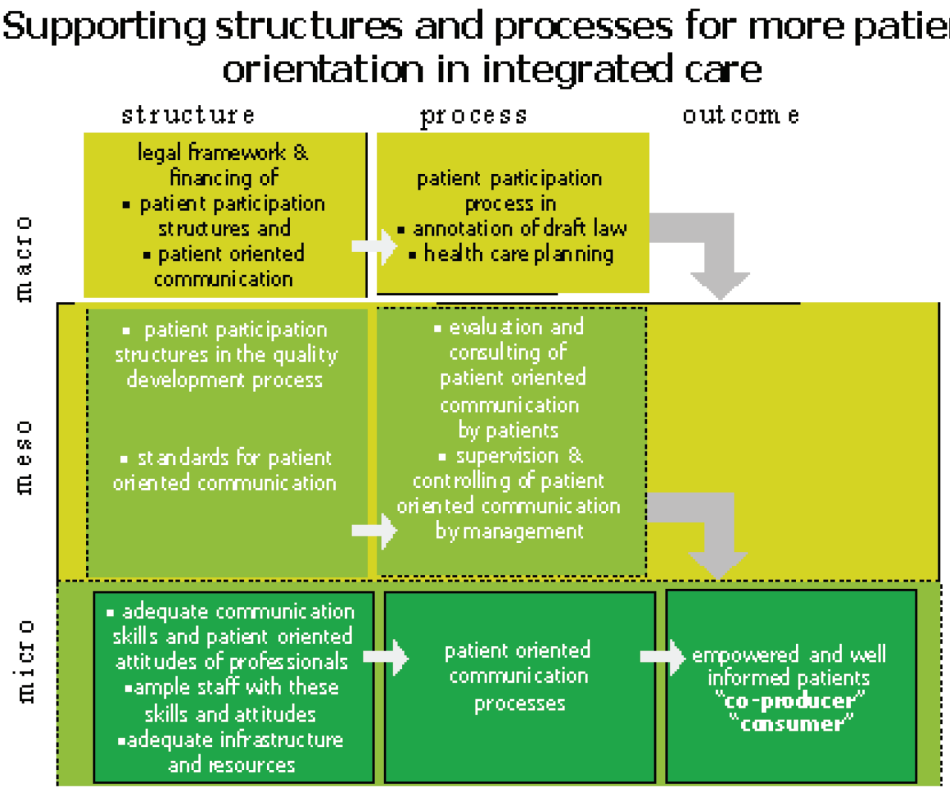


Source: http://www.aspe.hhs.gov/HSP/connections-charts04/figa.gif

Figure 32: *A Social Ecological Model*

Systems Level Model: A System Level Model provided the paradigm for the focus group methodology, see *Figure 33.* A systems paradigm supported the process for utilizing a series of open ended questions to explore in a naturalistic setting multiple-level responses such as storytelling, case histories, symbolism, and relational issues (being, belonging, and becoming). Questions were intended to explore potential for exosystems (additive and multiplicative models and effects); metasystems (indirect impact of events or factors on individuals and family members, from the direct impact on others in the family); macrosystems, mesosystems, and microsystems (evaluating proximal and distal factors, emotional and behavioral needs include families, cultural norms and values, and service sectors such as schools, health centers, specialty mental health systems, justice systems, protection services, and substance use treatment systems).

Other theoretical constructs requiring exploration was what influences structure, process and outcomes. Critical factors were: historical/social and public policy; community (culture and values); social institutions (culture and values); interpersonal/family/social networks; individual self-efficacy and resiliency (skills, abilities, cultural realignment).



Source: Christa Peinhaupt, Mag., et al

Figure 33: *A Systems Level Model*

Focus Group Structure: The SPW decision-making process was by consensus. A decision was made to conduct focus groups in each five regions of the state, see *Figure 2.* The number of focus groups per region was determined by the project regional consultants and the density of the population in each of the areas. A team of three individuals were identified to conduct all focus groups. For standardization and procedure consistency, the data collection team included a primary facilitator and the project director/facilitator, and when appropriate a videographer. Sessions were audio taped, and when possible videotaped for data collection and retrieval.

Focus Group Recruitment: SPW regional consultants were responsible for recruiting all focus group participants and for arranging logistics for each focus group meeting. Participant criteria were self-identified person of African ancestry, adult, California resident, and knowledge of the local mental and behavior health system or had experiences with the system and/or clients. Individuals were recruited from 19 different categories including, African American citizens, African immigrants, African nationalities, clients, consumers, family members, faith community, grassroots organizations, homeless, forensics, LGBTQI, substance abusers, foster care, older adults, musicians, artist, youth (students), government officials, mental health providers, social workers, African mental health workers, educators, teachers & academics. Participants were from diverse sub populations of African ancestry, who self-identified as African American, Continental African, Afro-Caribbean, Afro-Latino, Afro-Native American, and African other nationalities. Maximum participant was eight individuals for each focus group. This limit was imposed to ensure that every person had an opportunity to contribute to the discussion.

Focus Group Procedure: All focus group meetings lasted approximately 2 hours. Each individual was offered a $50.00 cash gift for participation. Participants signed a consent form, completed demographic information, and a short 5-question survey regarding thoughts, beliefs, and practices related to mental health. Participants were given the opportunity to use their actual name or a fictitious name, based on their comfort in sharing information. Participants were informed that data would be aggregated and reported **without** name identification. Some individuals gave verbal and written permission to use their names in the report. Focus group sessions were conducted in locations that were comfortable and familiar to participants, and offered easy access. During the focus group meetings participants sat in a circle facing each other to facilitate group discussion.

Focus Group Facilitators: Focus group facilitators were of two different backgrounds. One was a culturally competent trained social scientist, university professor, and a mental health client family member primary caretaker for over 30 years. The other facilitator was a licensed clinical psychologist, trained in African-Centered psychology, and had a large client practice in Los Angeles. Both were experienced in focus group facilitation. The assistant facilitator (project director) was a trained qualitative research scientist experienced in community-based participatory research, public health, social and behavior health, experienced in directing and delivering mental health services, and also a mental health client family member. The intent for using two different facilitation styles was to increase group discussion engagement of diverse participants.

Focus Group Data Analyses: To ensure culturally appropriate analysis and interpretation, diverse data analysts were employed. A second client family member was unable to continue due to family crises. Analysts represented people of African ancestry that varied in age, experience, profession, and California regions including:

- A Community Advocate (Los Angeles Region)
- Client Family Member Social Scientist (Northern & Central Region)
- Experienced African-Centered Psychologist and Researcher (Out of State)
- Experienced African-Centered Sociologist and Researcher (Bay Area Region)
- Trained Public Health Qualitative Researchers (Southern Region)

Each analyst was given a CD with verbatim transcripts for 35 focus groups, in addition to a paper copy of each transcript. Diverse qualitative software, such as ATLAS.ti, NVivo and SPSS, as well as manual data extraction was utilized for analyses. The intent was to reduce analysis outcome bias and strengthen the probability for proper interpretation and appropriate understanding of the population. Each analyst used his/her preferred qualitative analysis techniques. The community advocate was instructed by the African American CRDP director in manual data extraction using line by line qualitative methods.

Interviews #3: Small Group Meetings

Small group meetings were convenient samples. The project director was notified of several large state meetings or conferences related to mental health, and invited small group gatherings; a total of 6 small meetings. Conference organizers were contacted and a request was made for SPW members to attend and collect data on the CRDP.

Meetings included: the National Alternative 2010 Conference (for mostly mental health consumers), 2011 Northern Region Cultural Competency and Mental Health Summit, a church conference, 2011 California National Alliance on Mental Illness (NAMI) Conference, and a meeting with Black Los Angeles County Client Coalition (BLACCC). The CRDP African American SPW project director (Dr. Woods) and SPW members collected the data.

Meeting #1 & #2: National Alternative 2010 Conference was held September 29 to October 3, 2010 in Anaheim, California. This national mental health conference was organized by and for mental health consumers and survivors for in-depth technical assistance on peer-delivered services and self-help recovery models, as well as providing an environment for social networking, artistic expressions, and health. There were over 1,000 in attendance, mostly clients and consumers. Our SPW members attended **two separate meetings** of interest to collect data, (the African American Caucus (31 attendees) and the LGBTQI Caucus (25 attendees). The project director was notified the day before the meeting, however, our CRDP SPW mental health clients and consumers were able to obtain agreement from caucus leaders to allow attendance and data collection. This indeed demonstrated the power of consumers and clients as active participants in the CRDP process and to ensure that the voices of those most affected were heard. Information obtained centered on issues and concerns of each group. Individual members were invited to talk to Dr. Woods after the meetings. The Alternative 2010 Conference was funded by the U.S. Department of Health and Human Services (DHHS) Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Mental Health Services (CMHS), Washington, D.C.

Meeting #3: 2011 Northern Region Cultural Competency and Mental Health Summit XVII took place on June 27th and 28th, 2011 in San Jose, California. This summit was sponsored by the County of Santa Clara, the California Mental Health Directors Association, and the California Institute of Mental Health. Over 500 were in attendance. The CRDP African American SPW project director and SPW members attended and conducted one-on-one interviews, obtained information from groups, and participants of a 1.5 hour interactive workshop conducted by our SPW and African American community leaders (10 gave comments). One small group discussion was conducted with an Ethiopian mental health support group (10), African Immigrant Ethnic Cultural Communities Advisory Committee (ECCAC) of Santa Clara County; leader Mohammed Ali and co-leader Semert Haile. Information obtained related to meaningful practices of and for Black people for good mental health and culturally appropriate service delivery.

Meeting #4: 2011 Ephesus Empowerment Conference convened in Fontana at the Ephesians New Testament Church under the spiritual leadership of General Elder Emory B. James. The community conference was conducted for an entire week (August 14 to 18, 2011). The CRDP project director was invited to speak to the church leaders on August 16, at which time the survey was conducted. A total of 10 individuals completed the survey.

Meeting #5: 2011 National Alliance on Mental Illness (NAMI) Conference convened August 19 & 20 in Sacramento at the Double Tree Hotel, Point West Way. A workshop was conducted with consumers that were deaf and hard of hearing. There were 5 panel participants who shared their experiences with mental health issues.

Meeting #6: 2011 Black Los Angeles County Client Coalition (BLACCC) members met at a client resident in Long Beach on December 30, 2011. The meeting was arranged by a county mental health advocate and member of BLACCC. Some group members had expressed

that they really wanted to make sure their input was captured and documented in the report. All conversations were video recorded. There were seven (7) individuals present. All were clients or client family members and currently use the Los Angeles County public mental health system. Participants represented the cities of Long Beach, San Pedro, and Inglewood.

Interviews #4: In-depth One-on-One and Case Studies

By word-of-mouth, SPW members identified individuals to participate in one-on-one in-depth interviews; a total of 43 participants. Questions under investigation were intended to obtain deeper insight into community practices recommended by the population. In-depth interviews provided the opportunity to develop case studies. Case studies are presented to highlight specific insightful findings that help to illuminate the complexity of solutions needed to better respond to the needs of the African American population. Practices identified in each case study are real and implemented by the leadership of the Black community. Many of these practices are NOT funded my MHSA or the county DMH. The CRDP African American SPW director conducted all in-depth interviews, in addition to one other SPW research design team member. Interviews lasted for at-least one hour. The following questions were investigated:

- *Tell me about who you are?*
- *What interest do you have in good mental health for African Americans and other people of African heritage living in California?*
- *Describe interventions and practices that you believe are prevention and early intervention (PEI) methods to help African Americans and other people of African ancestry have good mental health?*
- *What changes do you recommend that the State of California needs to put in place in order for African Americans and other people of African ancestry to get mental health services that will truly help them?*
- *Any additional comments about your community and the public mental health service delivery system?*

Interviews #5: Regional Public Forums

Final data collection for this CRDP consisted of a series of public meetings convened in each region during October 2011. The intent of public meetings was to continue the community engagement process so that all interested individuals and people of African ancestry could have the opportunity to give additional input into the Population Report before it was finalized. The goals of the public meetings were to validate content and to obtain additional specific PEI practices and recommendation the population felt needed to be included in the report. Six (6) public meetings were conducted during the 30-day public review period of the DRAFT Population Report.

Additional request for three regional meetings (in Solano, Monterey and Long Beach) extended the data collection to December 30, 2011. The Long Beach meeting was scheduled as a small group meeting of clients, client family members and consumers. A total of nine regional public forums were conducted. Meetings followed the same protocol, i.e., two hour sessions, video or audio taped, in addition to field notes taken

summarizing information shared. All participants were adults and gave verbal consent to participate and to use or not use name in the final report. An agenda was provide with three items for public comment, (1) report content, (2) additional recommendations or community practices, and (3) additional recommendations for inclusion in the state strategic plan. Meeting discussions were facilitated by the CRDP director (Dr. Woods) at the locations below:

Regional Public Forums

DATE	TIME	LOCATION	ATTENDEES
October 7, 2011	8:00am to 9:30am	**AAHI-SBC** **Regular Community Meeting** 1800 Western Ave, San Bernardino	15
October 11, 2011	11am to 1pm	***The California Endowment*** Downtown LA, 1000 Alameda St., Los Angeles	32
October 12, 2011	12noon to 2pm	**Maxine Waters Employment Center** 10925 South Central Ave, Los Angeles	10
October 17, 2011	4:30pm to 6:30pm	**Tubman Chavez Multicultural Center** 415 N. Euclid Ave., San Diego	11
October 18, 2011	5:30pm to 7:30pm	**The DuBois Institute** 2060 University Ave., Suite 102, Riverside	50
October 27, 2011	5:00pm to 7:00pm	**African American Art** **& Culture Complex** 762 Fulton Street, San Francisco	20
October 29, 2011	11am to 1pm	**Double Tree by Hilton Sacramento** 2001 Point West Way, Sacramento	12
November 30, 2011	6:30pm to 8:30pm	**Solano County, Multi-Purpose Room** 2101 Courage Drive, Solano	13
December 15, 2011	6:00pm to 8:00pm	**Friendship Baptist Church** 1440 Broadway Ave, Seaside, Monterey County	22

D3. DATA ANALYSIS AND RESULTS

What is data analysis?

Data analysis is a careful, precise technique that follows a specific process. That process involves inspecting, cleaning, transforming, and displaying the data to obtain knowledge discovery for conclusions, and decision-making. The knowledge discovery is for descriptive and predictive purposes. Data analysis will describe the information collected. Then the data is further examined to determine future predictions of the subject under investigation. For the purposes of our report, the subject is mental health issues in the Black population, and specifically PEI practices and recommendation based on the perspective (or opinions) of the Black population.

Methods and Results

Data sets serve to organize and display how we obtained information from the population. There were five different data sets to be analyzed; *Table 26* is a summary of each. Each data set and results will be discussed separately. Data set #1 combined all surveys; a total of 635. The total for **all data sets equaled 1,224.** However, **total project participation** cannot be determined by adding all five data sets because overall project participation varied, and project participants engaged in diverse sampling methods. For example, the 260 focus group surveys were completed by the 260 focus group participants, however focus group data and survey data are different data sets, therefore only 260 individuals should be counted for project participants. Another example, of the 43 one-on-one interviewees, eight had participated in a focus group or small group meeting, or completed a consumer, client, client family member survey. The eight are only counted one time as project participants.

Table 26: *Summary of Data Sources by Data Sets*

	NAME	# MEETINGS	# PARTICIPANTS
DATA SET #1	Regional Surveys		635
	Telephone (n=66)		
	Email (n=4)		
	Focus Group Participant (n=260)		
	Consumer, Client, Client Family Member (n=305)		
DATA SET #2	Regional Focus Groups	35	260
DATA SET #3	Small Group Meetings	6	98
DATA SET #4	Regional In-depth (1 on 1) Interviews		43
DATA SET #5	Regional Public Forums	9	188

Note: Total participants cannot be added because 34 individuals participated more than one time. For examples see below; of the 5 who participated in the phone survey, they also participated in at least one other set; of the 12 who participated in focus groups they also participated in at least one other set, etc.

DATA SET	# PARTICIPANTS - MORE THAN ONE SET	TOTAL PARTICIPANTS IN DATA SET	% TOTAL PARTICIPANTS IN MORE THAN ONE SET
Phone Survey	5	66	7.58%
Focus Group	12	260	4.62%
1 on 1 Interview	8	43	18.60%
Small Group Meeting	2	98	2.04%
CCC Family Member Survey	13	305	4.26%
Public Forum	4	188	2.13%

The intent of mixed data collection methods was to triangulate data input to obtain relevant information from many perspectives to better understand PEI needs of the population. One to one interviewees wanted to give more in-depth information about their lived experiences and personal interaction with their county DMH.

In the process of cleaning our data to identify the total single individual participant count, we removed duplicates. We counted each person only one time for **a total of 1,195 "unduplicated"** individual participants in the African American CRDP. This unduplicated number includes all data set participants, in addition to 200 Africans in the Banche Project, one prison inmate, 24 contractors (some volunteered their time and resources) and community volunteers, and 16 student interns and research assistants. See *Table 27* for a total project participation count by groups.

Table 27: *Total Project Participation Unduplicated Count*

GROUPS	# UNDUPLICATED PARTICIPANTS
5 Data Sets = 1,224 participants - 260 focus group survey participants removed - 34 individuals who participated more than one time removed	930
Banche Project	200
SPW Members & Consultants & Advisors - 33 individuals removed	25
Contractors & Community Volunteers	24
Student Interns & Research Assistants - 1 individual removed	15
Prison Inmate	1
TOTAL	**1,195**

A demographic profile of the 1,195 CRDP participants indicated we were successful in including a diverse sub-group of the population by ethnicity, LGBTQI, age range, and consumer status. See *Table 28* for a demographic profile of self-identified project participants.

Table 28: *Summary Demographic Profile of the African American CRDP 1,195 Unduplicated Participants*

ETHNICITY	
African American/Black:	925
African	225
Afro-Caribbean:	6
Asian:	3
Haitian:	1
Latino:	10
White:	25
GENDER:	
Male: 38.1%	Female: 61.9%
LGBTQI:[1]	
4.8%	
AGE RANGE:	
17 - 82	
AVERAGE AGE:	
50 years	
CONSUMER, CLIENT, CLIENT FAMILY MEMBER:[1]	
50%	

[1]Individuals disclosed status either on a survey response or during group discussion; we believe the percent is much higher than what participants have disclosed.

Note: The unduplicated count includes participants from the following categories:

- 58 SPW members, consultants & advisors
- 24 contractors and community volunteers
- 16 student interns & research assistants
- 1 prison inmate
- 200 Banche Project survey participants
- 260 focus group participants
- 43 one-on-one, in-person in-depth interviewees
- 98 small group meeting participants
- 374 telephone, online, and consumer/client & family survey participants
- 188 public forum attendees

Table 29 is a summary of all project participants by resident county based on reported African Americans using the DMH services in Fiscal Year 2007 to 2008. Color coding in the table corresponds with the color coding in the GIS mapping (see *Figure 2a*) of the total African American population living in California. *Table 29* does not include counties where data was not available from the DMH on the African American population.

Table 29: *Summary of All African American CRDP Participants by Resident County*

County	SPW, Consultants & Advisors	Volunteers, Prisoner & Contractors	Student Interns	Phone & Email Surveys	Focus Group Surveys	Focus Groups	In-depth 1 on 1 Interviews	Small Group Attendees	Consumers, Client Client Family Member Surveys	Public Forum Attendees	Banche Project
Total[1]	58	25	16	70	260	260	43	98	305	188	200
Los Angeles	10	1	1	15	45	45	22	12	74	42	89
Alameda	8	7		6	27	27	3	17	12	3	14
San Bernardino	11	8	1	6	35	35	8	12	66	22	11
San Diego	6	1		7	43	43	1		13	11	20
Sacramento	5	1		5	27	27		1	24	10	3
Riverside	5	2	5	4	16	16	3		46	43	20
Contra Costa	2			4	7	7		2	4		5
Solano	1	1		1					14	14	
San Francisco	2	1		1			2		3	3	3
Orange	1			1					2		6
San Joaquin				1	8	8					
Fresno		1		1	5	5					10
Kern				1	8	8			1		3
Santa Clara	1			3				12	2	1	
San Mateo				2				2			
Stanislaus											2
Ventura	2			4	28	28		1	3	1	
Monterey				2					20	20	
Kings											
Merced				1					10		
Santa Barbara											
Sonoma							1	3	1		1
Marin				2			3		3	3	
Tulare											
San Luis Obispo											
Imperial									1		
Madera				1							
Placer										1	1
Yolo	1	1			2	2					2
Sutter/Yuba											
Butte	2			2	9	9			2		
Napa								1			
Santa Cruz											
San Benito									2	2	
Humboldt											
El Dorado									1	1	
Others[2]	1		9					35	1	10	10

[1]Total includes all participants in each category, including individual duplication across categories
[2]"Others" includes individuals who did not identify a resident county

Note: Color corresponds to the GIS map in *Figure 2a & 2b.* Excluded are counties where data was not available from DMH

Of the 58 counties in California, six counties are the home of 73% of the African American population (37.8% in Los Angeles; 8.7% in Alameda; 7.7% in San Bernardino; 6.5% in San Diego; 6.4% in Sacramento; and 5.6% in Riverside). An additional 19.5% of the population lives in 8 other counties (4.34% in Contra Costa; 2.52% in Solano; 2.20% in San Francisco; 2.19% in Orange; 2.15% in San Joaquin; 2.11% in Fresno; 2.05% in Kern; and 1.94% in Santa Clara). A total of 92.5% of the African American residents live in 14 of California's 58 counties.

Significant to the geographic disbursement of the African American population is the ability of our CRDP to reach and include the greatest number of people possible and to include regional variations. In the top 14 counties where 92.5% of the African American population lives, we secured 100% project participation (see *Table 29*). Of the 36 counties listed in *Table 29*, we successfully included participation from 28 (77.78%) counties; representing 106 different cities (see *Table 30*). Distribution of participants by our five project regions included 27.84% Los Angeles area; 26.81% Inland Empire; 25.30% Northern & Bay Area; 11.14% Central; and 8.91% Southern.

Table 30: *All CRDP African American SPW Participants by Resident City*

Antioch	Elk Grove	Monterey	San Francisco	Dublin
Adelanto	Encino	Murrieta	San Jose	El Cajon
Alameda	Fairfield	Newark	San Marcos	El Cerrito
Albany	Fontana	Newbury Park	San Pedro	Menifee
Alta Loma	Fresno	Newhall	Santa Ana	Mill Valley
Altadena	Gardena	North Highlands	Santa Clara	Mira Loma
Apple Valley	Harbor City	Novato	Santa Monica	San Anselmo
Athens Village	Hawthorne	Oakland	Seaside	San Bernardino
Azusa	Hayward	Ontario	Sebastopol	San Diego
Bakersfield	Hempstead	Oroville	Simi Valley	Moreno Valley
Baldwin Park	Hercules	Oxnard	Spring Valley	Downey
Beaumont	Hesperia	Pacific Grove	Stockton	Marysville
Benicia	Highland	Palm Desert	Suisun City	Salinas
Berkeley	Hollister	Palm Springs	Temecula	Hemet
Burbank	Hollywood	Pasadena	Union City	Davis
Chico	Inglewood	Perris	Upland	Marina
Chino Hills	Lake Elsinore	Pomona	Vacaville	Sacramento
Chula Vista	Larkspur	Port Hueneme	Valencia	Yucaipa
Colton	Lodi	Rancho Cucamonga	Vallejo	
Compton	Loma Linda	Rialto	Ventura	
Corona	Long Beach	Richmond	Victorville	
Dana Point	Los Angeles	Riverside	West Covina	

We were successful in reaching our projected 19 different categories of target specific participants (see *Table 31*) such as: African American citizens, Africans, clients & family members, consumers, faith community, grassroots organizations, homeless, forensics, LGBTQI, substance abusers, foster care, older adults, musicians, artist, youth (students), government officials, mental health providers, social workers, Black mental health workers, educators, teachers, and academics.

Table 31: *Interview Locations and Target Groups*

Richmond	Seniors 50 years and older, Consumers, Advocates, Providers
Oakland	Client Family Members & Consumers
Oakland	Transitional Aged Youth (TAY)
Oakland	Black Providers
East Bay Area	Adult Consumers, Client & Client Family Members
Alameda	Consumers & Client Family Members
San Jose	Consumers, Client Family Members, Providers, Advocates
Sacramento	Clients, Consumers & Advocates
Chico	Rural Client, Client Family Members & Consumers
Sacramento	LGBTQI
Sacramento	Foster Parents
Lodi	Providers & Client Family Members
Fresno	Providers & Client Family Members & Advocates
San Diego	Client & Consumers
San Diego	LGBTQI Gay Clients & Consumers
San Diego	African Immigrants & Refugee Consumers
San Diego	Advocates & Client Family Members
San Bernardino	Client Family Members & Advocates
San Bernardino	Clients, Client Family Members & Providers
San Bernardino	Ministers & Pastors
Palm Desert	Consumer & Provider
Bakersfield	Clients & Providers & Advocates
Victorville	Providers, Consumers & Advocates
Riverside	Transitional Aged Youth (TAY) College Students
Riverside	Providers & Advocates
Upland	Client Family Members & Advocates
Oxnard	Transitional Aged Youth (TAY) College Students
Oxnard	Family Members, Providers & Advocates
Oxnard	Consumers, Advocates & Providers, Northern Los Angeles
Anaheim	Consumers, Clients, & Client Family Members
Los Angeles	Skid Row Consumers & Clients
Los Angeles	Client, Client Family Members & Advocates
Los Angeles	Skid Row Residents – Homeless Clients & Consumers
Los Angeles	Black Los Angeles County Client Coalition (BLACCC)
Los Angeles	National Alliance on Mental Illness (NAMI-LA) Consumers
Los Angeles	Elected Officials
Los Angeles	Activist, artist, poets
Los Angeles	Black Provider
Compton	Black Providers & Client Family Members
Rialto	Elected Official
Inglewood	Client Family Member
San Francisco	Transitional Aged Youth (TAY) Client
San Francisco	LGBTQI Gay Advocate, Client Family Member & Business Man
San Francisco	NAMI-California Board of Directors & Client Family Member
Mill Valley	Provider & Activist
San Anselmo	Provider

A significant factor for participation in the CRDP was inclusion of diverse representatives of consumers, clients, client family members, males and females, LGBTQI and age groups. *Table 32* displays summary participant demographics across all data sets. Over 50% were consumers, clients, or client family members. However, we believe that many people did not identify as consumers because of shame and stigma. Average age was 52 years, with a range between 17 to 82 years. Gender representation was split 62% females and 38% males. Many LGBTQI individuals did not self disclose, but there were 10% of the participants who chose to identify. Other personal demographics were not requested, so as not to create barriers for participation.

Table 32: *Summary of Participant's Demographics by Each Method of Participation*

	SPW, ADVISORS & CONSULTANTS	PHONE & EMAIL SURVEYS	FOCUS GROUP PARTICIPANTS	IN-DEPTH 1 ON 1 INTERVIEWS	SMALL GROUP ATTENDEES	CONSUMERS, CLIENTS, CLIENT FAMILY MEMBER SURVEYS	PUBLIC FORUM ATTENDEES
Totals	**58**	**70**	**260**	**43**	**98**	**305**	**188**
Gender:							
Female	72%	70%	53%	46%	59%	68%	68%
Male	28%	30%	47%	54%	41%	32%	32%
LGBTQI[1]	1%	NA	9%	2%	13%	5%	3%
Age Range	28 - 73	NA	17 - 81	29 - 81	NA	18 - 82	18 - 82
Average Age	54	NA	46	56	NA	51	52
Consumer, Client & Client Family Member	57%	NA	69%	42%	65%	47%	35%

[1] Self-identified lesbian, gay, by-sexual, transgender, questioning/queer, and intersex
NA = Did not ask for information

GIS Mapping Demographic Survey: Banche Project

The *Banche Project* is discussed in detail in Section B, page 33. In Phase I, we conducted a simple mapping project to identify people of African ancestry by county, country of origin, and cultural identity living in California for inclusion into the CRDP. The purpose of the *Banche Project* was exploratory to discover locations of the target population.

A total of 200 individuals completed a nine question demographic survey (Appendix A). There were 11 African cultures identified (see page 36), of which the top three were Ethiopian, Nigerian and Eritrean, see GIS Map of county cluster locations (page 38). In the sample population, 85% of African people lived in Los Angeles, Riverside, San Diego, and Alameda Counties. No generalizations are drawn from this simple study. The intent was to locate diverse African people for inclusion in the CRDP. See *Table 33* for the different self-identified cultural groups of participants in our data sets.

Identifying Ethnicity of Participants in All Data Sets (N=1,195)

We asked all project participants to self-identify ethnicity. This was a write in question, which gave participants the opportunity to express what they believed to be their ethnicity. Some individuals verbally responded to the question **when asked** in the focus group discussions. Nearly, all identified with the words "African American or Black" except for those born on the Continent of Africa. They identified with their country of birth. Of particular interest is that people identified themselves with 34 multiple mixed ethnic groups, irrespective of physical features (see *Table 33*). Many research studies report that within the Black American population, physical features do not always inform as to how people *feel about* who they are. It is always safe to ask, how one wants to be recognized *within the Black population.* For many asking a Black person about their heritage allows for identification with family members that are loved and respected irrespective of physical features. Other participants in our CRDP identified their heritage as Afro-Caribbean, Asian, Latino, Afro-Latino and White. How one perceives self is critical to one's worldview, self-identity and socialization, as well as "fit" and a sense of connectedness and belonging.

Table 33: *List of Self-Identified Ethnicities by Participants in All Data Sets*

African American	Irish, Indian, African American
African American Scottish	Geechee, Creole, Black African American
Black Sioux, Born Rosebud South Dakota	American Indian Black
African American, Cherokee, Dutch, Irish	Black, Indian, White, German
Polynesian Native American, African American	Black French
Egyptian, Indian, African American	Black, Irish, Cherokee Indian
Filipino Black	African American Cree
White African American	African American Cherokee Indian
Cheyenne African American	Black, Native American (Blackfoot & Cherokee)
Afro-Cuban	Ugandan
Latin Black	Eritrean
Black, Indian, Portuguese	Kenyan
Creole Indian Irish Black	Burundian
Black American, Native American	Sudanese
Creole, Cherokee Indian, African American	Ethiopian
United Kingdom (English), African American	Afro-Latino
Cuban Black	Nigerian

DATA SET #1 – REGIONAL SURVEY RESULTS

Survey #1: Telephone Survey

A total of 66 telephone surveys were conducted, see below, of which 71% (47) were females; 28.8% (19) males. SPW members called county staff, providers, community organizations and leaders in each region to determine in their ***"opinion"*** or perception, were there any programs in their county they believed were designed specifically for the Black population. Several calls and call backs were made with the attempt to obtain information. Telephone responses were entered on a matrix, and manually extracted. Of the responses received, nearly 50% of the respondents could name at least one program in their region. Actual programs are listed in *Table 54* (in recommendation section). The assessment was to determine the PEI landscape and progress toward "intended" efforts targeting the population as identified in each MHSA County PEI Plan. The survey was conducted from November 2010 to February 2011. Program contacts were obtained for more in-depth inquiry related to specific targeted county PEI efforts toward the population, such as, *"What is the name of the program or intervention?" "What is the focus of the program or intervention?" "What successes have been obtained?"*

PARTICIPANT RESPONDENT CATEGORY	TOTAL
Ethnic Services Managers (ESM)	25
Community-based Organizations (CBO)	21
County/State MHSOAC	12
Providers	4
Community Leaders	4
Total	**66**

Respondent's responses to survey questions:

In your opinion, are you aware of current programs or interventions in your region that are tailored prevention and early intervention (PEI) for the African American population? (N=66)

Yes : 31 No: 4 Will Call Back: 31

When follow-up calls were made to the program contact person, 30 programs were identified: only 20 were actually tailored or designed specifically for the Black population. The tailored programs as described used principles of Black culture, values and practices, such as family unification, rites of passage, spirituality and faith to name a few. Programs focused on the needs of Blacks in developing positive like skills. However, of the 20 tailored programs, **12 (60%) were sponsored by community efforts not funded by the county DMH**. We believe this list is not complete. Several individuals contacted promised to send information or email information, but up to the completion of this report, no other information has been received.

Survey #2: Email Survey Results

The instrument used to solicit responses for emergent and promising practices for African Americans was created by the SPW, as described in D2: Phase II (pages 132-133) of this report. Email responses back from the survey were almost non-existent. **We received only 4 responses; see below.** The email survey was administered in January, February, and March 2011, and was sent to over 900 individuals and organizations by email. Respondents also had the option to return completed survey by fax or mail. Upon return of survey, data was manually extracted. Responses are listed below:

PRACTICE	COUNTY
The Village Project	Monterey County (funded by MHSA)
Skid Row Resident Positive Movement	Los Angeles County
African American Community Action Coalition	Ventura County
Progressive Life Center	Out of State (Baltimore, Maryland)

All respondents recommended practices targeting the African American population across the lifespan, and used approaches based on cultural values, practices and norms.

No demographic information was requested of the respondent, only name and contact information.

Respondents were split, 50% female and males. One was a county manager, and three were community-based leaders or organizational executives, of which one was from the State of Maryland. Community practices listed included in Table 54 (recommendation section) and presented in detail in the Case Study section (page 195) of this report.

Survey #3: Focus Group Participant Survey Results

Of the 260 focus group participants who initiated survey administration, one did not complete, and was excluded. Focus group participants, with one exception, were all over 18 years old; see *Figure 34* for percent in each age group. The one exception had the consent of a guardian to participate.

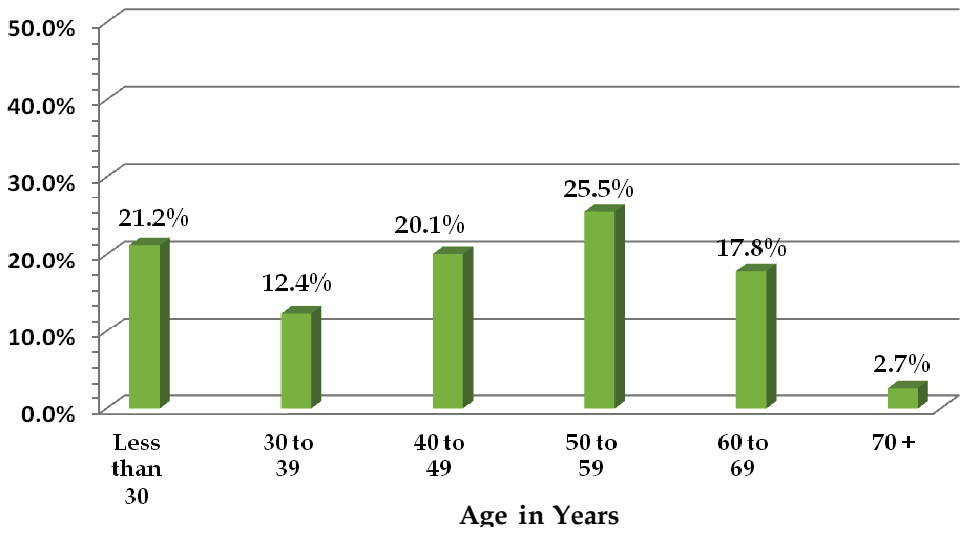


Figure 34: *Focus Groups Percent of Participants per Age Category, 260 Participants*

Below are the results of the individual surveys:

- All identified as having African American or African heritage, at least in part
- 38% had sought mental health services within the past two years
- 54% indicated African American mental health providers were their first choice
- 38% of participants indicated that they had no racial or ethnic preference in mental health providers, although many indicated a desire for cultural competence

Responses to questions about mental illness:

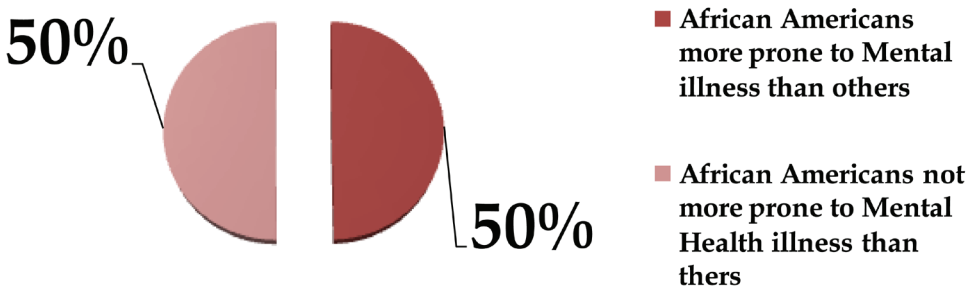


Figure 35: *What did the participants believe about mental illness?*

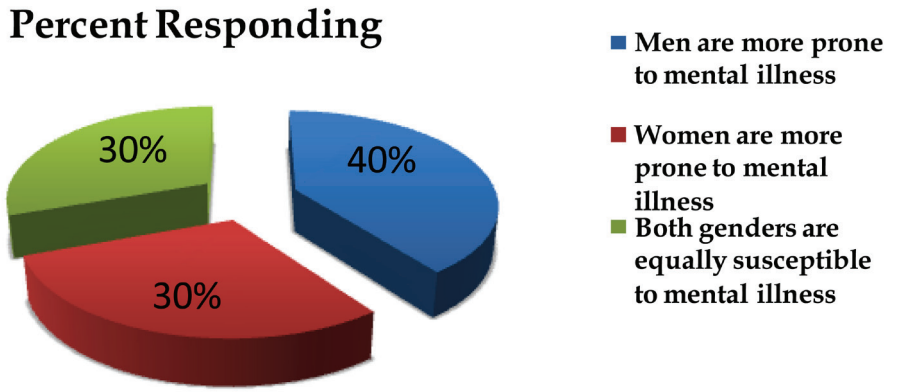


Figure 36: *What did the participants believe about who in the African American community is more prone to have mental illness?*

Table 34: *What did respondants state was their first choice for mental health help by males and females?*

GENDER	PROFESSIONAL HELP %	FAMILY, FRIEND, EMPATHETIC OTHER %	SELF, NO ONE %	GOD, CHURCH, SPIRITUAL PRACTICE %
Males (121)	47%	29%	4%	11%
Females (138)	41%	34%	3%	14%
Transgender (2)	(1)		(1)	

Note: One transgender marked female but indicated "transfer going to male." Total count is 259.

Although no age group indicated an overwhelming preference (over 50%) for professional mental health providers, those between 30 and 70 were most likely to indicate mental health professionals as their first choice. Among those over age 70, 50% indicated their first choice was for a spiritual practice of some sort.

Survey #4: Consumers, Client and Client Family Member (CCCFM) Survey Results

A total of 305 individuals completed the CCCFM survey (*Appencix G*). The instrument was a one page self-administered survey containing demographic questions and 3 simple questions about perception of mental health issues in Blacks with write in response options. The survey was created in this manner to give the participants the opportunity for self expression, and not to limit choices as with closed-ended questions and response options. The CCCFM was administered in all group public meetings after March 24, 2011.

The data was entered into an Excel spreadsheet for organization, storage, and analysis. Written responses were manually extracted and analyzed according to frequency of occurrences. Nearly 50% of respondents identified as a consumer of mental health services or a family member. We believe the number of consumers is higher than 50% because people did not identify, most likely due to shame and or stigma. Participant's ages ranged from 18 to 82 years with an average age of 51 years. See demographic profiles below, and *Figure 37*.

Females	68%
Males	32%
LGBTQI	5%
Consumers, Clients, Client Family Members	47%

Figure 37: *Consumer, Client, & Client Family Member Survey Participants by Age Category, 305 Participants*

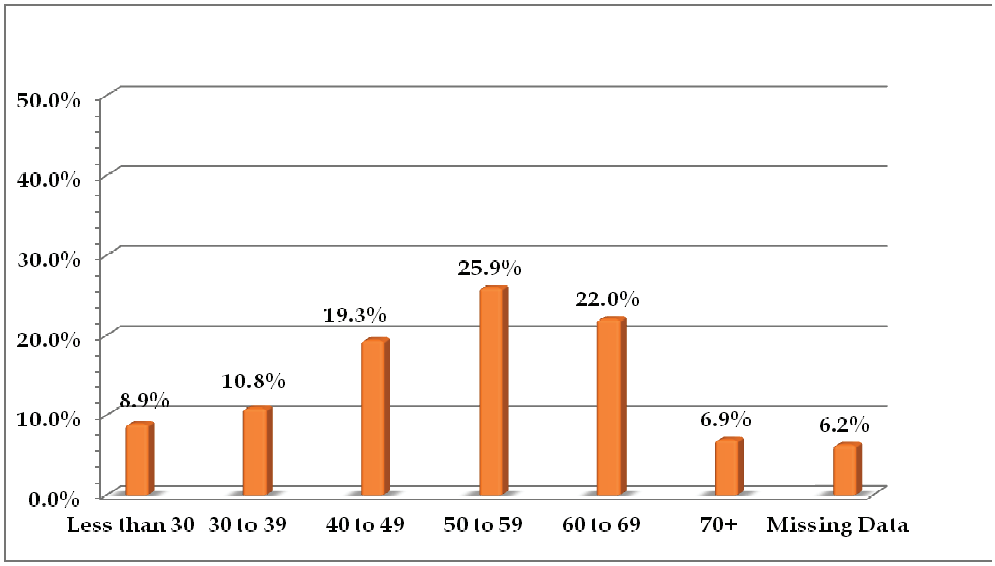


Table 35 identifies the most commonly stated mental health diagnosis that client participants believed they were "given" or, that a specific family member was "given." Most participants commented that assessments were not done, or were incomplete or inaccurate. The diagnosis they felt, were "labels" given by the practitioner to put into the record for reimbursement purposes, not because it was the real problem. Participants were very vocal about the system just wanted money and not really cared about the clients. The list is not arranged in rank order, but the top four conditions received the highest responses (bipolar, schizophrenia, drug addiction and depression).

Table 35: *Most Common Mental Health Diagnoses Identified by Participant Consumers, Clients, and Client Family Members*

Bipolar	Suicide Ideations
Schizophrenia	Anxiety
Drug Addiction/Abuse	Oppositional Defiant Disorder (ODD)
Depression	Psychosomatic Illnesses
Alzheimer	Reactive Attachment Disorder
Eating Disorder	Alcohol and Other Drugs (AOD)
Brain Disorder	Obsessive Compulsive Disorder (OCD)
Post Traumatic Stress Disorder (PTSD)	Attention Deficit Hyperactivity Disorder (ADHD)

In response to what participants felt were major mental health problems for Blacks, 48% identified a particular diagnosis, as listed above; others responses related to individual, environmental and/or systems problems.

When asked about the solutions to the identified problems, 70% responded and identified three solutions each (627 solutions); 20% identified two solutions each; others did not answer. Of those solutions identified the **combined description below best represents** prevention and early intervention categories:

- Adequate screening with early intervention
- African American family revitalization
- Culturally proficient positive programs and interventions specifically identified by local communities, with peer to peer support and counseling; and employing "survivors" to sustain programs
- Mass culturally proficient outreach and education on multiple levels (individual, community, system)
- Community support network that include collaboration with faith, family, culture centers, and empowerment groups
- Highly trained, culturally appropriate African American providers
- Valued community resources
- Individual help seeking behaviors
- Development programs
- Funds directly to the Black community and organizations
- Alternatives to jails, prisons and hospitals
- Mental health first aid
- Wholistic family-based community approach

Data Set #2: Regional Focus Groups Results

Focus group participants included mental health consumers, care givers/ family members, and mental health service providers. We conducted focus groups for a number of reasons. First, because of historically low response rates, lack of stable mailing addresses and unknown literacy levels, the team believed that surveys or other self-administered means of data collection would not work for mental health consumers. Second, because one-on-one interviews with mental health consumers can be quite challenging, depending on the individual, the research team believed that focus groups would provide a more comfortable and less-threatening venue for individuals to share their experiences with the mental health system. Third, the literature indicates that focus groups allow for interaction between participants, and the team hoped that these interactions would spur the recollections of the participants about experiences they might not have recalled on a one-on-one basis. This is especially important because of the suppression of memory that occurs with some treatment modalities. Fourth, focus groups allowed for the research team to contact more participants of varying types (consumer, caregiver, and provider) with limited resources than would have been possible with individual interviews.

Thirty-five (35) focus groups were conducted throughout the state of California (see *Figure 38*), with a total of 260 participants, see *Table 29* for geographic distribution. The focus groups took place from August 2010 to November 2010 (see *Table 37* for the meeting schedule). The distribution of the focus group participation by three California regions is presented below in *Table 36*:

Table 36: *Distribution of Focus Group Regional 260 Participants*

CALIFORNIA REGION	# PARTICIPANTS	% OF TOTAL PARTICIPANTS
Southern California (San Diego, Orange, San Bernardino, Riverside, Los Angeles, & Ventura Counties)	166	64%
Central California (Kern, Fresno, & San Joaquin Counties)	21	8%
Northern California (Alameda, Contra Costa, Sacramento, & Butte Counties)	73	28%

Table 37: *Final Focus Group Schedule*

DATE	LOCATIONS & ADDRESS
August 13, 2010	Richmond – Sojourner Truth Presbyterian Church
August 15, 2010	Oakland – Executive Inn & Suites Lighthouse Room
August 16, 2010	Sacramento – Natomas Park
August 16, 2010	Sacramento – Natomas Park
September 28, 2010	San Diego –Karibu Center of Social Justice and Education
September 28, 2010	San Diego – United African American Ministerial Action Council
October 5, 2010	San Bernardino – Knotts Parenting & Family Institute
October 5, 2010	San Bernardino – Knotts Parenting & Family Institute
October 6, 2010	San Diego – San Ysidro Comprehensive Health Center: Our Place
October 6, 2010	San Diego – Pazzaz, Inc.
October 16, 2010	Chico – Bethel AME Church
October 17, 2010	Sacramento – Sophia Restaurant
October 17, 2010	Sacramento – New Millennium Foster Family Agency
October 18, 2010	Lodi – Lodi Police Station Community Room
October 21, 2010	Fresno – African American Museum
October 23, 2011	Bakersfield – Grater Bakersfield Legal Assistance
October 25, 2010	San Diego – Alliance for African Assistance
October 27, 2010	Victorville – Cantrell Learning Center
October 28, 2010	Oxnard – Oxnard Community College
October 31, 2010	Oxnard – Life Skills African American Reading Room 213
October 31, 2010	Oxnard – Life Skills African American Reading Room 213
November 2, 2010	Oakland – First Place
November 3, 2010	Oakland – Bonita House
November 3, 2010	Oakland – Alameda County Children's Behavioral Health
November 4, 2010	Los Angeles – SHARE! Downtown LA
November 4, 2010	Los Angeles – SHARE! Downtown LA
November 11, 2010	Riverside – UCR Department of Psychology
November 11, 2010	Riverside – The DuBois Institute
November 14, 2010	Los Angeles – United Coalition East Prevention Project
November 14, 2010	Los Angeles – United Coalition East Prevention Project
November 15, 2010	Upland – The Grove Theatre
November 15, 2010	San Bernardino – Inland Behavioral Health Services
November 17, 2010	Los Angeles – SHARE! Downtown LA (BLACCC)
November 17, 2010	Los Angeles – SHARE! Downtown LA (NAMI)
November 20, 2010	Alameda – Client Family Member's Home

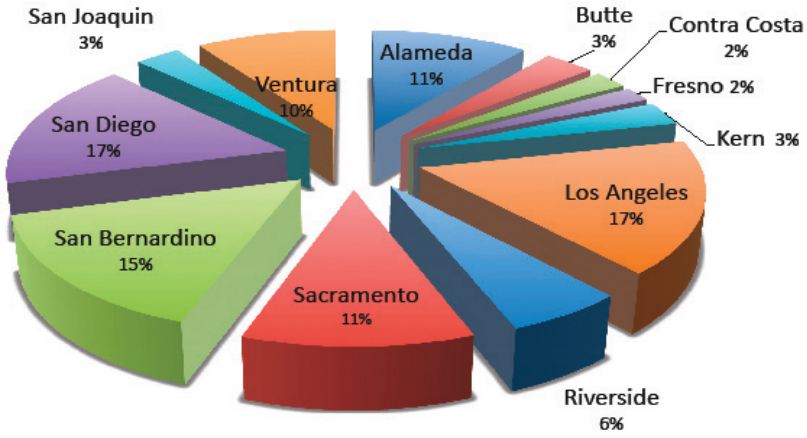


Figure 38: *Focus Group Participants by County*

Focus group participants, with one exception, were all over 18 (age range 17 to 81 years; average age 46; representing 53% females and 47% males). The 17 year old had the consent of a guardian to participate. Although four focus groups took place in agencies that directed their services to LGBTQI African American audiences, not all participants in these groups chose to self-identify (approximately 10% identified that they were LGBTQI or that they affiliated with this population); there were LGBTQI individuals present in other focus groups. Nearly, 70% of focus group participants identified as a mental health consumer, client or client family member.

All focus group participants had the study purposes and methods explained to them, and they completed consent forms and a short individual survey prior to the focus group. The focus group instrument is included as *Appendix D*. Generally, focus groups lasted approximately two hours, and ranged from 3 to 12 participants.

Focus groups were either audio or videotaped. The first 15 focus groups were videotaped, but after reviewing the tapes, it was determine that the extra expense of videotaping did not provide enough additional information to warrant the substantial expense, and subsequent focus groups were audio taped only. The video and audiotapes were transcribed verbatim, and both audio and video data were entered into *NVivo9*, or ATLAS ti, or SPSS for analysis, as well as manual extraction.

Transcriptions were triple checked for accuracy by three different independent transcription groups. Each focus group was reviewed by five members of the analysis team, with the identification of significant themes and responses to the focus group questions noted independently by each team member. Each analyst presented written reports on their findings with recommendations. Team meetings were conducted with all analysts to review and discuss results. Final recommendations for inclusion in the CRDP report were decided in a group data interpretation meeting that included 7 client and client family members, the 4 CRDP writing team members (2 are client family members and one is a consumer), 5 data analysts, and 2 community representatives.

Focus Group Analyses

Focus group analyses consist of 31 focus group transcripts, and data collected from one group meeting (African American Caucus, Anaheim) transcript and one group meeting (LGBTQI caucus, Anaheim) field notes. The average length of time for each meeting was two hours. Of the original 35 focus groups scheduled, one was a now show. The remaining 34 audio and video tape transcripts were returned from the contractor and double checked for content validity. Three transcripts were unable to be checked for content validation because the tapes were damaged, and therefore eliminated from the final analyses. The three final transcripts submitted from the contractor contained multiple transcription errors that could not be corrected. The second digital backup recordings for the three transcripts in question mal functioned and was too costly and time consuming to repair in order to extract the data. Therefore, the final focus group data set consist of 240 participants. The analyses consisted of the 240 focus group participants and the 56 small group participants; **a total of 296 participants**.

General Procedure

All analysts used grounded theory qualitative data analysis procedures, which consist of coding the data and identifying emergent themes. One analyst used ATLAS-ti software; others used manual extraction with SPSS and Excel spreadsheets for data organization. As a result of technical problems the NVIVO9 software was not used. For those analysts who did not use the ATLAS-ti, general procedure consists of reading the transcripts at least four times. The first reading was to get an overall feeling of the group conversation. The second reading was done in order to develop a coding scheme. The third reading was an attempt to immerse the data to identify key emergent themes. Subsequent readings were to confirm and verify the identified themes, to uncover underlying broader general principles, and to reduce the data into relevant categories for content interpretation. In addition, data analysis included reviewing the actual audio and video recording to observe group interactions and dynamics.

Guided by our social ecological theoretical framework for the focus group that considers the complex interactions (mesosystems) between macro and micro-level factors (i.e., individual, family community and societal factors), we could therefore examine the participants' understanding of mental health and the factors that may mediate access and utilization of mental health services. Participants described their own mental health experiences; their involvement with the treatment services and what they felt needed to be changed to improve the service delivery for African Americans, and the best approach to prevention and early detection.

To ensure that the focus group analysis captured the sentiment of the participants, we also analyzed data from community forums as well as public responses to the draft CRDP report posted online for the 30-day public review.

ATLAS-ti Procedure

The ATLAS-ti is qualitative analysis software used to uncover and systematically analyze complex phenomena hidden in text and multimedia data. This tool can locate, code, and annotate findings in primary data material, weigh and evaluate their importance, and visualize complex relations between them. After central themes are identified, the tool makes connections between themes and their quotes. It shows associations between coded themes and provides sophisticated views of the coded scheme. ATLAS-ti allows one to focus attention on parts of the dataset the researcher has identified as key themes for which to examine. All 31 transcripts were loaded into ATLAS-ti for analysis. Three primary themes were identified.

Overall Focus Group Analysis Outcomes

Results are reported as aggregate findings on all 296 participants responses in the final transcripts (n=240) and small group participant (n=56) responses. See *Table 38* demographic profile of final focus group data set. The majority participants were females (54%). Of those who shared their age, the average age was 44 years.

Table 38: *Demographic Profile of Final Focus Group Data Set*

	FOCUS GROUP PARTICIPANTS 240	PERCENT OF PARTICIPANTS	SMALL GROUP PARTICIPANTS 56^	PERCENT OF PARTICIPANTS	TOTAL 296	
FEMALES	125	52.1%	33	63.5%	158	54.1%
MALES	114	47.5%	16	30.8%	130	44.5%
TRANSGENDER	1	.04%	3	5.8%	4	1.4%
AGE RANGE	17 - 81		NA			
AVERAGE AGE	43.89		NA			

^Small group meeting participants do not equal 56; 4 individuals did not identify gender.

Each person in the focus group was asked how they wish to be recognized in the final report (example: name, title, group affiliations, etc), including if they identified with the LGBTQI population. See *Table 39* below of those who identified as consumer, client or client family member, as well as LGBTQI.

Table 39: *Participant Self-Identification as Consumer, Client or Family Member, and LGBTQI in Final Focus Group Data Set*

	TOTAL PARTICIPANTS 296	PERCENT OF TOTAL PARTICIPANTS
CONSUMER, CLIENT OR FAMILY MEMBER	201	67.9%
LGBTQI	36	12.2%

During data analysis, six major categories emerged with three overarching themes. The categories were: (1) defining mental illness, (2) defining mental wellness, (3) causes of mental health problems, (4) barriers to access/ineffective practices, (5) helpful/useful practices and (6) specific recommendations. Overarching themes identified were competency, connectedness and consciousness.

ATLAS-ti coded percentage of themes revealed **competency** at 38% (748 quotes); **connectedness** 24% (470 quotes); and **consciousness** 39% (770 quotes), see *Figure 39*.

This suggests that when discussing the context of mental health for this population these characteristics are paramount in our understanding of positive functioning. Positive functioning is essential to the concepts of prevention; it could be viewed as a map for individual reality. And, if lost the map can get one back to where one was. Positive functioning indicators could provide points of intervention when symptoms indicate unhealthy functioning.

Each focus group had a unique story and within focus groups there were individual stories. Consumers told their stories from their hearts and with passion as they described their lived experiences in the encounters with the mental health delivery system. Professionals and paraprofessionals told their stories from their heads as they described the system and its impact on consumers. For example, mental illness was defined by an inability to cope, function, thrive, or fit in. Erratic behavior, disheveled appearance, poor hygiene, hearing voices, and being incoherent to others are other symptoms. Being out of balance, off center, and outside the norm further describe mental illness. Mental problems are detected in the behavioral changes or patterns of those affected. Terms used to define mental illness relate to deficiencies or deviation from normal human behavior. Mental illness is placed in the context of not being able to control ones actions, not being able to think or behave normally, not knowing when ones behaviors are erratic, masking mental illness through false appearance/ mannerisms, and substance abuse/self medicating.

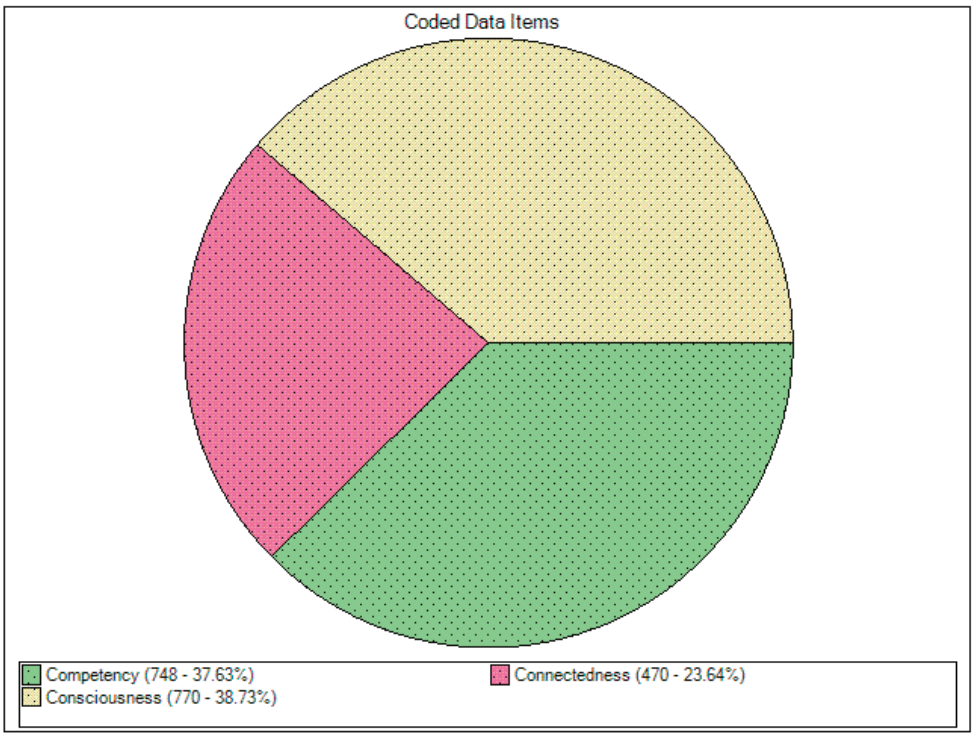


Figure 39: *ATLAS.ti Coded Themes*

Mental health was viewed as components of connectedness, competence, and consciousness. Connectedness was coded as familial, friends and community. The latter included institutions, community members, students/teachers, health professionals, or other members deemed important to interpersonal well-being. Competence was coded as educational training, daily functioning, and decision making. Consciousness was coded as comments regarding examples of spirituality, race and ethnicity, and group survival within the home, community, work, school, or institutions. This analysis examined *"What do Black people say they need in order to have good mental and behavioral health?"* And *"What do Black people identify as community practices they believe will help them get the help they need?"*

One of the three basic motivating principles of social behavior is the need to connect with others. Social belongingness, intimacy, affiliation, or maintaining a social contact speaks to the value of **connectedness**. Several participants shared information about how mental health is perceived within their communities. Participants shared the importance of "connecting with others" as friends, family and key members in their communities for healthy functioning.

Competency is a general repertoire of skills required for effective human functioning. This cultural analysis suggests that for African Americans their competency may be challenged when operating within a different cultural reality. Inherent in psychosocial competency is an individual's belief in his or her ability to function effectively with a sense of control (self-efficacy) in adaptive coping responses; associated with lacks of control. Participants shared the importance of making *"reasonable and appropriate decisions"* for everyday life (competence).

Consciousness at its basic level features the interplay between perception and conception. Perceptual consciousness is the process of attaining *awareness* or *understanding* as experienced through the senses. Consciousness is the state of awareness of internal and external activities. The revealing of one's conscious understanding occurs when the individual can perceive the outcome of the desired result based on act or thoughts. Participants shared the importance of "knowing who they are" as a spiritual racial/ethnic group (consciousness).

Emergent themes described and explained the way in which the meso-systems interact to contribute to the existing mental health disparities among people of African ancestry. Within the emergent themes were suggestions for remediation of the mental health delivery system to enhance greater access and utilization by African Americans. Focus group participants were clear in articulating 274 helpful practices and recommendations that would improve and enhance the existing mental health system, as well as assist in the prevention and early intervention of mental illness.

To reduce our data, we have presented themes with significant supportive quotes in *Tables 40-45*; followed by a summary description of emergent themes (see *Table 47*); and lastly a list of community practices, strategies and resources for prevention and early intervention in the Black population, see *Table 54*.

Table 40: *Question: What do African Americans consider "good" mental health?*

THEMES	RESPONDENT'S COMMENTS
Sound Moral Foundation & Being Self-mastered	*"I think being in control of yourself, regardless of the circumstances they're in and the very strong side of mental health, confidence, uh the ability to interact with different kinds of people and different settings."* **-FG #17: Byron, 63 year old male volunteer, Oxnard**
Responsible	*"Someone that's responsible. Goes to work every day and take care of family and stuff like that."* **-FG #5 Michael, 45 year old male, concerned citizen Karibu, San Diego**
Sharing	*"I think for me it's um when people are able to give back to others and they're able to support other people. And so to me that shows a healthy person. It is not always about themselves. It's about being able to give and to be able to support other people from where they're at. So that's kind of the standard."* **-FG #10: Sharon, 53 year old female, The Children of Promise New Millennium Foster Agency, Sacramento**
Independence	*"You have to be able to be independent. Do things on your own. You have to be able to pull your house all together, maintain a job."* **-FG #9: Mona, 43 year old female, mental health client & advocate, Chico**
Connected	*"I get there are three kinds of connections that are equally important. Any you have to have at least one in order for anybody to be mentally healthy and ah the first connection is with the family, you know um family connection. Then you have a community connection and you have a spiritual connection. And I think that if a person has any of the three they can be okay."* **-FG #3: Nassiba, 43 year old female African Muslim, Sacramento**
Self-Love	*"Loving myself when I know nobody else around is gonna do it. Not judging myself, being my own best friend."* **-FG #2: Khara, 33 year old female mental health practitioner, Oakland**
Hopeful	*"You know just being hopeful and keeping faith."* **-FG #4: Clarence, 51 year old male, Director of Group Home, Sacramento**
Functioning	*"Attention to things when we are in a very good mood. When our brains at work. That when there are some hindrances that come into our mind and we end up sabotaging the plan that we already have in place. So, mental health in this regard would probably mean especially we can be able to do stuff without sabotaging the plans that were laid out."* **-FG #15: Gerald, 27 year old Ugandan male Case Manager, San Diego** *"Ability to reason, be stable, coherent and function."* **-FG #33: Charyce, 54 year old female advocate/servant, San Bernardino County**
Coping	*"I feel its being able to cope with the different situations you're put in during life."* **-FG #17: Marcus, 19 year old male college student, Oxnard**

Community Practices

Table 41: *Question: What practices do Blacks say help them to have "good" mental health?*

THEMES	RESPONDENT'S COMMENTS
Natural Support System God Family Friends	*"I, I would have to say ah I go to my spiritual side as far as support would be when something is wrong or I'm feeling bad, I go to God. That's just what I do and then my church family is a great support system."* **-FG #5: 65 year old same gender loving (SGL) female Executive Director, San Diego** *"I'm gonna say God and my closest friends and my children. .... they are my support system. Just in case something happens they always there. ... to God, that's my Lord."* **-FG#12: Angela, 41 year old female foster mother & advocate, Lodi** *"For me, first of all it's God. My, my faith and my beliefs and that come from my family."* **-FG#22: Jennifer, 67 year old Executive Director, Riverside** *"Ninety-nine percent (99.9 %) I always go to God first. God has always been able to get me where I needed to go no matter what it is to organize my mess so that I can deal with it."* **-FG #11: 46 year old same gender loving (SGL) male , Sacramento** *"Aunt was on drugs, went to a foster care. She came to live with us and my mom took care of her. Now she is off medication and living independently, all because of my mom – not those who were to be helping her. The family is always a good support system"* **-In-depth Interview: Crushow, 33 year old Black male artist , City of Los Angeles Skid Row resident, Los Angeles** *"Enhance the spiritual being by dealing with the "effects" of post traumatic slavery. We must replace that which was taken."* **-In-depth Interview: 65 year old Black male physician, Los Angeles**
Positive Role Models	*"Create a model to incorporate family values for children. The model is cracked. Family values for African Americans have changed dramatically, and children have to observe a good model."* **-In-depth Interview: 56 Black female Client Family Member, NAMI-Urban, Los Angeles**

Family Settings	*"When there is a mental health situation, what helps the most, I think it's being around people you trust."* **-FG #20 Naeema: 34 year old female diagnosed: schizoid effective, Oakland** *"You know... in our culture, Black culture, grandma get sick, grandpa gets sick, stay in the room, nobody knows about it. We take care of them. We don't send them off to rest homes or mental institution and things like that...also, we need to find them better help. Better help is with other Black doctors, other Black people who can relate to them more than what a White doctor can because a lot of the things is dealt with ethnicity. You know because they handle their problems in certain ways. We hand ours in certain ways and I don't think, I don't see that changing anytime soon. And, I don't see really what..., uh White psychiatrist could tell me about me when they wouldn't know where to begin about me, okay."* **-FG#29 Gary: 51 year old Black male, family with issues, San Bernardino**
Prevention	*"...More help from wellness and um, working through issues instead of um, just putting a band aid on them. Because uh, the band aide has to be changed...."* **-FG#32 Sabirah: 38 year old Black female diagnosed with severe depression, family with mental issues, Alameda** *'You know, I think some people just need somebody to talk to. Somebody to listen to and somebody who is not looking down they nose at you, but are really trying to, you know help you live a better life."* **-FG#32 Lynda: 60 year old Black female, 35-year caretaker of son with developmental disabilities, Alameda** *"...give you tools to cope with it when it starts arising, instead of popping pills all the time."* **-FG#32 Rory: 50 year old Black male, Skid Row Los Angeles** *"...Holding up signs and stuff. Going in some of these, you know, bad neighborhoods, and stuff. Shutting down some of these liquor stores."* **-FG#19 Marcus: 23 year Black male TAY, Oakland**
Freedom from Micro-aggressions	*"That's why I'm saying that overall racism ah affects all levels of, of, of poverty but even when you have money, racism is still there. And, one of the things about racism, it's so irrational and it's so inexplicable. That you, you go to bed with it. You wake up with it. You wonder why it affects you. I mean you can have all kinds of education. You can, you know live in a "good" neighborhood. You can...all the things that marry... America says is proper and there still that discrimination and racism and that affects your psyche. You know, we have high blood pressure and all kinds of ailments because of the fact that ah you know we live in a racist society. And, I don't know what we can do about that um either collectively or individually. Other than, you know do what we've done what we've got away from, or what we used to do. As she said, be more of a community."* **-FG#1 Sonia: 70 year old female attorney and mediator, Richmond**

Positive Systems Interaction for Participation	*"Well you know it's difficult cause see I think for the doctor's part first like Linda was saying, y'all crazy so now as a doctor, as a doctor I've got to take some advice or advice from a person I'm really don't think is competent."* **-FG #22 Manuel: 61 year old Filipino Black male, artist diagnosed bipolar/crazy, Skid Row Los Angeles** *"Well that is not the traditional model with American medicine. American medicine basically is you have a demigod who makes pronouncements from up high and you simply follow instructions...Again, keep in mind that if you are on public assistance with respect to your needs medically and mentally, you are not considered to be capable of engaging with the doctor in a full scale discussion of problems that you have. Because you are not recognized as having the capacity to understand the situation in which you find yourself. Once you are classified as crazy, no one has to listen to anything that you have to say."* **-FG#22 Will: 68 year old Black male, diagnosed depression, Skid Row Los Angeles** *"Well, I guess as a though, I really would like to have here like a menu, when you go in for therapy, you have a menu. Okay, I want some shock therapy, maybe some medication, a little group action. You know, give me a range for other doctors and then let me pick and choose what I think is gonna work for me."* **-FG#22 Don: 61 year old Black male diagnosed bipolar, Skid Row Los Angeles** *"And compassion...some people got this job and their job is not to be compassionate with me. Their job is to come to work every day and to um, oh look at the time... not interested... you know that's what a lot of them do...ain't got time to talk to you."* **-FG#22 Linda: 49 year old Black female diagnosed clinical depression/neurophibroma, Skid Row Los Angeles**
Cultural Compassion	*"I feel out of place and disrespected because you're going off my skin color and that's not right. Cuz' I could be this color and be Black as hell. If both my parents is Black, I just came out light skinned with long good hair. I feel like that's stereotyping. If you wanna know what I am, ask me. Are you this? Are you that?"* **-FG#19 Erica: 20 year old Black female student social worker, TAY, Oakland**

Table 42: *Question: What constitutes poor mental health functioning?*

THEMES	RESPONDENT'S COMMENTS
Post-traumatic Stress Disorder	*"My experience with ah my first ah real maybe knowledgeable experience with my brother-in-law. So he was in... the bedroom and so he said someone is in curtains and he would like um he would set the bed on fire and he would say wow you know someone came in and did this and so he was experiencing mental, very deep mental problems and I would wake up and he'd be standing over my bed and he says I need you to get up now and come and help me."* **-FG#16: Mattie, 67 year old female, Victorville**
Problems Caused by Drugs	*"So, me dealing with different types of street people um..a lot of the times I feel like mental health problems comes from drugs or being under the influence. And not only that, by over the counter drugs that's being sold as street drugs to young, you know developing brains and brains already developed. A lot of the times we don't know how it's gonna react on their brain cells right. So a lot of the times it's really being sold to minors, which still have developing brains. And the medicines are strong so they taken this medicine that street drugs and it's making them crazy, it's making them coherent, it's making them delusional, they seeing extra things and they don't see it."* **-FG#14: Brannish, 20 year old female client, Bakersfield** *"But now if you got individuals that were, you know, um, you know born from, you know parents that were, you know ingesting different types of substances or alcohol then that's a whole 'nother ballgame pertaining to mental health in, in trying to you know deal with that particular aspect because the, because the parents or the individuals that, that came together don't even have a clue."* **-FG#3: 18 year old male, Sacramento**
Culturally-dependent	*"I would also say it's cultural too. Because certain cultures we're, you know we've very animated. You know we talk loud, we escalate our voice and there's fluctuations in our voice and if you're not from our community, you would think that we're aggressive or that we're acting out or that we're having issues. But really it's just how we get down, like how we communicate with each other."* **-FG#11: 43 year old gay male, Sacramento**

Identity Crises	*"Our people are confused, for example we do not know what to call ourselves. Such as African American, Black, Negro, Colored, Mixed, this is a mental health problem. We have an identity crisis."* **-In-depth Interview: Reverend Gloria Arrington, 77 year old female member Inland Empire Concerned African American Churches** *"Um...well, it just seems like, it's natural for me to act a certain way around all my African American friends....uh huh.....and then I'll be, I'll act a different way around the more Caucasian race ...uh huh...because it seems like they'll accept me, accept me more if I act more like them. And my African American friends won't accept me the way that the Caucasian kids would if I acted that same way... that gets real confusing."* **-FG#17: 19 year old bi-racial male student, Oxnard**
Identity Crises FG#10: The Children of Promise, Mental Health Advocates, Sacramento – *Conversation among focus group members*	**Sharon (53 year old female):** *"... ah young White lady came up to our booth, ... and so she had two children. They were mixed. Their father was African American and so the, ah oldest was looked to be about 3 or 4 and, so she asked me, she says, 'ah he continues to say he's White, he's not Black.' And so she was concerned about that, and what she could do to deal with that. And I'm just thinking, you know here you, you know we have a number of our, you know young people, ah our children who are a mixed race and they're gonna go through this whole thing with identity and how the world sees them versus how they see themselves. And, um you know I, I, I just you know see that as an up and coming issue that will... may impact, is gonna impact their mental health. Because if they don't identify with you know who they are and the world sees them we know as Black."* **Tommie (66 year old female):** *"Well I don't know Sharon if the world sees them as Black anymore cause they're a mixed race, now. They you know again, the news media or someone the government has said; that they don't have to be Black. When I was growing up if you had one little drop of Black blood in you, you were Black. Now you can be 'mixed race' so that they lower the number of African Americans."* **Sharon (53 year old female):** *"Except for I think that when they actually go out into the world and they're going to apply for a job they can check mixed race as much as they want to. That person interviewing them is seeing what they see."* **Tommie (66 year old female):** *"Yeah you're right."* **Sharon (53 year old female):** *"So um..."* **Tommie (66 year old female):** *And, and again there's where mental health is needed.*

Identity Crises	*"You know what else, is systemically how we've been portrayed as Black people. I mean you open up books to read, we're absent from the history. We're absent so to read about us or to talk about us, I mean people in foreign countries like the Japanese thought we had tails. I mean I think it's how people have described us. How, um the characters of our behavior. How we look. The lips way over to here. Nose way over there. We're black with nappy hair. Ah, we wore plats. And, we I believe are the only people in the history that are talked about so disrespectfully that people from other countries want to try to step in and treat us the same way."* **-FG#7: 49 year old homosexual male, San Diego**

Table 43: *Availability of Treatment*

THEMES	RESPONDENT'S COMMENTS
No Real Treatment	*"Okay that's one of the biggest problems. I also have find that you know accessing here in Kern County can be real rough. Unless, they fuss real treatment plan to say, alright let's go through some therapy. Let's go this. Let's try not to use the medication, should be the first. Unless that person really shows you that they need that med....but use, use low, low dosage instead of the dosage that make them high, delusional or just like zombies who can't move."* **-FG#14: Walter, 51 year old male, National Brotherhood Association, Bakersfield**
It's Hard to be Heard	*"And that's how they look at us with issues anyway and we don't have people that look like us that are there to give us the proper diagnosis or proper medication. They want to diagnose us with something we don't even have or they wanna put us on some medication that's not conducive to us and when they start breaking down our system and when we start acting out worse than what we were before, a lot of times all we need is somebody to listen to us. It's not a mental disease; you know stop what you doing to us and listen. Well she got issues we can't deal with her..._. You know what is wrong with the way I talk you know this is me. Just because you feel like I should come in and present myself to you so therefore I'm ignorant, I'm retarded, I'm abusive or I'm not willing to listen, that's not it I'm not trying to listen. I'm not you know here to fight with you. I want a proper treatment in which I'm coming here. Listen to what I'm saying. I know my body and my system better than you. So at least listen to me. Put somebody in there that's not afraid of me 'cause you know they're afraid of me because yeah they're afraid of us as far as women and especially our men and boys. I'm just as human as you are."* **-FG#9: Monia, 43 year old female, Client and Mental Health Advocate, Chico**

Difficult to Know Where to Go	*"Yes, because when my daughter ... had her baby and I guess the baby was like two weeks old and she start telling me that some cartoon character was talking to her, telling her to harm herself. I told her to come sit down with me and that would calm her down, you know. And, then it got to be more like aggressive, you know the behavior. So, when I did call for help, it wasn't clear where to go. But um, I took her to Kaiser and Kaiser refused her because she had Kaiser/ MediCal. So I took her to the hospital and they refused to see her. They talked to her but she had to go to like a county facility. You know, so it went on for about three weeks. Until she got so bad, 'till she was telling me that she can't be at home with me because she's a threat to the baby. You know, so you know for like three months, we struggling until I got to the place where I knew I had to get some help. Watch me, somehow I got her into the car, but they do not cooperate, and I mean she was taking the steering wheel, you couldn't drive down the street with her. You know, I went through all that, and we got her to the hospital, and finally got her seen, and gave her some medication to calm her down. And then they gave her the wrong medication, she ended up in a coma."* **-FG#12: Patricia, 55 year old female, Client Family Member, Lodi**

Table 44: *Attitudes Toward Medication*

THEMES	RESPONDENT'S COMMENTS
Medications Too Strong to be Used on the Street –High Abuse Potential	*"You know, my organization actually goes through the drug-dealing issues with a lot of gang members. And I've ran into a lot of different problems with mental health in that area with a lot of guys going through prison coming out on that type of medication. Um...my biggest problem is what it is that accessibility of the medicine that I feel is like a market and it needs to be kind a like toned down or a softer drug kind a like given to a individual because those, you know like in prison, when half of the population is on medication. Haldol and Thorazine and different heavy drugs and the place is different. It's not normal and then on this marketing in there just everybody finally trying to go to sleep. Especially the youth, you know so those are type of things that I have a problem with, when it comes to the mental health issues. The issue about those drugs, when they get to the street, it acts just like "Sherm" [a slang term for a methamphetamine-like street drug] or acts just like ah any other drug that they'll be on acting the way they act. But it's a lot of them dealing with the mental health issues. That's, what bring a new pitch to the topic that they really don't be talking about in a lot of different places."* **-FG#14: David, 46 year old male, National Brotherhood Association, Bakersfield**

Don't Want to be Medicated For Life	*"You know that doctor will, get that money if you're on the medication and it might be ultimately that medication is what helps you but having, if you let's say you're 25 and you're struggling with something that you know isn't right for a really long time and you're finally ... gonna go get that help and you're not very educated about the first help you get, is telling you okay take a pill. Now you're thinking this pill I gotta be on for all my life, you know I'm dependent on this and it's like, like buying a car at the first shop you go to. You know, I mean I should just take this pill. You're trusting that it's a doctor, um, so if someone you know is just facing it and coming and trying to get that help and the provider just wants to do medication, um that's an obstacle. You know, I don't want to be medicated. I've gone this long without medication. I don't want to you know maybe have to use that as my savior. You know, to help me with this so, you know if you just run into people and let's say you might go to 3 or 4 doctors. And, they all just want to, to pump medication. You know, so it's important that the health care, you know or the providers that are available are as individualized, as the conditions that we could have and people that are presenting them. Because you don't want to also just get a therapist who is like a friend and just tells you yes, yes, yes or you know you're right and the world you know is wrong."* **-FG#: Female, Sacramento**
Medication Making People Crazy	**<<< FG#7: Gay Males, San Ysidro Comprehensive Health, San Diego – Conversation among focus group members >>>** **43 year old same gender loving (SGL) male:** *"You know what, I'm gonna add to that now that you mentioned pills. You know, first of all I think that San Diego definitely need to make more services, but, um the services we have focus too much on drugs... I don't want anything that puts me to sleep 24 hours a day. Some of the therapy helps, but mine is, well I'm not taking any pills."* **49 year old homosexual male, certified nursing assistant:** *"That's the point I was about to get to. That's their profession to prescribe medication for you."* **43 year old same gender loving (SGL) male:** *"But you can also refuse that. You can say well you can take this...I'm communicating with you about my concerns, and you still coming with the pills. But you're listening to your therapist, you know and if you're seeing them which is what happened in my case, I was taken off of them and I told her this medication is making me crazy. I get violent taking the medication."*

Table 45: *Perception of Stigma in African American Community*

THEMES	RESPONDENT'S COMMENTS
It's not "OK"	*"I just want to say that an important aspect, I think individually, is the perception of the illness. Because you could be diagnosed, you know get that diagnosed but if you're still under the impression that well the world isn't gonna accept me. My family's not 'gonna be okay, or I don't want to be, you know, have this problem. I don't want to have this condition. I don't want to rely on medication and you still won't use and seek that treatment. So your perception is that it's not okay to have a mental illness. That it's not okay to be different. It's not okay to have, you know, something that everybody doesn't have. Regardless, you still might not be able to get the help that you need because your mind, you know you just won't let yourself get over it. So, in terms of you know, on an individual basis what would be key, you know to a person's mental health, that's healthiness. I would say to acknowledge...acknowledge and yeah, yeah and you know not have shame like that, not be shame. Shame will keep us from everything. So if you're ashamed you know that my mind works this way and not the way's everybody else's and you don't wanna get help or acknowledge that. So, so I think how you perceive it is very important to your general outcome."* **-FG#:.... female, Sacramento**

The social context in which mental illness occurs was very significant and includes trauma exposure, daily struggles to survive, high levels of stress, and setbacks to social mobility and advancement. Individuals are inseparable from the communities they are connected to; therefore, mental illness implies social disorder. Identified complex problems associated with mental illness in the Black population could be categorized into five domains, dehumanizing social encounters, inadequate or inappropriate treatment, perceived structural barriers, perceived cultural barriers, and personal barriers the system could help to overcome, see *Table 46* below.

Table 46: *Identified Complex Problems Associated with Mental Illness in the Black Population*

CATEGORY 1: DEHUMANIZING SOCIAL ENCOUNTERS	
• Lack of respectful treatment	• Being ignored; benign neglect
• Overt and covert racism	• Micro-aggression by mental health professionals
• Perceived lack of caring by mental health professionals	
CATEGORY 2: INADEQUATE OR INAPPROPRIATE TREATMENT	
• Misdiagnosis and incorrect treatment	• Lack of accurate mental health assessment
• Over-prescribed medications	• Lack of follow-up
• Timely access to care	• Mischaracterization of behavior
CATEGORY 3: PERCEIVED STRUCTURAL BARRIERS	
• Lack of community resources to address mental health issues	• Lack of properly trained mental health providers
• Missed opportunities for early detection, intervention	• Invisible mental health outreach in the community
CATEGORY 4: PERCEIVED CULTURAL BARRIERS	
• Lack of community resources to address mental health issues	• Severe lack of "good mental health" promotion based on cultural practices and beliefs
• Lack of properly trained community interveners	
CATEGORY 5: PERSONAL BARRIERS THE SYSTEM COULD HELP TO OVERCOME	
• Intergenerational traumatic experiences	• Isolation
• Fear	• Historical and ongoing feeling of oppression
• Shame	

Major expected outcomes of the CRDP were to engage the population in identifying community practices that bring about good mental health *based on their perspective*. From the data analyses, there were over 100 emergent themes identified that described personal, community and system perspectives on the topics explored (such as good mental health, causes of mental illness, support systems and access to mental health services). Many themes overlapped among the topics. Efforts were made to remove duplications, reduce data, and merge commonly clustered themes. *Table 47* is a summary description of the themes for each topic.

Table 47: *Summary Description of Emergent Themes*

1. **Defining Good Mental Health:**
   Self understanding
   Responsibility
   Resiliency
   Decision making skills
   Coping skills
   Spiritual connection
   Ability of person to be centered/grounded - having a strong sense of self, having a sound moral foundation and being self-mastered, responsible
   Bi-cultural, dual personality and flexibility in interaction
   Strong sense of spirituality
   Strong belief in God
   Having positive role models

2. Factors Causing Mental Illness:
Inadequate/Lack of coping skills
Environmental factors – lack of opportunities, media, limited opportunities
Substance abuse
Negative role models
Identity
Trauma/Traumatic life experiences – illness and/or death of family member, violence in community, domestic violence, father absence
Legacy of slavery/racism
Micro-aggressions
Racial profiling
Stress – financial problems, family relations, inter personal rejection
Neurological disorders – heredity
Mental deficiency, imbalance – learning disabilities
Character flaw - personal attributes and behavioral disposition, identity crisis, emotional instability
Misdiagnosis
Cultural loss
Isolation
Cultural change
Culture shock

3. Support System:
Individual resilience
Interpersonal relations – family, friends
Professional help
Higher power (God)
Support system/team
Safe environment
Power of prayer
Spiritual connection, laying of hands

4. Mediators of Access and Utilization of Mental Health Services

- **Mental health delivery system**
  Overmedication
  Misdiagnosis
  Agency runaround
  Mistreatment
  Inappropriate screening
  Lack of validation
  Systemic and systematic flaws
  Lack of cultural awareness
  Non-local services
  Stigma
  Impersonal treatment
  Male socialization
  Insincere services
  Unfair funding practices
  Lack of trust
  Insurance scam
  Inequitable distribution of resources
  Cost of services

- **Barriers to service**
  Not enough African American providers
  Stigma associated with mental illness
  Lack of health care
  Lack of knowledge, education about mental health
  Lack of trust
  Unequal treatment
  Funding
  Limited access
  Lack of trust
  Long waiting list
  Sterile environment
  Stigma associated with mental illness

Additional analysis of the data brought forward a global view of diverse strategies and approaches. Participants were clear in identifying numerous strategies they believed would help to bring good mental health, prevent mental issues from occurring, and to help sustain and maintain a state of total well being. Aggregating data outcomes to understand the "big" picture participants were presenting, we observed that the population repeatedly expressed concepts related to wholeness. It was clear the population had articulated that any early intervention or regular ongoing interventions must focus on keeping the individual, family, and community intact to be healthy. There were approximately 125 helpful practices identified.

At the interpretation team meeting, the group consensus was to report all suggested practices as stated. Attempts to categorize any of the practices would decrease the strength of the recommendation. It was expressed by the interpretation team that there was great variation in perspective as to how the strategy should be applied and how communities would choose to implement practices that are important to them. During regional data collection, it was observed that the Black community perspectives vary on what specific strategy would work best with what group of people (e.g., TAY, elderly, males & females).

It was clearly stated that Black communities can decide for themselves what works best for them. **They do not need outsiders coming in to tell them what to do.** After all, it is the community residents that live their experiences day in a day out. Outsiders cannot interpret their reality. See *Table 48* below which contains 125 helpful practices and strategies that the African American/Black community values and need. The recommendations listed are **NOT ranked in order of importance**, neither are they numbered so as not to confuse the list as priority recommendations. The list is a compellation of recommendations to be used as a resource tool for communities to design interventions that are culturally grounded in Black people's reality for promoting mental wellness.

Table48: *125 Helpful Community Practices and PEI Strategies for Promoting Mental Wellness in the Black Population*

- Create holistic interventions
- Build Resiliency in youth & young adults
- Work with the faith-based community
- Work with the criminal justice system
- Educate with statewide marketing media campaign targeting the Black community

- Provide "places" for people to meet for support and education
- Develop "roots to recovery" for cultural grounding
- Work with hospital staff in emergency rooms
- Family & consumer education
- Create mobile centers with medications for agencies
- Incubate and develop "homegrown" grassroots agencies grow to capacity & sustain efforts
- Development of "centers" to house programs that aid SMI's and families
- Train professionals to work with those with lived experiences to better serve Black community
- Work with the Police Departments & District Attorneys to develop alternative sentencing and housing options for the mentally ill entangled in the criminal justice system
- Train first responders to work in partnership with African American community
- Adequately staff and support community organizations
- Distribution of resources and funds to African American community
- Train & develop lobbyist
- Fund cultural programs, education and practices to save African Americans
- Community outreach
- Alternative treatments
- Mentoring & life skills
- Create, develop and fund family resource centers and one-stop health centers
- Spiritual development
- Culturally diverse staff, enhance training to service providers and all practitioners focused on culturally compassionate service delivery to African American community
- Enhance cultural training of service providers
- Increase the number of African Americans and African American men that provide services to African Americans
- Increase the number and length of therapeutic sessions
- Fund experimental cultural projects that promote traditional cultural practices, strengthen community ties, relieve stress, and help trauma. These should not be limited to evidence-based programs but should be given equal weight as free-standing community-defined practices. Emphasis should be placed on the client desired practice and measured by the quality of service delivery (customer satisfaction).
- Health services should be integrated to target the whole person, including substance abuse issues, other health problems, as well as social problems (legal troubles, lack of housing, unemployment, etc.).
- Neighborhood mobilization efforts, community defined solutions, the cultivation of local leadership, and political advocacy should be supported to address interrelated threats to Black health including substance abuse, mass incarceration, youth violence, and homicide

- African-centered education and childrearing practices (including community-based schools and child care facilities) must also be promoted and incorporated as part of a spectrum of Black health resources.
- Culturally relevant resources (especially educational) should also be available for those incarcerated to affect behavior change and lessen the trauma of exposure to the culture of incarceration. There must also be accountability for the mental health services being delivered to those who are incarcerated.
- Disparities in the allocation of resources based on actual need (prevalence, trauma exposure, etc.) must be documented and used for policy advocacy.
- Information and trainings on effective practices for addressing mental illness as documented by Association of Black Psychologists and Association of Black Social Workers researcher must be accessible to those providing services to African Americans and should also permeate strategic Black social networks.
- Fund projects to promote a balanced diet relative to the genetics of African Americans and based on the traditional diet of West African people as well as cultural retentions of African Americans.
- Create linkages between recent immigrants of African descent and African Americans centered on health promotion, cultural learning/preservation (including healing practices), and acculturation (without losing a sense of cultural identity).
- Eliminate financial barriers to accessing and maintaining mental health resources
- Support cultural centers that unify and empower communities and partnerships with cultural groups and institutions that preserve and promote African-centered traditions.
- Support neighborhood advocacy efforts to improve the communities we live in, systems of care, and recommended alternatives
- Create more opportunities for feedback related to care received
- Increase accountability for those who are funded to provide services
- Increased hours of operation
- Create mobile mental health outreach units
- Shift emphasis of service delivery away from diagnosis and drug prescription to ongoing relationships with health supporting resources
- Increase supports for culturally relevant counseling, therapy, practices and interventions
- Provide more jobs for survivors of mental issues
- Provide more treatment options
- Provide more housing
- Provide educational opportunities
- Develop and fund supportive mental health services focused on African American males and fathers
- Promote culturally compassionate mental health application to address the historical and current experiences of African Americans (Afro-Centric Therapy)
- Direct funding to programs and projects African American CBOs targeting males & fathers
- Seek out and utilize existing approaches to African-centered healing

- Mandate sub-contract opportunities to homegrown grassroots agencies providing mental health services
- Create a monitoring and evaluation process that rewards, practices for reducing stigma and increasing access to mental health services for African Americans
- Hire and train lobbyist to advocate for mental health services
- California Reducing Disparities Project (CRDP) Speakers Bureau
- Implement "Project LINKS" Outreach & Engagement
- Replicate Genesis/Spirit Integration Model
- Use cultural assessment tools & perceptions of racism
- Getting Upstream – New Expanded Vision for AOD
- Effective collaboration with measurable positive outcomes
- Revised data collection to document exact services received and outcomes
- Quality Improvement, oversight and accountability
- Restrict CIS (Central Information Services) from case files and replace with a quality improvement plan that includes treatment assessment and performance outcomes for all services provided to an individual
- SMI (Severely Mentally Ill) restricted to high-level care in restricted lock-down institutional settings
- Person-centered care that is self-directed
- State provide funding for education and outreach to consumers, providers, and community-based organizations to implement advanced directives
- State requires counties to invest in building capacity of existing and new African American mental health programs and integrated primary care, and fund their community accepted practices; provide incentives funding for outcomes that are not just response focused but are recovery and remission focused
- Community consciousness raising advocacy, leadership and collaboration
- Fund community-based/indigenous concrete practical experienced-based common sense oriented services
- Training non-African American clinicians on the realities of stereotypical beliefs society members have/hold about African Americans
- Community citizen review councils in every county
- Neighborhood-based services that address residential segregation challenges (lack of resources, healthy foods, poor quality schools neighborhood violence)
- Youth leadership around service delivery advocacy, safe & secure out of home placements where out of home placement is required
- African American community agency leaders convening's to support coalition building & protection of vulnerable at-risk African American community consumers/families
- Giving consumer voices opportunities to be heard in various ways
- Work with churches and community at the grassroots level
- Support family involvement (includes family of choice)
- Visible campaign to disseminate information
- Focus groups as a part of every program that is developed

- Trauma focus losses
- Address environment through policies assertive case management & outreach
- Have culture specific linkages between formal and informal providers
- Train African American providers on issues of projection
- Change structure for contracts barriers and financial flexibility
- Develop African American network of consultants for each other
- Revise systematic consumer satisfaction documentation
- Fathers & males targeted services
- Increase funding for community practices
- Community focused trainings
- Culturally focused short term crises care
- Special training for pastors & faith-based counselors
- Utilize & fund NAMI family training model
- Provide transportation for consumers who need it
- Respite care for family providers
- More wholistic approaches to wellness and illness
- AB4 can provide support in instances of community trauma
- Wellness Centers staffed by community members
- Provide list of criteria setting the standard for culturally specific collaboration and outcomes accountability
- Education & training for youth, adults & elderly
- Creative wholistic parenting efforts
- Education & training on healthy eating and healthy lifestyles
- Community mental health fairs
- State and systems policy changes
- Financial freedom for use of funding
- Coalition building
- Increase consumer self-efficiency
- Association of Black Psychologists serve as statewide community responsive team for catastrophic & life course traumatic events for the African American community
- More social and mental health prevention programs in schools
- Community Healing Circles
- Race matched group mentoring
- Prevention & early intervention community building programs and activities
- Intergenerational parent support groups and activities
- School-based wellness centers for youth
- Universal, primary prevention services focused on youth development to strengthen relational ties and development
- Services for returning citizens that includes training them in community organizing

- Community-based participatory research with community social service agencies to assist them in establishing evidence of the effectiveness of their programs
- Brain Exercise Program
- Physical Exercise Program
- Spiritual Exercise Program
- Culturally Congruent Practices
- Financial Partnership with grassroots' organizations
- Training for community leaders, places of employment, parents and/or support person(s)

Data Set #3: Small Group Meetings Results

Small group meetings were strictly convenient samples and the CRDP director (Dr. Woods), had no control over the data collected. As an invited guest, the meeting agendas had been previously set by meetings participants. Each meeting was different and group findings will be discussed separately.

Group #1: African American Caucus, 2010 Alternative Conference, Anaheim
Total attendees 31; 64.5% (20) females and 35.5% males, of which 67.7% (21) were consumers, clients and client family members; only 2 identified with LGBTQI; all participants were African Americans. The meeting was audio taped and transcribed, as well as field notes taken. To prevent redundancy and to reduce data for better management, the transcript from Group Meeting #1 is included in the focus group analysis section of this report.

Group #2: LGBTQI Caucus, 2010 Alternative Conference, Anaheim
Total attendees 25 plus (several people came in but would not give any information, other than they were attending to network with a group that they understood each other); of those who shared (21 individuals) information 76.1% (16) were females and 23.8% males, of which 85.7% (18) were consumers, clients and client family members. Of particular interest (of those who shared information) is that only 52.4% (11) self-identify with LGBTQ. Three volunteered that they were transgender. The participants were ethnically mixed, and there were 8 Blacks present; all participated in the discussion.

Permission was given the CRDP director (Dr. Woods), to sit in the meeting and take notes of interest. Some individuals stated they wanted their names out there and gave permission to attach their name to their comments. Issues discussed in the meeting centered on emotions and mental distress. Statements made are listed below, and do not appear in any rank order.

- LGBTQ individuals need to have merit; they need to have their needs met
- Fearful of phobia
- Rash of suicides in colleges & schools, need to do something about that
- Need to feel love and support and energy
- Many LGBTQ have pain
- Have opinions that are not popular; then what do you do with your thoughts and feelings on the subject?

- LGBTQ needs to be understood
- People can be more cruel than you think. What can be done when you are in the closet?
- Suicide is a selfish act and must be discussed; and it is not an easy topic.
- This is not a "gay" lifestyle. Do not like the name "gay." "Same sex-loving" is understandable. This has not been happy. Searching for happiness. Happiness is having a committed partner. Internalized homophobia is great.
- Shame of being bi-sexual
- Not appreciated as a human; looked upon as sub-human
- Like term "same sex loving;" same sex is preferred; other labels acceptable are "Quire" & "Trans-friendly"
- Highly effected by discrimination
- Older people living very demeaning lives
- Not clear about inter-sex; inter-sex people have atypical chromosomes; people are born in different types of bodies; labeling especially inter-sex people wait and see what will happen; parents are responsible for reassignment of gender; wrong decisions about gender really is depressing and causes serious emotional distress
- The question regarding how inter-sex children are created is related to transgender people in older age; people have preferences; no early diagnosis or cultural sensitivity
- LGBTQ need to feel comfortable; when going through a transgender process, you miss the person that is leaving
- Terrified of passing for something they are not; there is an increased suicide rate
- LGBTQI have not been looked upon and is an underserved community; cannot get money needed to have money moved toward the community
- Gays are almost erased
- Christian neighborhoods are very un-accepting
- Media presentation of gay is stereotypes, traditional. There are greater issues to address. There needs to be a change in the media.
- A great deal of shame thrown toward gays; not that gays are ashamed of themselves
- Must combat societal ills toward gays
- There is the first Gay Shelter for teens in New York
- Do we have a database across country? There are places such as Fruits & Nuts, Daily strength.org, and Pink and Blue (Mark Davis Founder); need data regarding gay mental health

Group #3: 2011 Northern Region Cultural Competency and Mental Health Summit XVII, San Jose

There were two groups of participants; a total of 20 individuals. Group 1 was an Ethiopian mental health support group called African Immigrant Ethnic Cultural Communities Advisory Committee (ECCAC) of Santa Clara County. Total in the group was 10; 90% (9) males, 10% females; all were consumers, clients and client family members. Group 2 consist of participants in the African American CRDP SPW workshop session, of the attendees present, 10 gave specific information during the workgroup meeting and afterwards gave more in-depth information on mental issues

related to PEI. Information shared related to having resources for African people living in America, who are all traumatized when they are taken from their country. Resource information shared by this group is listed in *Table 54.*

Group #4: 2011 Ephesus Empowerment Conference, Fontana
Total attendees 10, gender split 50/50% females and males, of which none openly admitted to being a consumers, clients and client family members. However, from comments and examples given during the meeting, it was clear that consumers were present. Participants made comments on two areas related to mental illness: (1) what causes mental issues? And, (2) what are the solutions?

Responses to what causes mental issues?

- A combination of environmental, personal and community factors
- Trauma that people have experienced
- Living conditions (stress)
- Use of drugs inappropriately

Responses to what are the solutions?

- Seek help, see psychologist
- Get educated
- Identify the problem; own the problem; recognize and accept that there is a problem; acknowledge that you need help
- Find someone to identify with, especially someone in the same age group
- Send messages to the younger generation by mainstream media; have information on the TV in the church; use role models
- Re-educate the family; use better communication with the children so they can understand

Group #5: 2011 National Alliance on Mental Illness (NAMI) Conference, Sacramento
Information obtained during this meeting was from a workshop with the deaf and hard of hearing with five panel members, 80% (4) females and 20 % males, of which all were consumers, clients and client family members. Panel participants shared their lived experiences and made recommendations for state system changes. Field notes were taken. Recommendations were manually extracted and the final CRDP recommendations are inclusive of this special needs group. Comments are included in a special section of this report, Section B4c, on page 105. Recommendations include providing deaf individuals with proper assessments, the use of providers proficient in American Sign Language (ASL), updating equipment to allow appropriate communication with the deaf, and to make care for people with hearing and visual limitations a priority.

Group #6: 2011 Black Los Angeles County Client Coalition (BLACCC) Meeting, Long Beach
This group meeting consists of a total attendance of seven clients; 86% (6) females and 14% males. Clients shared their lived experiences and insight with recommendations of what would help for prevention and early intervention of mental issues. Entire conversations were videotaped. Testimonies and specific recommendations were manually extracted and included in the overall final recommendations of this report. Summary recommendations include:

- Teach recognition of signs of mental issues so intervention can take place

- Peer to Peer Programs for people to have help from those who understand
- Family support groups
- Treat people nice and with respect
- Integrate family in every part of recovery and interventions
- Elevate consumers to contributors
- Use "survivors" in providing PEI services
- Hire "survivors" to work full-time as counselors, educators, and in supporting roles
- People live in a traumatized society, use approaches that are trauma interventions
- To take care of people and help people have good mental health must use tailor made approaches
- Must rehabilitate communities
- Re-educate mental health service providers to understand how to meet the needs of consumers
- Current DMH planning is not sufficient to meet the needs of a community that is broken
- Utilize a common sense approach and principles – take time with people, develop PEI systems that are in the community where people can walk in for help, and staff with people who care and want to help individuals
- Create an African American Center and staff with African Americans who care about people
- Providers must use a spiritual approach, Black people love God and they must include in any intervention dealing with our people

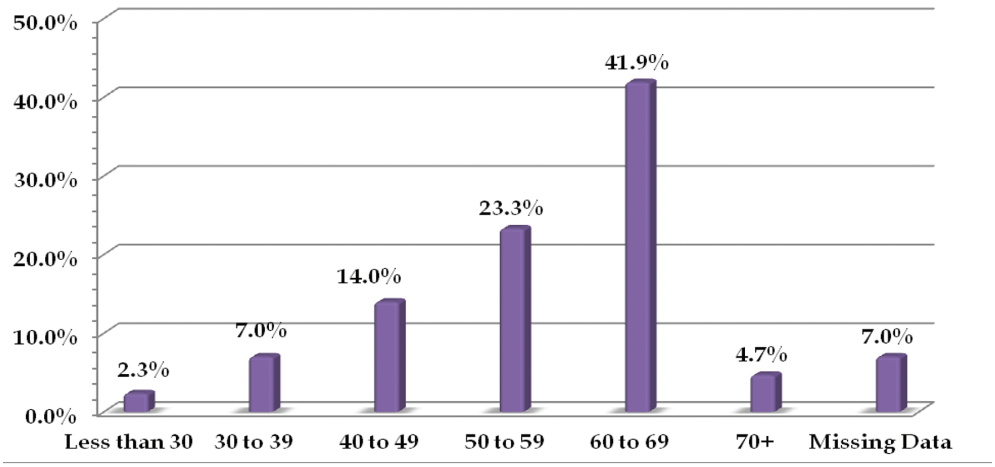
Data Set #4: Regional In-depth Individual Interview Results

Individual interviews were conducted in locations and times familiar to participants. A standard set of open-ended questions were asked. Responses were recorded on a matrix, manually extracted, and categorized by themes. One question related to personal background and interest in mental health issues. The other two questions were related to community practices for PEI and recommendations for PEI delivery system that would be appropriate for Blacks. Each interview lasted approximately 45 minutes to one hour.

Total participants were 43; 54% male, and 46% female; average age 56 years with an age range of 29 to 81. See *Figure 40* for distribution of age category.

Participant's demographic profile covered a broad range to include clients, client family members, parents, business men and women, advocates, artist, academicians, activist, providers, LGBTQI, and elected official.

Figure 40: *In-depth Interviews Percent of Participants by Age Category, 43 Participants*



Age in Years

In response to the question, what interventions and practices that you believe are prevention and early intervention methods to help African Americans and other people of African ancestry have good mental health? Most responses related to family and family values, community and cultural resources; see list below.

- positive role models
- dignity and self-respect and respect for others
- expressions of love and caring
- parenting skills
- establishing an environment for cultural expressions
- Change the system from a "Euro Model" to a culturally appropriate model to work with Blacks that include communication, personal interaction and expressions of emotions
- NO one size fits all; NO do not want quality with uniformity
- Need personable care; Blacks are ashamed to accept mental help, need closeness
- People need non-discriminatory services
- Better and more compressive strategic dissemination of present resources
- Need more people to get the word out, there are pockets and clusters; need to fund marketing for vehicles to get the message out. Los Angeles County has a visibility problem, it is too large and the information is not getting out there
- Early exposure to culture and discipline; educate people
- Make connection with Spirit and culture
- Give people dignity
- Teachers and parents need to be more interactive to help kids early
- Need psychologist in middle school with peer counseling every day
- Have health clinics in the community staff with the right people who care
- Need better assessment, to assess what level of mental health people are in

- Train community to recognize early signs of mental problems and how to work with people
- Mental health providers needs to listen to clients; system needs to change
- African Americans are not recognized; need more people like "us" who understands; NO stereotypes
- Model to incorporate family values; need to build up the family; family support
- Everything starts with culture, must know your culture (know who you are)
- Racism is keeping people down because they are Black, Latino, or poor White; practices that are racist must get rid of it
- All teachers should be experts in "cultural pedagogy"
- People do not want to be seen as crazy; they cannot talk about it; we need drama therapy to allow for expression of feelings and acting out the problems
- Need a safe place where people know they can go, "a safe zone" and people working in the safe zone should be people from the community
- Use models that provide strength and include relationships, people talking about issues, parenting, psycho-social and developmental issues, belief, peer support, events to celebrate success
- Change the social image of Black people
- First we must identify the unserved, we need screening and testing; need appropriate psychological evaluation of people
- Please need help before a crises happens

Data Set #5: Regional Public Forum Results

A total of 9 regional public meetings (page 141 for meeting schedule) were conducted in San Bernardino, Los Angeles, San Diego, Riverside, San Francisco, Sacramento, Solano, Seaside, and Long Beach, with a combined attendance of 188. More females, (68%) than males (32%) attended. The age range was 18 to 82, average age 52, of which 35% identified as consumer, client, and client family member. Only 3% self-identified as LGBTQI.

All meetings were facilitated by Dr. Woods with assistance from local community volunteers. The public meetings were intended to accomplish three items, (1) to validate content of the draft report, (2) to provide additional community practices, and (3) to obtain additional recommendations for the statewide strategic plan. Each meeting lasted for no longer than 2 hours. All meetings were videotaped except for two (videographer was not available); field notes were taken or an audio recording. Videotapes were made available to the writing team and data analysis team for review.

Participants had the opportunity to individually provide their comments, to give their name, age and affiliation. Additionally, to register each person was asked to complete the Consumer, Client, & Client Family Member Survey (Appendix G). Of the 188 attendees, 139 completed and returned surveys. Some attendees (17) stated they wanted to write more information on the survey and mail it back, even after instructed to turn the survey in because it was the registration form, or they refused to turn the survey back in. There were 20 students, five parents, and three teachers who attended, but did not complete surveys. And, four attendees had previously completed a survey.

Regional meetings were conducted from October 2011 until December 2011. A draft copy of the African American CRDP Population Report was posted online at the AAHI-SBC website for a 30-day public review for the month of October. During this time there period there were 834 visits to the web page. A pdf copy of the report could be downloaded and a survey was available for all who submitted comments or downloaded the draft report.

Public Forum

No new content, community practices, or recommendations were introduced during the public meetings. All information shared was already in the report. Nearly all comments were to expand sections and to give more examples. For those who identified information they wanted to be included in the report were asked to also submit written statements or information by email or postal services to ensure that whatever pertinent information they wanted added to the report was added exactly as they desired. Participants were informed that the information would be share with the writing team for review and consideration for inclusion. More examples will provide a more robust strength to recommendations in the report.

The most common input was the personal examples of local grassroots programs and interventions that were currently in use and needed to be added to the report. Some comments were related to areas of clarification. Other comments were the identification of data to document African American usage of the DMH services, resources used by the Black community and provided to the Black community.

Irrespective of location in California, Black people have the same problems with mental issues, and the local DMH. Black people, irrespective of regional residence suggested the same solutions.

There was one issue discussed by a couple of people during the public meetings, the recommendation to change the name of the report because they felt the language "crazy" was not appropriate for mental health. In review of all 188 surveys related to the title, 39 comments were recorded. ***Only 10*** survey respondents stated, *"Do not use the word crazy."*

In addition, attendees were invited to send an email or written comments on any aspect of the report, the layout, colors, design, title, etc. Not one email was received or telephone call received related to the report design. Only four respondents stated, *"Do not use the word ain't."* Other 25 comments entered on the survey about the title are listed in *Table 49.*

Table 49: *25 Written Comments Received During 30-day Public Review of the CRDP African American Population Report Title*

I like the title "We Ain't Crazy"
Make the title with larger fonts
Include more Black faces in the circles
"We ain't crazy" reaches out and captures your attention
OTHER SUGGESTED TITLES:
"We Ain't Crazy, and We Ain't Stupid Either"
"We Ain't Crazy: Just Misunderstood"
"We are not crazy"
"We are Strong Minds"
"We Contribute: We are Part of Your Family"
"Our Mental Health is our Community"
"Root of Wellness"
"We Aren't Crazy"
"We're Not Crazy"
"We Ain't Crazy and We Ain't Lazy Either"
"You're Not Alone"
"Perfect Storm"
"Tipping Over"
"On the Edge"
"Consciousness Raising"
"Rise Up"
"Moving Up"
"Celebrating Our African Heritage"
"How Do You Cope"
"We Are Here"

Given the complex psychological predicament that African Americans face, it is clear that examination of mental health emanate from basic psychological models that represent African American reality structure. The focus group findings in conjunction with other data collected with this CRDP provides overwhelming evidence of what the Black population in the State of California express they need (and, probably in Black communities across the Nation), and what they believe to be meaningful and important factors to create and sustain good mental health. Recommended practiced are outlined in Section E.

It is incumbent upon all governing bodies, law-makers, political decision-makers, and others in position of designing a "new" mental health system to provide the architect and structure for securing functional communities. Recommendations for this responsive integrated system to occur are incumbent in this CRDP African American Population Report.

Good mental health for people of African heritage has been clearly described in the report by various people living in different regions throughout California. Individuals who have participated in this study have taken the inquiry extremely serious. The information and recommendations are shared from a deep sense of "culturally rooted and grounded" values, beliefs and norms, as lived in the 21st Century. We have clearly articulated what is important and meaningful to us as a "collective" voice for effective prevention and early intervention methods that will help heal people of African ancestry.

D4. MODELS: COMMUNITY-DEFINED PREVENTION AND EARLY INTERVENTION (PEI) PRACTICES FOR BLACKS

Section D presents several models that get positive results for PEI. The concepts and principles, as well as the term "prevention" have different meanings to different fields of health. The classic definition used in public health refers to concepts of primary prevention, secondary prevention and tertiary prevention (DHHS, 1999). By definition, primary prevention is taking action to prevent disease, or health and social problems before they occur. Secondary prevention is the early intervention or recurrences or exacerbations of a disease or condition that already has been diagnosed. Tertiary prevention is the reduction in the amount of disability caused by a disease or condition to achieve the highest level of function.

Primary prevention fosters or encourages health supporting community environments and seeks to make the healthy choice the easy choice. Primary prevention is a skill. You cannot assume that just anyone can do prevention. It is critical to understand, that a person who is skilled and knowledgeable about prevention will be more likely to have resources to resist being drawn into intervention, crisis management, and service provision at the expense of prevention, proactive planning, and capacity building (Cohen, Chavez, and Chehimi, 2007).

Concepts of risk and protective factors, risk reduction, and enhancement of protective factors (commonly referred to as fostering resilience) are critical to prevention programs, activities, and efforts. Risk factors are characteristics that increase personal ability to develop a particular disorder or condition. Effective prevention will focus on the risks associated with a particular illness or problem, as well as the protective factors (DHHS, 1999).

D4a. Protective Factors: Rationale for Community-de fined PEI Practices

The barriers and issues identified in this report are directly impacted by protective factors that are associated with greater successful outcomes for African Americans. These protective factors tend to be related to environmental qualities that are juxtaposed against the landscape of barriers that bring about high levels of burden for Black families. For example, the distinguished work of Margaret Beale Spencer (2005) resulted in a dual-axis model of vulnerability that categorized multiethnic high school students as high, masked, low, and undetermined vulnerability, using a ratio of risk and protective factors. Risks included level of poverty, number of parents in the home, and skin color pigmentation. Protective factors included perceptions of school climate, parental monitoring, and consonance between skin pigmentation and preferred skin color. The model then predicted psychosocial and achievement outcomes, confirming the impact of risk and protective factors for African American students.

Given the importance of environment, these protective factors can be a relevant focus for public health approaches. For example, Miles, Espiritu, Horen, Sebian, & Waetzig (2010) suggest the following guiding principles for a public health approach to children's mental health:

- Taking a population focus, which requires an emphasis on the mental health of all children. Data need to be gathered at population levels to drive decisions about interventions and to ensure they are implemented and sustained effectively for entire populations.

- Placing greater emphasis on creating environments that promote and support optimal mental health and on developing skills that enhance resilience.
- Balancing the focus on children's mental health problems with a focus on children's "positive" mental health—increasing our measurement of positive mental health and striving to optimize positive mental health for every child.
- Working collaboratively across a broad range of systems and sectors, from the child mental health care system to the public health system to all the other settings and structures that impact children's well-being.
- Adapting the implementation to local contexts—taking local needs and strengths into consideration when implementing the framework (p. xvii).

For a discussion of protective factors for African Americans in California, we emphasize the importance of *creating environments and developing skills* that lead to resilience. Prevention efforts should include environmental prevention strategies which target policies and norms that threaten health. These strategies must be community-based utilizing themes of mobilization, coalition building, and empowerment. They must also seek to create and/or promote safe communal spaces that foster wellness.

In African American communities, there are cost-effective protective factors that can bring about significant increases in resilience, if tapped by public health initiatives. This is true for adults as well as children. Research on protective factors for mental health is largely organized around children's functioning. A few adult studies cited here are retrospective investigations of variables associated with measures of resilience. The elements listed in this overview become the targets of all recommendations included in our CRDP Population Report.

Skills that Lead to Resilience

Resilience is a dynamic, multidimensional construct that incorporates the bidirectional interaction between individuals and their environments within contexts (family, peer, school and community, and society). Over time, models of resilience have become more ecologically focused, reflecting the fact that youth develop in context (e.g., individual, environmental, sociohistorical). Consideration of context is fundamental to any serious effort to understand development and experience. There has been more focus on the individual's feelings and perceptions of his or her experience, as well as an understanding of how **multiple factors** in the environment contribute to risks and protective factors. However, not systematically included within the ecological framing of resilience is the **explicit inclusion** of factors that specifically encompass the racial, ethnic, and cultural experiences of African American youth (APA, 2008).

Positive Racial Identity. According to the American Psychological Assoication (APA, 2008), it is imperative that African American children develop a positive sense of self and racial identity in order to foster resilience and strength. Research shows that with a cultural and ecological perspective of optimal social development, interventions do provide the opportunity to leverage change in African American children's and adolescents' development. Empowering youth and their primary socializing agents increases the prospect of authentic and sustainable resilience.

Positive gendered racial identities are essential to the personal and collective well-being of African American youth. African American children and adolescents must develop a positive sense of self in a society that often devalues them through negative stereotypes,

assumptions, and expectations of others (Cross, 1995). Negative racial identity in African Americans has been theoretically linked to low self-esteem, problems with psychological adjustment, low school achievement, school drop out, teenage pregnancy, gang involvement, eating disorders, drug abuse, and involvement in crime (Cross, 1991; Poussaint, 1990).

Research has identified racial socialization as a contextual protective factor. Socialization influences children's racial identity and self-concept (Alejandro-Wright, 1999), beliefs about the way the world works, repertoire of strategies and skills for coping with and navigating racism, and inter- and intraracial relationships and interactions (Coard & Sellers, 2005). African American parents are instrumental in transmitting values, beliefs, and ideas about lifestyles based on cultural knowledge of the adult tasks and competencies needed for appropriate functioning in society (Harrison, Wilson, Pine, Chan, & Buriel, 1990). For example, Okech and Harrington (2002) found a significant positive relationship between Black consciousness and self esteem and between Black consciousness and academic self-efficacy.

Although the socialization messages of both mothers and fathers benefit the child, research (e.g., Thornton, Chatters, Taylor, & Allen, 1990) has suggested that more optimal outcomes occur when both parents engage in the racial socialization process. African American children and adolescents who learn that others have negative perspectives on African Americans but who have these messages mediated by parents, peers, and other important adults are less likely to have negative outcomes and more likely to be resilient in adverse conditions. However, negative stereotypical assumptions and expectation of others need to be destroyed if society is going to reconstruct the way it treats Black people.

Lerner, Dowling, & Anderson (2003) propose the following skills that lead to resilience in African American youth:

Critical mindedness. This protects against experiences of discrimination by producing a critique of existing social conditions that buffers internalized racism.

Active engagement. This includes behavior in school, at home, and with peers, that results children and adolescents proactively and positively impacting their environment. Impact on settings, however, must be executed effectively, and flexibility becomes essential. For African American children and adolescents to develop into individuals actively engaged in optimal personal and collective development, they must be placed "at promise" as opposed to "at risk" in order to become contributing members of their families, schools, communities, and the broader society (Boykin, 2000). This can help them to emerge as agents for meaningful and sustainable positive change.

Flexibility. This can include bicultural competence or fluency across multiple cultural contexts that youth must traverse.

Communalism. This includes the importance of social bonds and social duties, reflects a fundamental sense of interdependence and primacy of collective well-being, and offers the drive for connection and promotion within and across diverse groups. For example, studies indicate that African Americans, among other cultural groups, advocate more of a communal orientation than an individualistic one, and this has stimulated significant research into the role of the communal perspective on learning in school. The associated empirical work has been consistent in demonstrating that African American students

learn more and prefer learning contexts that support the expression of a communal orientation (Dill & Boykin, 2000).

Emotional Regulation. Children who are emotionally well-regulated generally display a positive mood, are optimistic, and demonstrate empathy and prosocial behavior with peers (Zeman, Shipman, & Suveg, 2002). As children develop these tasks, the role of cultural factors cannot be ignored. An examination of the cultural expression of emotion (i.e., emotional strengths of African American children, including spirituality, cooperation, respect for others, a sense of humor; Lambert et al., 2005) and expressive individualism (Boykin & Toms, 1985) is critical to understanding emotional development and its relationship to resilience and strength in African American children and adolescents.

Rather than being distracted with perceived threats and self-defeating attitudes, African American youth with well-developed emotional competence are able to mobilize resources, learn new information, acquire new insights, or develop their talents despite negative messages from society to the contrary. This is particularly salient given the potential for African American youth to be stereotyped as hostile or excessively reactionary. Positive and optimal emotional regulation includes being critically minded in emotionally tense settings. Flexibility across circumstances is critical for emotional regulation, as is engagement, which in the case of emotional development prevents social withdrawal and isolation through anxiety and depression. Collective culture and socialization experiences help to buffer African American children and youth from harmful forms of emotional expression.

In addition, programs that foster the growth of empathy in African American youth (e.g., the Aban Aya Youth Project; Jagers, Morgan-Lopez, Howard, Browne, & Flay, 2007), promote racial socialization as a method for reducing anger and aggression (e.g., Preventing Long-Term Anger and Aggression in Youth; Stevenson, 2002), improve aspects of parenting associated with the early development of conduct problems, and promote social and cultural competence in early-school-age children (e.g., Black Parenting Strengths and Strategies; Coard, Foy-Watson, Zimmer, & Wallace, 2007) have shown promise.

Optimal Environments

While there are many environmental and systemic conditions that place African Americans in California at considerable risk, research also shows that some environmental factors have the ability to offset the risk of others. A strategic public health approach to PEI for African Americans should consider the large body of research on protective factors for those of African decent. The improvement of these environments is the logical outcome of an effective public health PEI plan.

Positive Religious Environments. Central to the resilience of African American children and youth are individual characteristics such as empathy and religiosity (e.g., personal beliefs in God or a higher power, church attendance). Concern for others and a sense of a higher purpose help youth become engaged leaders and advocates for their community. Haight (1998) found that storytelling within a church community was an important tradition that encouraged cooperation, such as in a game called *Oregon Trail*, and spirituality, such as in Bible stories. Particularly in communities where African Americans are isolated through small numbers, church was clearly a center of community.

In other ways, Haight (1998) found that the church also provided a bridge to competency in the outside world, such as through development of a computer club, that focused on skill development for youth and provided a training ground for majority culture interns from the local college who provided professional expertise. In this environment, practitioners gained "hands on" cultural competence and youth developed ties to those at the college as a form of outreach and college preparation. In the church or mosque setting, an integration of life skills and cultural bridge-building could take place in a trusted environment.

Positive Family Environments. Positive family relationships are extremely important in emotional development. Research on emotional self-regulation in African American children has demonstrated similar findings with other ethnic samples, showing that, the better (i.e., the more positive, supportive, educational) the parent–child relationship, the more able the child is to develop effective emotional regulation (Kliewer et al., 2004; Little & Carter, 2005).

African American children and adolescents, like other youth, benefit from close relationships with and monitoring by caregivers, two factors which, within the context of family, prevent problem behaviors and promote competence (Sale, Sambrano, Springer, & Turner, 2003; Wills, Gibbons, Gerrard, Murry, & Brody, 2003). African American caregivers have evidenced culturally specific parenting practices (e.g., racial socialization), which can be conceptualized as parental strengths that foster children's social development (Hughes et al., 2006).

Parental involvement in the educational process is a significant predictor of academic achievement for African American children (Shumow, Vandell, & Posner, 1999). Other family characteristics are also predictive of school functioning. In Clark's (1983) analysis of low-income African American families, those children achieving academically had parents who were warm, monitored their children's time, and set standards for academic behavior.

Parents who possess and practice attitudes, goals, and behaviors directed toward academic achievement are crucial to fostering positive school outcomes for their children. Contrary to the notion that harsh parenting styles are beneficial to children growing up in urban, low-income settings, research has associated harsh parenting styles with poor academic achievement (Shumow et al., 1999). African Americans are disproportionately represented in low-income populations. The relation between low SES and academic and cognitive outcomes (i.e., children from wealthy families demonstrate greater academic success than those from low-income families), however, is not straightforward or always strong. Research in this area has moved beyond simply documenting poor outcomes to investigating the process by which financial limitations operate to influence cognitive success. Parental involvement, parent–child relations, and the qualities of the home environment appear to be key mechanisms in the influence of SES on cognitive outcomes (Shumow et al., 1999). For example, Mandara and Murray (2000) found that African American adolescent boys with nonmarried parents are at risk for developing lower self-esteem, but a more structured home environment may buffer these effects.

Constructs such as positive family environment and social support are not the domain of any particular gender, age, or ethnic group and exist to some extent for all groups of children. These constructs are shared across racial and ethnic groups, but their expression may be culturally defined. Research has shown that diverse cultural groups

have different ways of enhancing positive outcomes for their children (Johnson-Powell & Yamamoto, 1997).

Positive School Environments. In school, the social processes between teachers and students and among peers are important for setting behavioral norms and expectations that promote cooperative engagement in school. Promising protective factors in social resilience are related to teacher practices (e.g., "warm demanders" [Vasquez, 1988] and "compassionate disciplinarians" [Irvine, 2002]), the behavioral norms of the classroom, and the atmosphere of the school as a whole. African American students' social development may also depend on the influence of peers in the classroom, and research on peer norms, peer affiliation in schools, reduced aggression, and increased cooperation is emerging.

Because we live in a racially conscious society that tends to oppress as opposed to uplift, African American youth are especially vulnerable to that which injustice provides: the suboptimal development of the very skills that are critical for their prosperity. Despite these hardships, African American youth demonstrate resilience. Research is beginning to show this. Individual characteristics such as academic self-efficacy or the child's belief in his or her academic competence operate as protective factors for African American children at risk for poor cognitive performance (Bandura, 1986).

Academic self-efficacy may affect children's choice of activities, the amount of effort they commit to meeting a goal, and their persistence on tasks. Some evidence has supported the idea that academic self-efficacy is particularly important for African Americans' high academic achievement. Research has also established the relation between self-esteem and academic outcomes for African American children, but exclusive focus on any one factor likely masks the complex associations of self-identity, including racial identity and adaptive cognitive functioning.

Although a sense of school belonging is important for all students, it may be especially important for African American students, who are more likely to feel estranged in school environments where values and beliefs are discordant with their own (Ford, 1993). Although most children experience some stress (e.g., lower grades) when they transition to middle school and high school, African American children are at greater risk for school failure than their European American counterparts and feel more disconnected when the culture of the school environment is dissimilar from their own (Ford, 1992). Teachers' discriminatory attitudes and their relationships with African American students pose risk for poor cognitive outcomes (Richman, Bovelsky, Kroovand, Vacca, & West, 1997). Studies have shown that African American children exposed to teachers who displayed sincere concern for their academic success demonstrated better cognitive outcomes (Steele, 1992).

In addition, the way children navigate the transition to middle school is a critical protective factor. A study of 62 African American families living in poverty, found effects of psychological, family, and school factors on students' grade point average (Gutman and Midgley, 2000). Students experienced a significant decline in grade point average across the transition from elementary to middle school. Students who felt more academically efficacious had higher grade point averages across the transition than did their peers. Significant interactions were found between family and school factors. These results suggest that focusing on the combination of family and school environment together may be most effective in supporting the academic achievement of poor African American students during the transition to middle level schools.

Evidence-based programs such as Families and Schools Together (FAST) may support and enhance these protective factors.

In another study of the middle school transition for African American youth, Burchinal, Roberts, Zeisel, & Rowley, (2008) related severity and timing of risk exposure to academic achievement and adjustment between 4th and 6th grade in 74 African American children. Longitudinal analyses indicated that **severity more than timing of risk exposure** was negatively related to all outcomes and that language skills mediated risk. **Language skills** and parenting served as protective factors, whereas expectations of racial discrimination was a vulnerability factor. Results imply that promoting parenting and, especially, language skills, and decreasing expectations of racial discrimination provide pathways to academic success for African American children during the transition from elementary to middle school, especially those exposed to adversity.

Positive Community Environments. Community context is critically important to the well being of African American youth. High-quality child care, after-school programs, and faith-based institutions are protective resources (Leventhal & Brooks-Gunn, 2000; Shinn & Toohey, 2003), as are preventive intervention programs. Such programs need to be developmentally and culturally appropriate, address multiple health-compromising behaviors, offer services, sustain intervention over time, and include a school focus with family, peer, and community components (e.g., Kellam & Langevin, 2003; Kreuter, Lukwago, Bucholtz, Clark, & Sanders-Thompson, 2002). **The most exemplary programs harness cultural and community processes already occurring in African American communities to effect outcomes and enhance participant recruitment and retention.**

Neighborhood and community influences also serve as protective factors for emotional development. High-quality, stable neighborhoods and schools (e.g., resource rich, supportive, nonviolent) are important contributors to the well-being of African American youth (Kowaleski-James & Dunifon, 2006).

Positive Physical Health. African American youth who are in good physical health are more likely to experience positive mental health, fewer behavioral and social difficulties, and sharper or more responsive cognitive functioning (DHHS, 2000a). In the context of both positive and adverse outcomes, social determinants of health such as poverty and access to quality health care have had a unique impact on African Americans (Giles & Liburd, 2007). Moderating the effects of contextual factors are, among other considerations, SES at an individual and community level and access to and quality of health care and information (Marmot, 2005; McLoyd, 1998). An important literature has emerged describing the independent and cumulative effect on health of factors such as social inequality, social cohesion, and educational parity (e.g., Berkman & Kawachi, 2000; Marmot & Wilkinson, 2006).

The African American community has begun to address obesity and its comorbid conditions in a number of ways, focusing on two important protective factors for childhood obesity: diet and physical activity. For example, a number of churches have developed and promoted cookbooks supportive of traditional recipes that use ingredients that promote good health. Likewise, a number of churches now offer athletic activities for youth congregants or dance ministries as a way to promote physical activity.

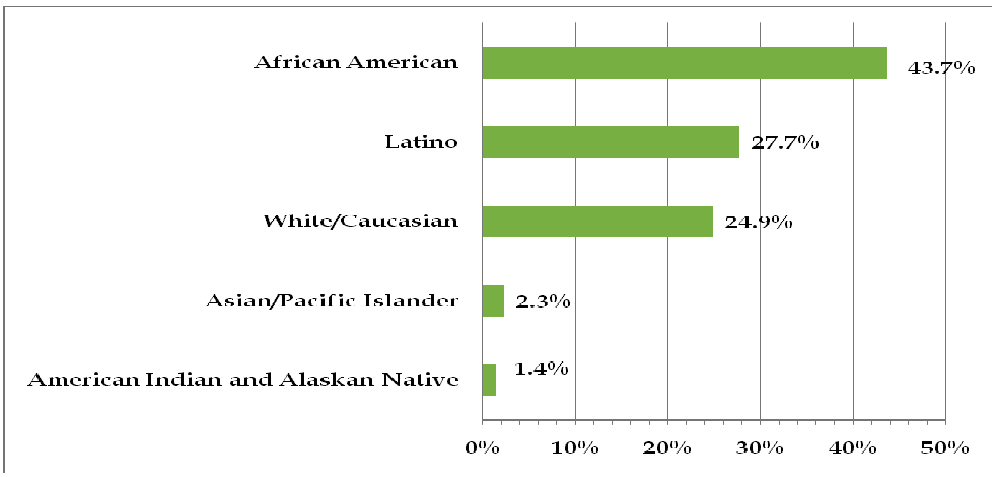
D4B. CASE STUDY EXAMPLES: COMMUNITY-DEFINED PEI PRACTICES IN CALIFORNIA

Case study generally refers to a form of qualitative descriptive research that investigates and collects detailed information about an individual or small participant pool, drawing conclusions only about that participant or group, and only related to the specific context under investigation. The goal for our project was to identify community-based practices from the perspective of local African Americans working on population level "self-help" efforts currently underway. We used a multi-modal approach to collect data from interviewees, direct observation, and published reports for Northern, Southern, Central and Los Angeles regions, with specific attention to rural, urban and inner-city settings. Information shared during focus groups, meetings, and surveying provided by participants warranted an in-depth interview to capture the local details related to PEI and mental health. No selection criteria were imposed. The information contained in the case studies is the opinion of local residents based on their **lived experiences**.

Case Study #1:
Los Angeles County - Skid Row Resident Positive Movement

The homeless are the most vulnerable population at-risk for mental health services. Every two years as a part of a national effort the U.S. Department of Housing and Urban Development (HUD) counts the homeless population. The Greater Los Angeles Homeless Count (LAHSA, 2011) is the nation's largest count of homeless individuals and families. According to HUD, a homeless person is defined **ONLY** when he or she resides in one of the following conditions:

- An *unsheltered* place not meant for human habitation, such as cars, parks, sidewalks, abandoned buildings, or on the streets
  Or,
- A *sheltered* place such as an emergency shelter; or transitional housing for homeless persons who originally came from the streets or an emergency shelter



Source: Los Angeles Homeless Services Authority (LAHSA), 2011

Figure 41: *Los Angeles County Homeless Population by Ethnicity, 2011*

According to LAHSA (2011), there were 51,340 homeless in Los Angeles County during January 25 to 27, 2011. *Figure 41* identifies that nearly 45% of the homeless counted were African Americans. The City of Los Angeles accounted for 23,539 or 45.8% of the homeless population. In Los Angeles County, the homeless mental illness rate is 33% of the population, which is higher than the national average (LAHSA, 2011).

City of Los Angeles Skid Row

Skid Row (Figure 42), known by some as *Center City East Los Angeles*, has the highest concentration of the homeless population in the County, and the nation (LAHSA, 2009). As identified by LAHSA, Skid Row consists of three census tracks, see *Figure 43.*



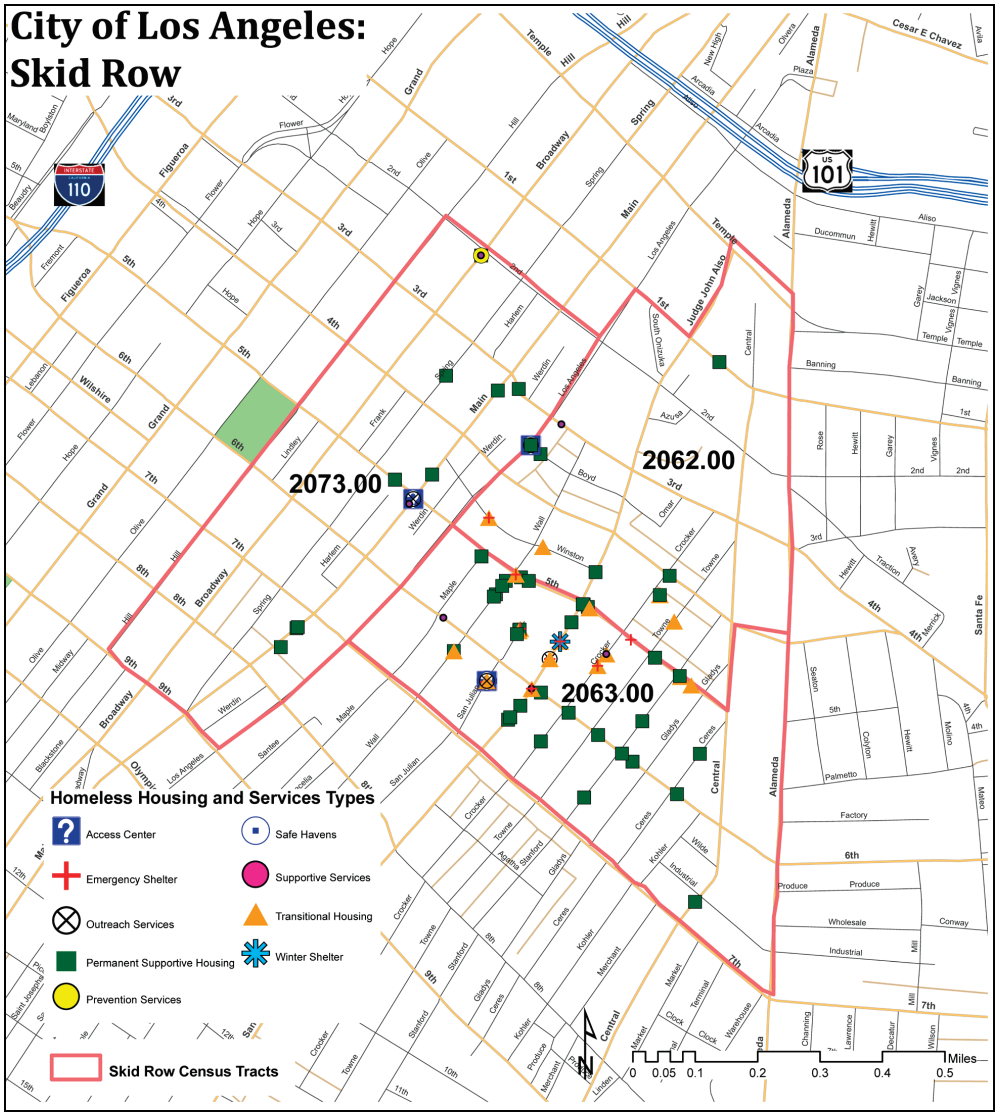
Location: Center City East Los Angeles

Population: Unknown, approx. 18,000

Ethnicity: Uncertain, approximately:
49.3% African American
24.4% Latino
22.3% White/Caucasian
2.7% Asian/Pacific Islander
1.3% American Indian/Alaskan Native

41.8% of the population lives below the poverty line (Wikipedia, 2011)

Figure 42: *City of Los Angeles Skid Row*

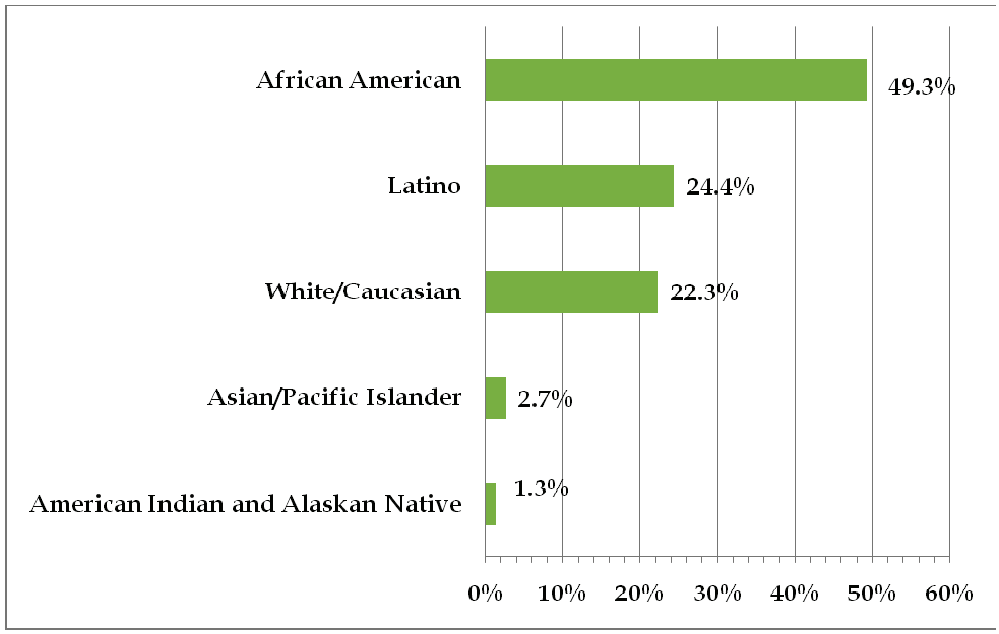


Source: Los Angeles Homeless Services Authority (LAHSA), 2009

Figure 43: *City of Los Angeles Skid Row Census Tracts*

For the purposes of our CRDP African American Population Report, the City of Los Angeles Skid Row community is presented as a case study because of decades of homeless and poor families living in this geographical area. The Skid Row community meets the target population requirements of the MHSA for the high risk factors category and because residents are current and potential clients for the public mental health system. The CRDP SPW used extra time to obtain information, practices and recommendations from this population based on their lived experiences. Additionally, the SPW felt engaging the Skid Row community was an excellent utilization of CRDP financial resources. It is commonly accepted fact, that nearly 50% of those who are homeless have a mental illness. The New Freedom Commission on Mental Health reports that "the lack of affordable housing and accompanying support services often causes people with serious mental illnesses to cycle between jails, institutions, shelters, and the streets" (Judicial Council of California *Task Force for Criminal Justice Collaboration on Mental Illness: Final Report (2011, p.305)*.

The 2011 LAHSA homeless report did not include a subpopulation report on Skid Row. Information of interest regarding the City of Los Angeles homeless report was gender, ethnicity, and persons with mental illness (24%). According to the report, of the 23,539 homeless persons in January 2011, the majority were adult males (57.7%) followed by adult females (27.0%); and children under 18 years of age equally represented by males (7.7%) and females (7.6%). Homeless ethnicity data for the City of Los Angeles was almost identical to the County profile, see Figure 44. Of particular interest is nearly 50% of the homeless in the City of Los Angeles identified as African Americans.



Source: Los Angeles Homeless Services Authority (LAHSA), 2011

Figure 44: *City of Los Angeles Homeless Population by Ethnicity, 2011*

During the data collection stage of our CRDP Population Report, we conducted four focus groups with 30 participants and 10 one-on-one interviews with residents of Skid Row.

Let's take a walk with the residents of the City of Los Angeles Skid Row, to see and hear what they think about their community.

"Everybody here (Skid Row) ain't crazy or on drugs."

Bobby May,
47 year old Egyptian, Indian, African American male Skid Row resident

"God's presence is in Skid Row. There is no way people last as long as they do, because God is here. That's why."

OG Man (Manuel Benito Compito),
62 year old, Filipino Black male resident

"Here in Skid Row, people want to live; speak the positive into people."

Yvonne Michelle Autry,
44 year old, Black female, Skid Row Resident Advocate

"Skid Row represents the world. Everybody has culture"
Ceveto Jones, 33 year old Black male, former Skid Row resident

"Lots of people on Skid Row do not have families, did not have a good base, no parents."
Crushow Herring, 33 year old Black male Skid Row resident artist

"Skid Row needs to be redesigned so people can live respectfully. People need positive home life environment. They need 'normal'."
Patricia Berman, 64 year old White female Skid Row resident
Board of Directors, Downtown LA Neighborhood Council (DLANC) Skid Row

"People on Skid Row need motivation. They need to experience success to get people to make it. We use the best of the community, to make the best of the community."
-Big MACK (Timothy Mackey),
42 year old mixed Black male, Skid Row resident

"Energy in Skid Row is dead. Must plant positive seeds, restore pride and hope; people are disconnected."
General Jeff, Black male, Skid Row Resident Community Activist
Board of Directors, Downtown LA Neighborhood Council (DLANC) Skid Row

Table 50: *What do Skid Row residents describe as interventions and practices they believe would help African Americans have good mental health?*

SKID ROW RESIDENT	RECOMMENDATIONS
Charlyne Brooks 54 year old Black female (aka, Mama Cat); diagnosed with bipolar	*"Inner city schools need classes in drug prevention."* *"Need psychologist in the middle schools with peer counseling every day."* *"More interaction with children, teacher and parents, parents need to be mandated everyday to school to interact with children."* *"Need to redesign single resident occupancy (SRO) housing to accommodate children and families, to help people make a reasonable living and move them from one level to another."*
General Jeff Black male Community Activist, Downtown LA Neighborhood Council (DLANC) Board of Directors	*"Need natural support system, which is the family."* *"Need to create family housing structures; families in Skid Row currently do not have a place to live."* *"Invest in people. Recovery model is the current method to help people. It does not work for people NOT in addiction."* *"Need love and caring for fellow man."* *"Need programs and curriculums in Skid Row that use the normal natural support system, which is the family."*

Big MACK (Timothy Mackey) 42 year old mixed Black male; diagnosed with PTSD	*"Screen people to see where they are at. Everybody's on a different level."* *"Give people options, not just medication, such as mentoring, connect to networks, help with self-support, and need to be more proactive."*
Ceveto Jones 33 year old Black male, former Skid Row resident	*"Need to not put people of medications. Medications make people believe they need medication and causes people to act crazy to get benefits."*
Yvonne Michelle Autry 44 year old Black female resident advocate	*"Need opportunity to interact, to spark people to life, to have recovery of life skills, re-apply talents, occupational job training, spiritual maintenance & counseling, community involvement."*
Coach Ron Black male Skid Row resident advocate, health educator, parent, minister	*"Mental health is physical activities; keep people moving."* *"Need to eliminate mental anguish to having family housing."* *"Need more positive influences working in Skid Row."* *"People need to have ownership of property. Co-opt the independent hotel to create family structures."* *"Must beautify the community. Skid Row is depressing."*
Crushow Herring 33 year old Black male artist	*"Need a Cultural Center with entertainment, art, workshops, counseling, a place to learn a trade, a chapel for spiritual needs."* *"People need appropriate diagnosis."* *"People need a support system that believes in them."* *"Need the right people down here on Skid Row to help the people. For example, people need to be a people's person, patient, an attitude of acceptance, and help people work through life crises."* *"We need brochures, signs, advertisements about mental health programs and other programs to help people. No one comes around to get people into mental health programs."*

Table 51. *Skid Row community activities and practices by residents to improve their community and individual well-being*

PRACTICES	EXPECTED OUTCOMES
System Change Agent *Don Edmondson*	Member of California Mental Health Service Act (MHSA) Oversight and Accountability Client Family Member Committee Member of the California Multicultural Mental Health Coalition (CMMC) Member of the Los Angeles County Under-represented Ethnic Populations Mental Health Coalition (UREP) Member of the MHSA statewide California Reducing Disparities Project (CRDP) African American Strategic Planning Workgroup (SPW) for the development of a comprehensive Population Report documenting community practices to eliminate disparities in mental and behavioral health, and statewide system change recommendations for the Department of Mental Health (DMH) Mental Health Services Act (MHSA) California Reducing Disparities Project (CRDP) to be included in the DMH Multi-Cultural Mental Health Strategic Plan for the re-design of the DMH (2011)
Annual Father's Day Event in the Park *OG Man (Manuel Benito Compito) initiated in 2005*	Role model positive fathering Increase self-esteem Positive family interaction
Fun Zone Reading Club for Homeless Kids *Coach Ron Crockett*	Increase reading levels Positive socialization
WAKE-UP Peace N Hood Coloring Contest Stop the Violence, Keep the Peace Book Club *Coach Ron Crockett* *Big Mack (Timothy Mackey)* *OG Man (Manuel Benito Compito)*	Collaborative effort to visit schools in Skid Row to make reading fun for children; interactive project for teachers and students Decrease violence Positive male role modeling
Skid Row Photography Club *Michael Blaze, initiated in 2007*	Healthy artistic outlet Develop new possibilities of positive self-expressions and personal self-development and growth Art therapy
Downtown Art Walk	Positive interaction with community, monthly event
Skid Row Theater Group	Gives life to people Allows for expression and to work through regressed feelings and emotions

Operation Face Lift: Skid Row *General Jeff & OG Man (Manuel Benito Compito), initiated in 2008*	Change environment to positive expressions Painting bright colorful murals Give residents a positive sense of belonging Give residents opportunity to clean up their own environment Stimulate positive thoughts
3 on 3 Street Basketball League *OG Man (Manuel Benito Compito) Initiated in 2007*	Self discipline Positive release of energy Physical fitness Positive collegial relationship building 2011 Major event – Venice Beach Basketball League (VBL) with ex-NBA players against the Skid Row Ambassadors; Event was a positive family-friendly affair that involved a variety of activities for the entire community
Multi-dimensional Media Advocacy *General Jeff, initiated in 2007*	Present positive promotion of Skid Row resident's awards, honors, and recognitions Engender hope in Skid Row residents Change the public image of the Skid Row community, featured on CNN, ABC, CBS, national public radio (NPR), ESPN Experience, Radio Disney, KCET, local radio stations, local news papers, and the Associated Press (AP) Increase visibility of a positive Skid Row community Skid Row positive movement featured in daytime soaps won 2011 Daytime Emmy Award for Outstanding Drama Series and Directing Team of the Bold and the Beautiful (CBS) Coordinated with Reshoot Production Company to donate over $10,000 dollars to School on Wheels to help homeless students

Environmental Systems Change Agent *General Jeff, initiated 2008*	Board of Directors, Downtown Los Angeles Neighborhood Council (DLANC) Skid Row Facilitated meetings with Los Angeles Department of City Planning and Skid Row residents for input into the 10-year Downtown Los Angeles Land Use Plan (2008) Initiated the testing and change of underground water pipes for drinking fountain units in Skid Row parks (Gladys Park and San Julian Park) by the Department of Recreation and Parks (2008) Series of meetings with Skid Row Housing Trust to redesign and change "overnight guest stay" policies (2009) Workshop with Los Angeles Police Department (LAPD) focused on "Homelessness and Mental Illness" in Skid Row for officers training on sensitivity issues facilitated by LAPD in-house doctors (2010) Facilitated change through CBS Outdoor and Hennessey's corporation offices in France for the removal of multiple billboards in Skid Row that advertise their products; efforts to decrease substance abuse and mental illness (2010) Successfully worked with Los Angeles Metro Transit Authority (MTA) to bring 720 Rapid Express bus stops to Skid Row (2010) Collaboration with "The Serving Spoon" Soul Food/ Urban Eatery Restaurant's EBT Food Program to bring hot soul food to Skid Row; addressing nutritional food options for residents (2010) Facilitated the inclusion of African American Skid Row residents in data collection and development of the comprehensive CRDP Population Report documenting community practices to eliminate disparities in mental and behavioral health, and statewide system change recommendations for the Department of Mental Health (DMH) Mental Health Services Act (MHSA) California Reducing Disparities Project (CRDP) for the DMH Multi-Cultural Mental Health Strategic Plan to re-design California' mental health system (2011) Chosen for President Obama's "Community Leaders Briefing Series" in Washington, D.C., (August 2011)

Culturally Grounded Approaches: Family
"When You Are at Home, Your Troubles Can Never Defeat You"

Survival of the group is valued over competitive survival of the fittest individual. So the default unit of service and self determination is understood primarily as family, or community, over individual, time consuming community dialogue is valued over the point, counterpoint of "healthy" debate.

The Primacy of Family: For people of African ancestry, the primacy of family cannot be overemphasized. Regardless of whether the consumer is adult or youth, the family is the conduit of culture and identity. Treatment or prevention can either be an intrusion or a companion to their patterns of everyday life (Parham, 2010). At the family level, outcomes can include those functions that families serve in African life. Families are child-centered; they include support networks, multiple households, flexibility to meet daily challenges, connections to faith communities, oral traditions between generations, and community involvement (Bagley and Carroll, 1995). They provide racial awareness, positive cultural identity, and self esteem. When these functions break down, individual members may suffer. These should be explored as resources and goals of restoration in the family. Bonding is a necessary rite of passage and is the foundation of growth, *development and connection with the energy of the natural world* (Afrika, 2000).

Activities developed and initiated by Skid Row residents embrace their "positive movement" to create a respectful environment for people to live, work and play. All of the activities are designed to enhance the ability of the African American family and community to establish positive rituals that can help restore hope and healing. Skid Row residents are acting with urgency, and have vowed to save their people from total destruction and annihilation with or without the help of local authorities. General comments from Skid Row residents are, *"No one seems to give-a-damn. People are playing games with other people's lives, and people are dying. The problems are critical and nobody is acting with any sense of urgency."*

> *"MHSA decision-makers have never met us, have never spoken with us and therefore do not qualify to represent Skid Row as a community! How can they, when they aren't even aware of our collective concerns as residents in Skid Row, Downtown Los Angeles? Whenever MHSA decision-makers are ready to speak with us directly, we will be here, in Skid Row, waiting to greet them with tons of compelling testimonies from the various demographics in Skid Row. Demographics such as homeless transients, homeless vets, victims of domestic abuse, people suffering from complete poverty including mothers with children and more; all victims of mental illness. And, please be reminded that there are even more than these specific demographic categories. Some people are too scared and intimidated to speak publicly about their concerns, such as those with HIV/AIDS. We are all people, too, and we have a constitutional right to not only be heard, but have our issues addressed in a timely manner. We are suffering. We are confused. And, we are dying!! We need the appropriate help, not lip service."*
>
> General Jeff, Skid Row Resident & Community Activist
> Board of Directors, Downtown Los Angeles Neighborhood Council
> (DLANC) Skid Row

Case Study #2:
San Bernardino County –
African American Mental Health Coalition (AAMHC)

The African American Mental Health Coalition (AAMHC) is a group of African American consumers, client family members, faith-base individuals, stakeholders and providers. The AAMHC partnerships includes welcoming individuals with mental illness to exercise their authority to make decisions, and choose from a range of available resources and options to effectively develop their full capacity to think on their own behalf.

To further address the needs that African Americans have for mental health services, the AAMHC recommended to the San Bernardino County Department of Behavioral Health (DBH) cultural competency advisory committee that funds be allocated for capacity-building. The recommendation was well received and the county allocated funds to conduct an outreach program to actively inform African-American led and serving organizations of the MHSA and increase their capacity to provide services by providing training and technical assistance. The AAMHC believed training would increase non-profits chances for success in responding to RFP's and obtaining funds for PEI, as well as private foundation funding to address the needs of the African American population.

Over 65% of the African American population in San Bernardino County lives in the Westside of the county. The geographical location is depicted as the concentrated areas on the map (*Figure 45*) in the lower border of the county.

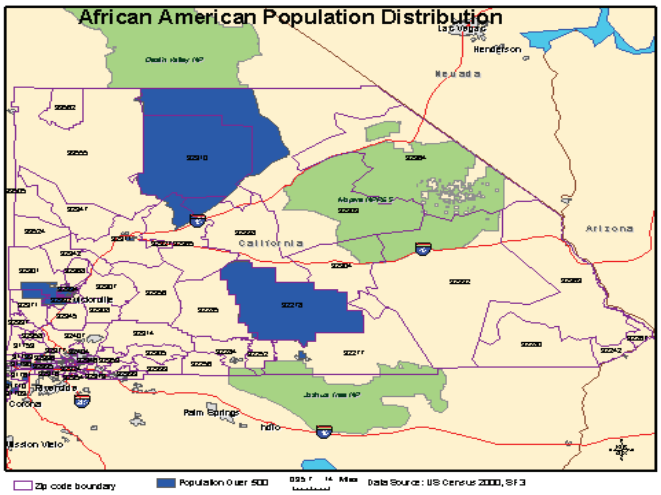
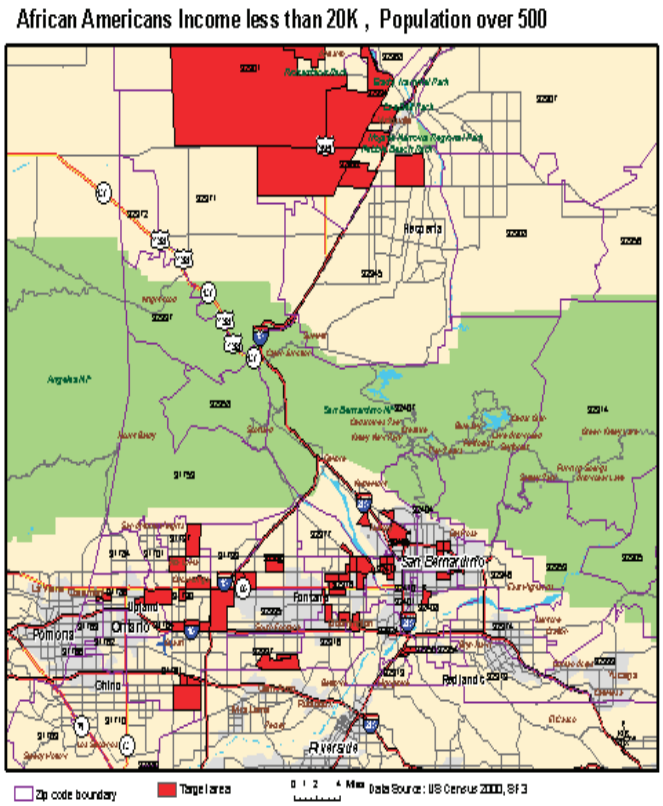


Figure 45:
Westside
San Bernardino

Areas on the map (*Figure 46*) highlighted in red are the locations of the highest poverty rate for African Americans. The red shared areas have annual household incomes of less than $20,000 per year.



Location: Westside San Bernardino

African American County Population: 166,671 (appx. 108,336 live in the Westside)

5,121 – actual served in San Bernardino County DBH (2007-2008)

11,657 – projected number needed to be served in San Bernardino County DBH

Type of Mental Health Services Received (2007-2008):
14 - 24 Hour In-patient
89 - One Day Outpatient
1,303 - 2-4 Days of Service
1,975 - 5-15 Days of Service
932 - Greater than 15 Days of Service

(Data Source: California Department of Mental Health, CSI website, August 9, 2011)

Figure 46: *Enlargement West Side San Bernardino*

To significantly impact the needs of African Americans to have culturally appropriate mental health services, the AAMHC in collaboration with the San Bernardino County DBH have successfully implemented:

African American Outreach Project: A 6-month target specific mental health African American Outreach Project. Funds were also successfully secured to hire an African American project manager. The AAMHC and project manager launched the project on March 9, 2009 utilizing the principles of the Community Needs and Readiness Assessment. This project identified 60 community and faith-based nonprofits, and assessed the needs and effectiveness of these organizations to provide mental health services. Among the participant organizations were the Inland Empire Concerned African American congregations, members of the Inland Empire Minority-led Resource Development Coalition and other minority-led organizations. As a result intensive training in grant writing, board development, building partnerships, collaboration and strategic planning occurred. Some participants (12) received one-on-one technical assistance in nonprofit operations and management. The AAMHC's intent is to continue to build a system of care that provides appropriate services, reduce stigma and bring awareness to improving outcomes for African American consumers and their families.

Community Outreach Liaison Positions: Continual advocacy efforts with the DBH and the AAMHC resulted in major systems changes. *Two community outreach liaison positions* for African Americans were created and staffed with a TAY and a LGBTQI individual to target efforts specifically toward these sub-populations, as well as the general targeted population.

African American Mental Health Regional Conference: Another major accomplishment of the AAMHC was the convening of an *African American Mental Health Regional Conference* to address issues of stigma. Nearly 100 individuals attended, including mostly TAYs.

Tailored African-Centered Programs: Of critical importance is the advocacy and collaborative efforts of the AAHC resulted in funding two tailored African-Centered initiatives with MHSA funds in 2010. One was the *African American Resource Center*, and the other, *Resilience Promotion in African American Children Project.*

Significant Funding to African American Community: Connecting with the established African American community in active collaborative efforts demonstrates that meaningful mental health activities can be generated in a short timeframe, and can produce tremendous results. Collaborative efforts in San Bernardino County with the Department of Mental Health and the African American community demonstrates that *significant investment of MHSA funds (over $2 million dollars)* in target specific community-defined practices can and will result in improved service delivery and mental health outcomes, including systems changes.

Culturally Grounded Approaches to System Changes:
"It Takes a Whole Village to Raise a Child"

In the process of restoration of order in the African-American community, there are several critical components of an African-centered model of PEI for the family that need to be implemented. At the institutional level, RFP's can request that bidders provide evidence of the following:

1. Establish African-centered theories of human development and transformation;
2. Develop culturally consistent intervention, prevention, and treatment methods;
3. Create African-based development and training programs in response to the concrete conditions affecting the viability of African peoples;
4. Create contemporary examples of traditional African-American techniques of child development without violating the traditional cultural core; and
5. Develop methods and processes designed to force societal institutions to respect, reflect, and incorporate the cultural integrity and expressions of African peoples (Wade & Goddard, unpublished proposal).

Case Study #3:
Marin County – Wealth/Poverty/African American and Inner City,
"ISO JI (e-so-gee) Project

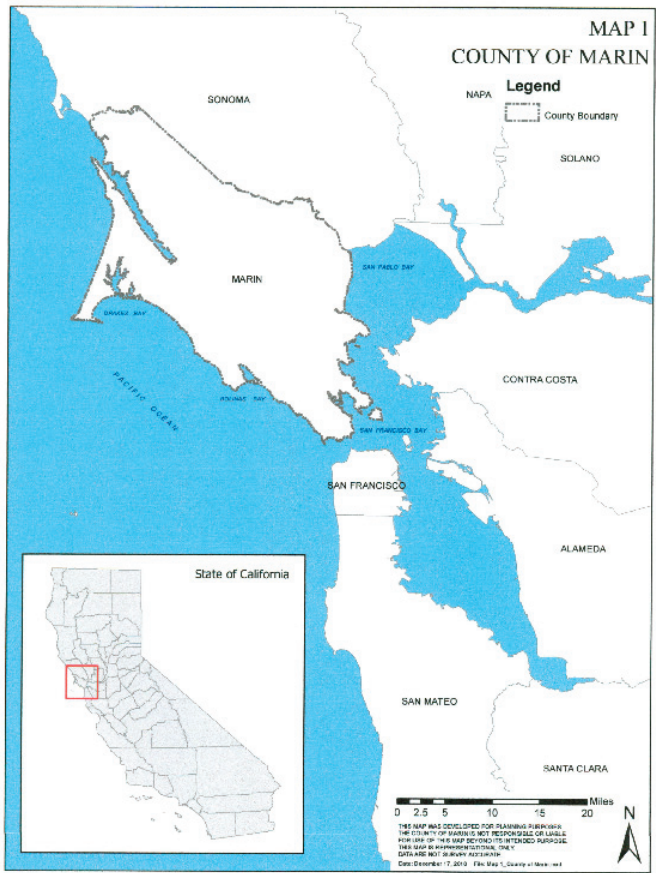
Marin City is an unincorporated community and *census-designated place* (CDP) in Marin County, California, United States, with an underserved and ethnically diverse population of families and individuals at risk of mental illness and other health issues. Many of the **African American** shipyard laborers who had migrated from the Southern U.S. ended up living permanently in Marin City either by choice or because many of the Black families were not allowed to live or buy homes in the towns surrounding Marin City due to racism. They became the core of the community when most of the other guest laborers departed at the end of WWII.

The Marin County (Figure 47) population is predominantly 72.8% non-Hispanic white, 15.5 Hispanic or Latino, any race; 5.4% Asian, and 2.6% non-Hispanic or African American. According to needs assessment reports by ISOJI (e-so-gee), a grassroots community organization which began in 1999, working on social justice concerns in the community, the African American population is characterized by under-education, lack of access to timely family and individual mental health services, untreated conditions, and the lack of transportation that fits the community's needs.

Due to the continued lack of response to community needs by funders and policy makers, the *Health & Wellness Center* was opened in Marin City in 2006. It has expanded from treating under a thousand residents a year to treating over 4000 residents from Southern Marin. In early 2011, the *Health & Wellness Center* was under threat of funding cuts due to lack of funding opportunities. However, on August 9, 2011 one of the greatest affirmations that could have been received by community leaders came from the United States Government notifying the *Health & Wellness Center* and its collaborative partners that they were recipients of the Federally Qualified Health Center (FQHC) status. FQHC status gives the *Health & Wellness Center* the ability to deliver comprehensive health care, dental services, mental health, and prevention and health education to the community and school district. Congratulations to the community for enduring tremendous obstacles, and persevering through great challenges.

The *Marin City Network*, a community based program, was approved for PEI grant monies to provide emotional and educational support to middle school youth. Funding to provide non-mental health services was brought into the community and cancelled the PEI grant for the Network, with no community input.

Other issues within this community are problems with unemployment (40%), a huge educational achievement gap, housing problems, and a community with historical resilience, unable to utilize services proactively to address its acute and chronic health problems. The historical trauma experienced by the African American population has been, and is reinforced by the institutional policies and paternalistic mentality that impacts the service needs of this community. The majority of services are not community driven. This Southern Marin community is still made up of individuals and families, rooted from the WWII era, who are continuing to work towards a unified community based on the resiliency found currently in the area.



Location: Marin City

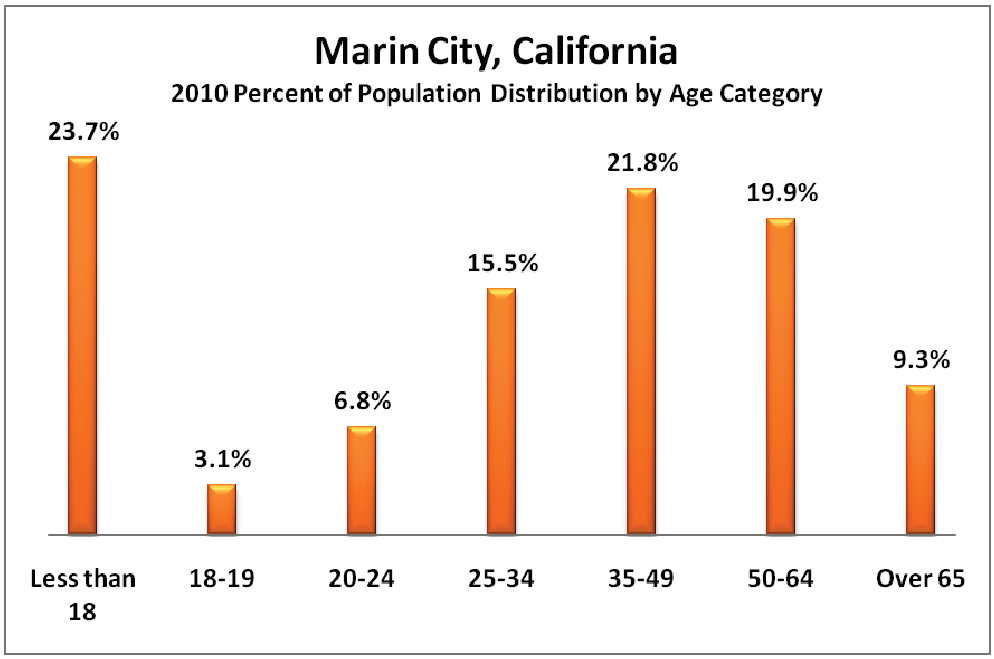
Population: 2,666 (2010 Census Bureau, 2011)

Ethnicity:
38.8% White
38.2% Black / African American
13.7% Hispanic (any race)
10.8% Asian
6.3% Two of More Races
4.5% Other Races
0.79% Pacific Islander
0.56% Native American



Source: U. S. Census, 2010

Figure 47: *County of Marin Map*



Source: U. S. Census Bureau, 2010. Note, categories as reported by the census

Figure 48: *Marin City Age Distribution*

Marin County is well known for its natural beauty, liberal politics, and affluence. According to the U.S. Census, and in 2009, Marin County had the fifth highest income per capita in the United States at $91, 483. Marin County is also the number one richest county in California. However, Marin City is demographically unique to the rest of the county. Besides having the highest concentration of the Black population in the county, Marin City also has the highest per capita death rate in the county and the highest rate of children of color in the juvenile justice system. Figure 48 is a distribution of the age category for Marin City residents, nearly 25% are under age 18.

ISOJI(e-so-gee) is a Nigerian word for 'rebirth, or revitalization, or renaissance. The mission of ISOJI is to facilitate the process of *building community from within* through social justice, advocacy, and effective communication. *ISOJI* has facilitated the development of several programs that support family resiliency, early childhood education, mental health, health & wellness services, and collaborative efforts of community building between family and community members, service providers, and organizations, leadership and policy makers, while maintaining neutrality, integrity, transparency, and accountability to the community.

Through in-depth interviews with community activists, community forums, and community surveys, the following are a list of issues identified by the Marin City residents. The need for:

1. Clear roles, boundaries, education, transparency, and communication regarding responsibilities and accountability of service providers
2. Strong "culturally competent" coordinated services
3. Information that describes existing resources, service providers, and services provided
4. "Authentic" community participations and input
5. Consistent coordination, collaboration, and team building, from within the community and outside of the community
6. Positive relationship building
7. Insufficient activities for youth and transitional age youth
8. Programs that address addiction across all age groups
9. Leadership education/programs Communication system to inform community of issues, services, & political support

Table 52: *Marin County Community Created Solutions*

All services are community-based and community developed for the African American population, and services all ethnic groups.

ACTIVITY	AGENT	OUTCOMES
ISOJI, 1999	Ricardo Moncrief	Developed responsive programs and interventions for Marin City Facilitates forums on community issues, provides neutral dialog and communication, brings together community & families, service providers and organizations, and policy makers
Southern Marin Multidisciplinary Team (MDT)	Elberta Eriksson, BCD, LCSW	Coordinates services for underserved/no services populations in Southern Marin with collaborative/team modality
Southern Marin Intern Project (SMIP)	Leslie Johnson, M.S.W., PPSC Elberta Eriksson, BCD, LCSW	Provides culturally appropriate in home/ onsite social services, and mental health services to families/individuals; advocacy, parenting support services
Marin City Health and Wellness Center, 2010	Curtis Robinson, MD	Provide medical care to low/moderate income populations in Southern Marin
Marin City Network	Sharon Turner, Director	Working collaborative providing youth focused academic leadership development opportunities to middle school youth and their families
Hanna Project	Bettie Hodges	Provides support to boost academic performance and college graduation rates of African American student and other low income Marin students
Community Development Corporation (CDC)	Makini Hassan	Economic development self sufficiency, job skills for Marin City and North Bay populations
Marin City School Readiness Program	LaDonna Bonner, Coordinator	Work with children 0 to 5 and their families getting them ready for school, social/ emotional development, parenting, advocacy
Southern Marin Service Center	Dr. Jeffrey Hall	Mental health services for families/ individuals, parent aide program, groups for children funded by Prop 63
Women Helping All People	Royce McLemore	Charter School support services for low income families

Marin County, particularly Marin City, is a perfect example of how deep community needs are masked by wealth.

"The closeness to wealthier communities makes disparities much more significant and extreme when contrasted against them. We have a wealthier sector within the community that is relatively non-integrated in public affairs. This is a civic problem that typifies how neighborhoods can isolate themselves from the common community interest."

Ricardo, Chair, ISOJI

The community is represented at the table for fair, meaningful, and equitable input into the distribution of resources. ISOJI group felt there needs to be community representation on County boards, commissions, and other decision-making groups to enable the design of culturally appropriate strategic plans for the community. Stakeholders in the community need to be trained and educated to appropriately represent the voices of the community.

"All service providers and stakeholders working in the community must shed the "silo" mentality and work collaboratively in the best interest of the community."

Elberta Eriksson, BCD, LCSW

"The MHSA Prevention and Early Intervention category of funding has made no impact on the delivery of mental health services. The community service based organizations need to be able to take advantage of these monies to ensure culturally competent services within the community."

Leslie Johnson, MSW, PPSC

Community Involvement in Developing Mental Health Services

As reported by Ms. Eriksson and Ms. Johnson, up to the date of the completion of this report, the community involvement has been negligible. When funding has been earmarked for the community, the community is neither respected nor heard as to what the community sees as an appropriate design for service delivery.

Case Study #4: Butte County –
African American Family Cultural Center: A Path to Positive Change Project

The Southside Oroville stakeholders, those who live, work, play or worship in Southside, were invited to participate in a community visioning process facilitated by the National Community Development Institute (NCDI). This project was collaboration between Butte County Department of Behavioral Health (BCDBH) and S. H. Cowell Foundation. The S. H. Cowell Foundation contracted with NCDI to conduct a community process called, A Path to Positive Change (PPC). BCDBH initiated the process to build on their approved PEI plan which includes an African American Family and Cultural Center in Southside Oroville. S. H. Cowell was interested in finding out specifically what the community stakeholders thought was needed to improve their community and if the needs were consistent with the Foundation Funding portfolio. By coming together in one process, there was hope that PPC would garner a wide variety of stakeholders and support to increase community member engagement.

The PPC was designed to celebrate the rich history and promise of Southside Oroville, as well as to identify what needs to change, how to affect the change, and where to continue to work together to create opportunities for change.

The Process

The process included a series of listening sessions with residents, faith-based and organizational leaders, participating in community tours, convening co-design meetings with residents, and facilitating several large community meetings and workgroup sessions. As a result of multiple meetings the development community workgroups were created to address, Community Pride, Blight, & Housing, Crime, Safety, Drugs, Community Relations & Racial Tension, Education and Employment, and Family Connections, Sports, Recreation, and Youth. Each of these groups created goals and objectives which they implemented over the next year. The final workgroup of the PPC was the group that developed the implementation plan for the **African American**

Family Cultural Center (AAFCC) and the creation of the AAFCC Community Advisory Team. A strong and powerful AAFCC mission statement was developed and has been a foundation for implementing the AAFCC.

AAFCC Mission Statement:

The mission of the African American Family Cultural Center is to empower and embrace African American families and community by reclaiming, restoring and revitalizing cultural heritage, values and identity. The African American Family Cultural Center is a place where people convene, connect and celebrate the essence of community in order to bring about healing to create prosperous vibrant lives.

Implementation of the AAFCC

The implementation plan involved the AAFCC workgroup and Community Advisory Team (CAT) at all levels including development of the RFP, reviewing the RFP, and working with the contractor in all phases of implementation and hiring for the AAFCC.

BCDBH continued to use PEI training and capacity building funding to keep NCDI an involved partner in the implementation of the AAFCC. The RFP was awarded to Youth for Change (YFC) one of Butte County's larger non-profits. This non-profit had been asked by some of the Southside residents submit an RFP. Both YFC and BCDBH were and are committed to helping build capacity in Southside Oroville especially with the AAFCC guiding it to obtain an independent non-profit status. Having the YFC umbrella to start the process toward independence allows the AAFCC to focus on program development, center stability, and community engagement, instead of focusing on the overbearing details of a large contract with the county.

A key element of implementation has been the input and direction from the AAFCC Community Advisory Team (CAT). The CAT and other community members have renovated the center into a stellar example of an Afrocentric warm and welcoming community space. Staff has been hired. A variety of events have been conducted and well attended. Some of those events include drumming circles, an African American film festival, a teen 'shout out' young women, graduation ceremonies for community graduates, an African American Reading Club for Young Men, a John Madden Football Tournament, and more.

The implementation of the center has not been without challenges. Finding the right staff has been a difficult journey. Wanting to find people who lived in the Southside Area was a key goal, yet finding the right qualified staff has been a struggle. It took the young center several months to identify a Director. Unfortunately the first director was not a good fit for the center and after a few months the center found itself without a director. Currently, the center is running without a director which means that YFC is spending much unanticipated time in helping with the day to day details of running the AAFCC. Communication between the three collaborating entities has been challenging at times, but all three are committed to keeping this dream and center alive. CAT, AAFCC staff, YFC, and BCDBH continue to work through differences and find solutions to whatever issues arise. Continued involvement from NCDI has helped the process of moving our goal forward of creating a vibrant AAFCC in Southside Oroville.

S. H. Cowell has also continued its involvement with the center by providing a Leadership Academy which consisted of Southside Community members and stakeholders. This helped to increase the capacity and skills of AAFCC staff and CAT members, as well as the capacity of Southside members involved in the other workgroups form the PPC.

Progressive Growth Takes Commitment

The Butte County's project demonstrates a major commitment to its African American population. The African American population in the entire county is only **2,967**. African Americans consist of 1.4% of the county's population; Southside Oroville has 11.3%. Additionally, 53.7% of Southside Oroville residents live below the poverty level, compared to 19.8% of the general Butte County population.

Southside Oroville at one time had a rich and thriving African American community. Over time this area has been hit by high unemployment and underemployment, increased poverty, and drug use. The African American population has developed a low trust for government programs due to the in and out nature of a variety of programs who were unable to sustain funding. The PEI community planning process had strong input about the need to provide more community based services in Southside Oroville.

Thank you, Butte County for being culturally responsive to your residents of African ancestry, although a small county with a small population this makes your investment even more significant.

Case study #5: Riverside County's MHSA PEI Initiative:
Building Resilience in African American Families (MHARC-054)

In 2008-2009, Riverside County's PEI initiative resulted in a Request for Proposals (RFP), for the African American Community, (RFP # MHARC-054), which stated the following:

> *The PEI community planning process, which included focus groups, community forums, and survey completion, resulted in the identification of culturally-tailored parenting services and after school programs for the African American population as a priority and necessary intervention for this group in order to prevent the development of mental health problems. The Riverside County Department of Mental Health proposes to establish a new program to target the African American population within Riverside County.*

Three African American vendors received initial funding for a three-year cycle, adopting and offering three programs in three county service areas:

Western Region Target Communities:
Rubidoux, East Side Riverside, Arlanza, and Moreno Valley
Mid-County Region Target Communities:
Lake Elsinore, San Jacinto, and Perris
Desert Region Target Communities:
Coachella Valley, Desert Hot Springs, and Eastside Banning

Western and Mid-County vendors began in September 2010, with enrollment beginning in November, December, 2010 and January, 2011. The Desert vendor was awarded a contract in January 2011, with enrollment beginning in September, 2011. This initiative included mandated training and fidelity with three programs, *Effective Black Parenting Program (EBPP), Africentric Youth and Family Rites of Passage Program (ROPP) and Cognitive-Behavioral Intervention for Trauma in Schools (CBITS).* Analysis for Year I data is in process. Two programs each completed two cycles of the EBPP, one cycle of ROPP, and one cycle of CBITS. Year II is just beginning and will include enrollments from all three regions into all three programs.

Effective Black Parenting Program (EBPP)
The EBPP is for parents/caregivers of African American youth ages 2-18, including teenage parents. The complete EBPP consists of fourteen 3-hour group sessions and a graduation ceremony for small groups of parents (usually 8 to 20 participants) and is taught by a Master's level or higher Clinician. A briefer version of the EBPP is also available (a one-day seminar version - approximately 6 hours) which is taught with larger numbers of parents (a minimum of 20 participants). This is a cultural adaptation of the Confident Parenting Program. EBPP is a cognitive-behavioral program created for African American parents to foster effective family communication, healthy identity, extended family values, child growth and development, and self-esteem. The program hopes to combat child abuse, substance abuse, juvenile delinquency, gang violence, learning disorders, behavior problems, and emotional disturbances.

Each of the parenting strategies and skills is taught by making reference to African proverbs such as "Children are the reward of life," and "A shepherd does not strike his sheep." Systematic use of these proverbs helps to ground the program in the wisdom of African ancestors, and is one of the many ways that the program promotes cultural pride. Interactive groups address topics including appropriate and inappropriate behavior, discipline, pride, coping with racism, African-origin family values, preventing drug abuse, and single parenting.

Africentric Youth and Family Rites of Passage Program (ROPP)
This program was adapted from The MAAT Adolescent and Family Rites of Passage Program (Harvey & Hill, 2004), and included training from Dr. Harvey. It is a strengths-based perspective grounded in an ecological framework, designed to promote resilience in at-risk African American youths through a multifaceted Africentric approach (Harvey, 2001). It aids youths in the development of emotional strength to become self- and community advocates through peer support, use of the Nguzo Saba, and Africentric principles. The group process consists of an eight-week pre-initiation or orientation phase followed by weekly meetings emphasizing African and African American culture. The final phase consists of the "transformational ceremony" during which the youths demonstrate their personal growth, knowledge, and skills to an audience consisting of family members, friends, staff members, and significant other individuals. The Rites of Passage program has three interventions: (1) an after-school component, (2) family enhancement and empowerment activities, and (3) individual and family counseling.

Cognitive-Behavioral Intervention for Trauma in Schools (CBITS)
This program has not been adapted for African-Americans, but was included in the RFP #MHARC-054 because of the recognized need for more trauma services to be available to our community. Evaluation studies occurred in the Los Angeles Unified School District and included a number of African American participants.

CBITS is a skills-based, group intervention that is aimed at relieving symptoms of Post Traumatic Stress Disorder (PTSD), depression, and general anxiety among children exposed to trauma. Children learn skills in relaxation, challenging upsetting thoughts, and social problem solving. They work on processing traumatic memories and grief. These skills are learned through art expression and group sharing individually and with a group. The program is ten weekly sessions, 1 hour each (6-8 children) in a school, mental health or other office setting. Group sessions highlight six cognitive-behavioral techniques.

For information about the Riverside tailored African American PEI programs, please contact:

Dr. E. M. Abdulmumin, President
The DuBois Institute
2060 University Ave., Suite 102
Riverside, CA 92507
(951) 686-9930

Tinya Holt, Director
Perris Valley Recovery Program
236 E. Third Street, Suite B
Perris, CA 92570
(951) 657-2960

Sandra Austin, Executive Director
Family Health and Support Network
74410 Hwy 111, Suite D
Palm Desert, CA 92260
(760) 340-2442

D5. RESEARCH: TAILORED PEI FOR BLACKS

In addition to multiple mixed methods of collecting data with the population to identify PEI programs and strategies that work to meet mental and behavioral health needs, we conducted an extensive literature review on culturally specific tailored programs. Results indicated there were three basic categories of interventions identified, i.e., tailored African Centered, culturally competent, and multicultural.

African Centered

Culturally grounded tailored programs for our population are commonly called African-centered. By definition, African Centered is the perspective of the African worldview (i.e., philosophy, norms, social organization, ceremonies, practices, etc.) from the distinct history and culture of African people… collectivism and communalism (Kambon, K. 1998, p. 277 & 281). Parham, Ajamu, and White (2010) discusses the limitations of traditional psychological theories and approaches when applied to people of African descent and provides a framework on how the African Centered perspective is defined, as well as how it operates in the context of the African American family with regard to identity development, education, mental health, research and managing contemporary issues. Research by Parham et al., are critical links in understanding the context of African American life to the traditions, values and spiritual essence of their African ancestors in an attempt to acknowledge the African worldview and assist the African American community in addressing some of the challenges they continue to face. The African Centered definition therefore is individualized to mean using African values, traditions, worldview as the lens through which personal perceptions of reality are shaped and colored (Parham, Ajamu & White, 2010).

An article by Gilbert, Harvey, Arminius and Belgrave (Social Work, 2009), identified eight PEI research projects tailored for African Americans dealing with mental and behavioral health, see *Table 53* for a description. Those programs and interventions were, The NTU Project, A Journey toward Womanhood, Culturally Congruent African–Centered Treatment Engagement Project, Sisters of Nia, MAAT Africentric Adolescent and Family Rites of Passage Program, Kuumba Group, Healer Women Fighting Disease, and JEMADARI Program. Other tailored interventions that work and are listed in *Table 53* include: Flint Fathers and Sons Program, Joy of Living: A community-based mental health promotion program for African American Elders!, Social Skills Traning and Positive Adolescents Choices Training Program.

Common accepted culturally grounded practices of people of African ancestry:

- Professing strong belief in a Creator Sovereign God (Spiritual orientation, moral strengths)
- Protecting and promoting the sanctity of family (kinship unification, participating in family occasions and rituals especially with food)
- "Story telling" (preference for oral communication, preserving heritage by sharing lived experiences, culture, ethnic pride)
- Healing circles (proper functioning, promoting health, nurturing people)
- Community rituals (collectiveness, connectedness, identification, bonding, preference for group activities)
- Outwardly expressed emotions (brotherly/sisterly hugs & kisses, greetings, eye contact, talkative with animated gestures)
- Demonstrating respect toward elders (hierarchal family structure)
- Nurturing children (participating in many rites of passages)

- Endurance, self-respect, and integrity
- Presenting excellence (intelligence, achievement, hard working)
- Reliance on familial network for social, economic, and healthcare issues
- People of movement and motion (admiration of art, dance and music)
- Respect for ancestry and cultural roots

Cultural Competence

The California Department of Mental Health has invested tremendous resources in developing and implementing cultural competence standards. Each county is required to develop cultural competency plans, and the State DMH has developed an audit process to measure compliance. These measures and others demonstrate a high level of commitment to cultural responsiveness. Significant is the investment of the DMH in hiring county ethnic services managers, as well as consultants and master trainers. The California Mental Health Directors Association sponsors regional cultural competency conferences for training, exchanging ideas, networking, and updates on scientific practices to facilitate the development of statewide standards of practice.

The California DMH has adopted the cultural competence definition by Cross, Bazron, Dennis & Isaac (1989), *"Cultural competence is a set of congruent behaviors, attitudes, and policies that come together in a system, agency or among professionals, and enable that system, agency or those professionals to work effectively across-cultural situations. Culture implies the integrated pattern of human behavior that includes thoughts, communications, actions, customs, beliefs, values, and institutions of a racial, ethnic, religious or social group. Competence is used because it implies having the capacity to function effectively" (p.20; cited in the DMH Information Notice, 02-03). Cross et al., describes cultural competence as "a developmental process for the individual and the system...It is not something that happens because one reads a book, or attends a workshop, or happens to be a member of a minority group" (p. 21).*

To ensure a cultural competence system of providers, the DMH has implemented statewide training utilizing The California Brief Multicultural Competence Scale (CBMCS, 2008) and it's Multicultural Training Program. The program is implemented with master trainers, of which two are members of the African American SPW, Dr. Gloria Morrow and Dr. Robin Huff-Musgrove. The CBMCS consist of four major factors, i.e., multicultural knowledge, awareness of cultural barriers, sensitivity to consumers, and sociocultural diversities. In addition, to the five essential elements of cultural competence, as described by Cross et al., (1989), for organizations (valuing diversity, cultural self-assessment, managing for a dynamics of difference, institutionalization of cultural knowledge, adaptation to diversity policies, structure, values, and services) as well as individuals (awareness and acceptance of difference, awareness of own cultural values, understanding dynamics of difference, development of cultural knowledge, and ability to adapt practice to the cultural context of client).

Multicultural

By definition a multicultural approach is a set of behaviors, knowledge, attitudes, and polices that come together in a system, organization, or among health professionals that enables effective work in cross-cultural situations (Satcher & Pamies, 2006). This approach involves diversity and culture; commitment to knowledge/awareness of cultural groups (how they differ from dominant, from one another, other groups); recognize class, age, gender, race, sexual orientation, homelessness, immigration/ refugee status, socio-economic status, poverty, disabilities and all other defining characteristics (Fact Sheet: California DMH Office of Multicultural Services, July 2009).

Table 53: Research: Tailored PEI Programs and Interventions That Work for Blacks

INVESTIGATOR	PROJECT	FOCUS	OUTCOMES
Cherry et al., 1998	**The NTU Project** (Quasi-experimental)	African American fifth-and sixth-graders; a substance use education program, a rites of passage program, a family therapy program, and a parenting program	Protective factors, particularly knowledge of African culture, increased racial identity, improved self-esteem, and improved school behaviors
Dixon et al., 2000	**A Journey Toward Womanhood** (Quasi-experimental)	Girls of African descent ages 12 to 17; African "rites of passage" tradition; healthy self-esteem; instill cultural pride and self-appreciation; teach life and social skills for self-sufficiency; and discourage teenage pregnancy, juvenile delinquency, school dropout, and drug abuse	Decrease sexual activity, delay sexual activity, less likely to get pregnant, positive behaviors, ethnic pride, increase school attendance
Longshore and Grills, 2000	**Culturally Congruent African-Centered Treatment Engagement Project** (Quasi-experimental)	African American drug users; Africentric concepts in counseling; involved client, the counselor & former (peer) drug user; African and African American values, spiritualism, interdependence, and transformative behavior based on the principles of MAAT	less likely to use drugs; promotes overall recovery; increases self-esteem
Belgrave et al., 2004	**Sisters of Nia** (Quasi-experimental)	African American girls in early adolescence, cultural values and beliefs, leadership, faith	Increased resilience; increases in ethnic identity; decreases in relational aggression;
Harvey and Hill, 2004	MAAT Africentric Adolescent and Family Rites of Passage Program (Quasi-experimental)	African American adolescents ages 11.5 and 13.5 years and their families; to reduce substance abuse and antisocial behaviors and attitudes; after school program; family enhancement and empowerment; individual family counseling; African and African American culture; peer support	Increased self-esteem, parenting skills, racial identity, and community involvement
Washington et al., 2007	**Kuumba Group** (Uncontrolled, Pre-Post)	African American males ages 9 to 17; therapeutic, recreational group intervention, mentoring, Afrocentric values; individual and family focused; cultural identity, self-exploration, value clarifications and nonviolent conflict resolution	Increase in spiritual orientation, improved school and home behaviors
Nobles, Goddard & Gilbert, 2007	**Healer Women Fighting Disease** (Quasi-experimental)	African American women; substance abuse prevention; African-centered behavioral change model; infusion of traditional African and African American cultural values; self-worth; develop protective factors to decrease engagement in risky behaviors	Increase motivation, decrease depression, increase knowledge and self-worth, adopting less risky sexual practices
Gant, 2003	**JEMADARI Program** (Random Control Trial)	African American men ages 18 to 63 in residential treatment centers; drug and sexual risk-related behaviors; using vignettes and case studies of male writers and artists with discussions on African American life	Drug abstinence, condom use, reduction of sexual partners
Caldwell et al., 2010	**Flint Fathers and Sons Program**	African American boys ages 8 to 12 years old; strengthen father-son relationships; prevention multiple-risk behaviors, violent behavior, substance use, and early sexual initiation (for sons)	Increase in behavioral capacity/skills building; foster positive racial identity; cultural pride; community involvement

Examples of multicultural approaches with African Americans as one of the sample population include research in substance abuse (Resnicow, Soler & Braithwaite, 2000), complementary and alternative medicine for mental disorders (Woodward et al., 2009), and with youth and depression treatment (Ngo et al., 2009).

Crewe, 2006	**Joy of Living: A Community-Based Mental Health Promotion Program for African American Elders**	African American elders; resilience; increase access to mental health services	Increased awareness of normal and abnormal mental health; increase awareness of mental health resources
Banks, Hogue, and Timberlake, 1996	Social Skills Training (SST)	African American boys and girls ages 10 to 14; comparison between Africentric approach and non-Africentric cultural approach; social skills, anger management, seven principles of Nguzo Saba	Both groups demonstrated improvement in social skills
Hammond and Yung, 1991	Positive Adolescents Choices Training (PACT) Program	At-risk African American youth, culturally relevant to teach social skills training (SST) and to reduce and prevent violence; peer interaction for behavior change	Improvement in skills area; giving positive & negative feedback, accepting negative feedback, resisting peer pressure, solving problems and negotiating

Culturally Grounded African American PEI: The Culturecology Model©

"Culturecology" Model©: Culturecology represents a unique and radically innovative model for the delivery and development of public health services (King, 2000) and strategies targeting health disparities, particularly in the African American community (Nobles, et al, 2009). Emerging from the importance given to "cultural congruency" associated with African centered thought, the question and role of culture in human understanding and functioning is believed central to the work of social-behavioral science (Nobles, 1972, King, et al, 1976, Akbar, 1984,). Technically, culture represents "the vast structure of behaviors, ideas, attitudes, values, habits, beliefs, customs, language, rituals, ceremonies and practices peculiar to a particular group of people and which provides them with a general design for living and patterns for interpreting reality" (Nobles, 1986). Culture is the defining substance of all human action. It is fundamental to human life and living. It enwraps all of human reality and nothing happens outside of it. To make this point, Nobles (1986) has suggested that *"Culture is to humans as water is to fish."* It encompasses everything. In arguing that culture is the defining substance of all human action, King and Nobles (1997) coined the concept of *"Culturecology,"* as a contraction of "culture", (i.e., the process that provides people with a general design for living and patterns for interpreting reality) and "ecology", (i.e., the relations/interactions of organisms, including people to one another and to their physical environment), to capture the totality of cultural framing and the significance of cultural congruency which they define as the need for services and programs to be in agreement with the cultural reality of the community being served.

"Culturecology" recognizes that both people and the environment are cultural organisms. In the monograph commissioned by the Center for Disease Control (CDC, 1996) King and Nobles argued that incomplete, flawed and a historical conceptions of African American human relations undermine the good intentions of clinical interventions and that a radically new approach was needed in which a culturally constructed self in a web of relations replaces individualism. As such, the model posits that what people do and how they behave is largely determined by their culture and social condition and that the person, as cultural agent, has a sense of efficacy and wellness resulting from the sense of being human which is culturally defined.

Accordingly, the inviolate assumption of the *Culturecology Model©* is that human well-being is a "relational event" resulting from and defined by situationally bound units of relationships between the person as cultural agent and the environment as having cultural agency. The Culturecology Model© recognizes that the "relationship" between persons and environments must also be understood and that the "relationship," between person and environment cannot be understood in absence of their cultural meaning. The Culturecology Model© recognizes that (1) "the nature of the person" and "the nature of the environment" are inextricably connected, (2) both the environment and human beings are cultural phenomena, and (3) the "cultural grounding" and meaning of each (person and environment) must be culturally understood in order to fully understand the interactive relationship between persons and health and disease. It, in effect, requires the simultaneous examination of the forces that promote and prevent disease in the African American community.

Culturecology provides us with a unique and innovative opportunity to examine all and any human phenomena, including mental functioning as a "relational event" wherein the developmental trajectory is equally influenced by the person as cultural agent and the environment as having cultural agency. From a rearticulated "person X environment"

representation, the structural logic of the model can generate a framework which identifies the central parameters that inform health behavioral outcomes. Conceptually, the "person," in this model is more than being biological. The person has cultural substance with a history of beliefs, values, life practices, expectations as parts of the script in an on-going story. As such we use the distinguishing label, "character," to refer to the enduring mesopsychological (incomplete and ongoing) consciousness of the person reflecting the complex of mental and ethical traits growing out of a relationship history, marking or distinguishing their personhood (King, 1996).

The person can be defined by its content, its conduct and its communication. The "environment," in this model is more than physical. It has both physical and sociocultural substances with a history of beliefs, values, life practices, expectations, natural and artificial structures to include food, shelter, water supply, habitat, weather, and geography all of which impose themselves on the historical and unfolding relation. The environment is "subject" and has "agency". It also can be defined by its content, its conduct and the nature of its communication.

When the King-Nobles model is refigured as health quadrants formed by the intersection of the person (as cultural agent) and the environment (as having cultural agency), then one can posit that the quadrant of the greatest health is that in which the African American experiences the highest level of cultural congruency or cultural grounding and the lowest level of environmental toxicity or contaminants (Q#4). The quadrant of the least health is that in which the African American experiences the lowest level of cultural congruency and the highest level of environmental contaminants (Q#2) (see *Figure 49*, used by permission of Dr. Nobles).

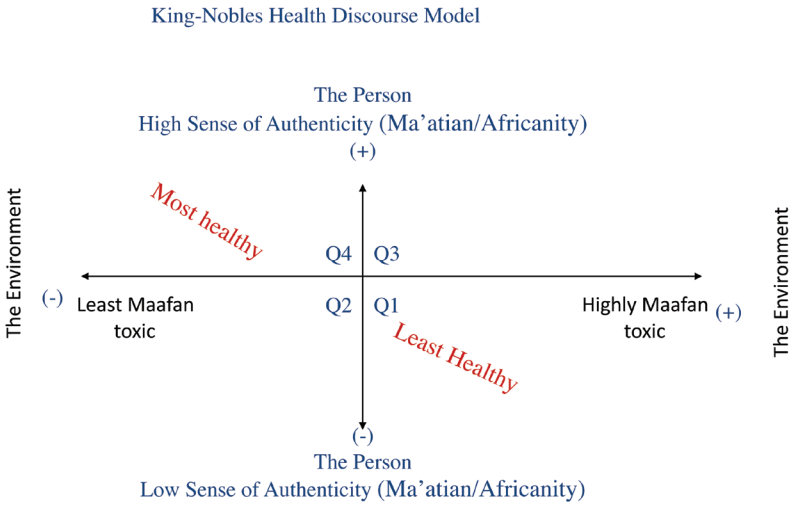


Figure 49: *Model of Cultural Identification/Location African American*

In regards to African American mental health and *Culturecology*, Nobles and King (2000) argue that, in the face of persistent negation and nullification, the African American search for coherence; i.e., mental wellness is a quest for human authenticity. The term "authenticity" refers to the condition or quality of being "authentic" or "genuine." To be "authentic" is to possess the condition of actually being what one claims to be. It is to be "real." To be "authentic" is to have an undisputed origin that is directly connected to the producer or creator. It is to be "genuine" which, in turn, means to be original, unmutated or not a copy, variant or distortion. The "gen" in genuine or generate means to produce, to bring into existence. Hence, the deeper meaning of "human authenticity"

is to be indisputably connected to that which brought you into existence. To be human, African American must realize (have a sense of) their indisputable connection to their African origin and that which brought them into existence. This is the quest for human well-being or authenticity.

To date most models of disparity reductions have largely ignored the scientific application of cultural dimensions of human behavior. To address health disparities, then, one necessarily has to address the cultural and psychological dimension of reality that promotes health and well-being among a people. The critical and missing factor in the medical approach to reduction and/or elimination of health disparities in the African American population is that behavioral change must occur in the population and for this to occur the change activities have to be grounded in the cultural wisdom traditions, values, and beliefs of the targeted population. Public health prevention strategies targeting the health disparities in the African American community would benefit from a systematic testing of *Culturecology and African Centered Behavioral Change* in meeting the goals of reducing health disparities (Nobles, et al, 2009).

Healer Women Fighting Disease: An Evidence-Based Best Practice. Nobles, Goddard and Gilbert (2009) presents the core components of this African-centered prevention program for women. Grounded in the theory of Culturecology the program rests on the presupposition that for African Americans culture is central to both behavior and behavioral transformation. The results of the study point to the utility of an African-centered approach as the critical, but missing, component in reducing and/or eliminating health disparities in the African American community. Based on the **African Centered Behavioral Change Model© (ACBCM)** [Nobles et al, 2009] and under independent review The Healer Woman Fighting Disease project has been designated as an evidenced-based best practice and listed in the Substance Abuse and Mental Health Services Administration (SAMHSA) National Registry of Effective Programs and Practices (NREPP).

The **ACBCM©** (Nobles et al, 2009) is, accordingly, grounded in the fundamental notion that ideas, as manifestations of culture, are the substance of behavior and that everything we do (our behavior) is the result of the "choices we make" and the "chances we take." The choices we make and chances we take are based essentially on the meaning of the person; i.e., what it means to be a human being. The meaning of the person is ultimately determined by the cultural grounding of the person. Only through one's culturally grounded humanity can anyone effectively manage and maintain the business of living a productive, harmonious and healthy life. Given the historical experience of Africans in America, African culture has been devalued and seen as a source of ridicule and/or contempt. Consequently there is a failure to see African thought, values and beliefs as being of value and essential to addressing the critical questions of life and living. Seldom are African ideas seen as having full and equal value in the understanding, planning and determination of the future of human affairs. This cultural "blindness" is an unaddressed aspect of the overall mental health system and limits the assessment, comprehension and incorporation of mental health research and practice to only Western ideas, practices and procedures.

In the **ACBCM©**, PEI is driven by behavioral change which occurs through a process of "culturalization" wherein the person minimizes negative social conditions and maximizes conditions that are pro-social and life-affirming. According to Nobles and associates, culturalization is accomplished through the techniques of cultural realignment, cognitive restructuring and character refinement. The technique of

cultural realignment is a process wherein one is re-aligned with traditional African and African American cultural values. African American families are a catalyst for change to bring about this structural alignment (Hanna, Walker, & Walker, 2004). It is proposed that realigning with traditional cultural essence and integrity draws upon a source of "energy" that ignites and enhances our spiritual, mental and physical well-being and, in so doing, guarantees our human liberation, enlightenment and on-going development. An example of cultural realignment would be to shift the cultural grounding of behaviors, beliefs and attitudes from "individualism and selfishness" to "collective worth and mutual responsibility."

Public Health Model for Children's Mental Health: The Center for Mental Health Services (CMHS) at the Substance Abuse and Mental Health Services Administration (SAMHSA), in conjunction with the National Technical Assistance Center for Children's Mental Health at Georgetown University developed a monograph that presents a conceptual framework for a public health approach to children's mental health. The document is *A Public Health Approach to Children's Mental Health: A Conceptual Framework* (Miles, Espiritu, Horen, Sebian, & Waetzig, 2010). This public health approach is heavily grounded in the social determinates of health. Social determinants of health are factors from biological/physical geographical, social, and economic realms that positively or negatively influence the health of a population. A summary of key points in the conceptual framework include:

1. Utilizing well-established public health concepts to present a conceptual framework that was grounded in values, principles, and beliefs.
2. Linking environmental supports, services, and interventions across child-serving systems.
3. Identifying and promoting shared language and definitions that could form a platform for communication between the various child-serving sectors that are integral to success of a public health approach.
4. Providing examples of interventions and policies that have shown promise as components of the new framework .
5. Presenting suggestions on how partners, providers, decision-makers, and consumers might use the framework in their communities to strengthen the mental health and resilience of all children.

Source: Miles, Espiritu, Horen, Sebian, & Waetzig, 2010. *A Public Health Approach to Children's Mental Health: A Conceptual Framework*, page xviii

Multisystemic Therapy (MST) Model

MST is a SAMHSA-recognized, culturally-sensitive program that is effective with African American youth (Brondino, Henggeler, Rowland, Pickrel, Cunningham & Schoenwald, 1997). In a metanalysis of 10 randomized, controlled studies, Painter & Scannapieco (2009) reported sample sizes of 16-155, a majority was male, and African Americans were overrepresented, just as in juvenile justice and child welfare systems in the United States. They comprised 15.5% to 80.6% of the sample. In six studies, over 50% of the sample was African American males. Outcomes report no significant differences between races and effectiveness is demonstrated in preventing out of home placements and criminal recidivism for inner city youth. The model's success is tracked by clients'perception of the service process. Treatment completion rates range from 82-98% (Henggeler, Pickrel, Brondino and Crouch, 1996). Cost effectiveness estimates over 25 years suggest that states in North America have saved over $31,000 per criminal justice participant when using MST (Washington State Institute for Public Policy, 2001).

Nine principles of MST include a focus on 1) the fit between identified problems and their broader systemic context, 2) positive and systemic strengths, 3) responsible behavior, 4) specific and well-defined problems, 5) multiple systems that maintain identified problems, 6) developmental fit, 7) daily or weekly effort, 8) overcoming barriers to successful outcomes, and 9) empowering caregivers across multiple systemic contexts (Henggeler, Schoenwald, et al., 1998). The California Institute of Mental Health (CIMH) recommends this approach, but county participation is voluntary. To date, participating counties include Alameda, Davis, Los Angeles, San Francisco, and San Diego.

Family Psychoeducation for Schizophrenia Model

Falloon's (1985) treatment success with family involvement for schizophrenia was pioneered with African American families in the Watts neighborhood of Los Angeles. In 1984, MacFarlane's (1993) dissemination study began with 172 participants (41% African American) across six New York community-based sites who successfully participated in family psychoeducation. Since then, MacFarlane's (2002) approach became a model program of SAMHSA (Randomized Control Trials). African Americans responded better to single-family rather than racially integrated multifamily formats. There are ethnic-specific groups emerging, but no outcome data available yet for African Americans. As a PEI initiative for early-onset psychoses, the use of single and multifamily psychoeducation for African Americans matches what consumers ask for, not realizing that this model of early intervention has been encouraged by the California Institute for Mental Health (CIMH) and SAMHSA for a number of years.

Six principles of FPE are 1) consumers define who family is, 2) practitioner-consumer-family alliance is essential, 3) education and resources help families support consumers= recovery goals, 4) consumers and families who receive ongoing guidance and skills training are better able to manage mental illnesses, 5) problem-solving helps consumers and families define and address current issues, and 6) social and emotional support validates experiences and facilitates problem-solving (SAMHSA, 2009). There is compatibility with African Centered epistemologies that encourage "strength in numbers" and depathologized views of symptoms in need of "healing." Outcomes include lower-relapse rates and more days working (McFarlane, Dunne, Lukens, et al., 1993; McFarlane, Dixon, Lukens, & Lucksted, 2003).

Culturally Grounded Community-based Participatory Evaluation Model for African Americans

Dr. Cheryl T. Grills is the National President of The Association of Black Psychologists and expert in community-based participatory research, multi-site program evaluation, African centered psychology, and community wellness models. She has seminal chapters on African centered psychology in both volumes of the books on Black Psychology edited by Dr. Reginald Jones' (1986). A professor of psychology and former Chair of the Department of Psychology, Dr. Grills is currently Associate Dean in Bellarmine College of Liberal Arts at Loyola Marymount University in Los Angeles.

Dr. Grills' research interests and current projects include African Psychology, African concepts of consciousness, altruism and compassion research, developing and testing African centered models of treatment engagement with African American substance abusers, research on traditional medicine in West Africa and program evaluation with community-based organizations engaged in social action, community change and prevention. She is the Principle Investigator on a 22 site national program evaluation focused on childhood obesity in communities of color funded in part by the Robert Wood Johnson Foundation. She is the founder of Imoyase Community Support

Services, a non-profit, community based, multiethnic research and program evaluation organization. Dr. Grills is a registered member of the Ghana National Association of Traditional Healers and founder and on the board of a program evaluation NGO in Ghana, West Africa with projects in Ghana and Sierra Leone. She consults on a number of prevention and treatment issues particularly regarding matters of cultural and social competence, multiculturalism and Africentric interventions.

Dr. Grills provides this exposé on a culturally congruent evaluation model for African Americans.

Mental health practitioners have a moral and ethical responsibility to provide effective interventions to all clients by explicitly accounting for cultural context and cultural values relevant to client well-being (Trimble & Fisher, 2006). Likewise evaluations of these interventions should be held to the same standards of accountability with respect to the inclusion of cultural values, beliefs, and practices and cultural context in their program evaluations.

Evaluations of mental health services are typically oriented toward assessing delivery of services that treat individuals diagnosed with mental illness. Often they focus on treatment effectiveness to determine whether treatments that are being considered or delivered a\have actual value (Patrick and Chiang, 2000). They are not organized to understand the role of culture, context, the broad array of relationships and community support structures that help promote and sustain mental health, or underlying social forces that may be contribute to or exacerbate mental illness. From the perspective of cultural relevance, they also beg the question "effectiveness for whom". Outcomes and outcome measures validated in diverse populations is not common weakening the generalizability of treatment effectiveness results (Patrick and Chiang, 2000). Unfortunately this has not abated the promulgation of evidenced based practices that populate many mental health interventions today.

Evaluation as practiced today is faced with a series of conundrums.

> *"The original mission of program evaluation in the human services and education fields was to assist in improving the quality of social programs. However, for several reasons, program evaluation has come to focus (both implicitly and explicitly) much more on proving whether a program or initiative works, rather than on improving programs. In our opinion, this has created an imbalance in human service evaluation work – with a heavy emphasis on proving that programs work through the use of quantitative, impact designs, and not enough attention to more naturalistic, qualitative designs aimed at improving programs (Kellogg, 2004)."*

In its discussion of the current imbalance in mental health program evaluation, The Kellogg Foundation exposes among other things the inappropriate dominance of the research paradigm on human services evaluation.

Particularly with African Americans, evaluations should not be conducted simply to prove that a particular mental health intervention worked, but also *to improve* the way it works for African Americans in general, and, for specific constituencies among people of African ancestry (e.g., Caribbean Blacks, continental African Blacks, and Latin Blacks etc).

Evaluation of services to African American clients should address issues of process, implementation, and improvement of services and interventions. Emphasizing

measurement of statistically significant changes in a narrow band of quantifiable outcomes (e.g., reduction of symptoms) hinders the ability to appreciate the complexity of current human services strategies as they relate to African Americans. There are a number of consequences to such a myopic (simplistic) approach to evaluation.

1. We begin to believe that there is only one way to do evaluation.
2. We do not ask and examine equally important questions.
3. We come up short when attempting to evaluate complex system change and comprehensive community initiatives.
4. We lose sight of the fact that all evaluation work is political and value laden. (Kellogg, 2004)

Finally, it is imperative that we acknowledge the limitations in current evaluation and research. We must contend with issues of measurement, method, and the limitations of empirical (particularly quantitative) approaches making adjustments where needed in their application with African American process and outcome evaluations. For example, assumptions of equivalence should be avoided; the field is replete with assumptions of the cross cultural application of mental health constructs, measures and tools and the assumption of methodological equivalence. It is not safe to assume that there is linguistic, conceptual, and methodological/procedural equivalence when designing evaluation studies using the accouterments found in the extant literature.

> *"Differences in interpretation arise even when respondents report about concrete circumstances of living. Nuances and shadings of meaning, idiomatic expressions, and reactions to the assessment process itself may subvert the attainment of full cross-cultural equivalence" (Snowden, 1996).*

It is critical that the evaluation ensure measurement equivalence. Burlew and colleagues (2009) provide clear examples of the need for caution and attention in this regard. They include:

"The situations mentioned in a measure may apply to one group but not another."

"Various cultural groups may differ in the connection between specific behaviors and the underlying trait."

"Differences in the opportunity structure may lead to differences in the manner in which certain traits are manifested." (for examples related to matters of employment, housing, access to recreation etc)"

"Group differences in circumstances may result in differences in the meaning of a specific behavior." (p. 27-28)

In the selection of process and outcome measures attention must be given to issues of reliability and validity. For most measures alpha coefficients that are greater than 0.70 are considered adequately reliable. Ascertaining the reliability of measures is necessary, but not sufficient, for determining whether the scales may be considered valid. Whereas reliability refers to the extent to which a set of items appear to measure a construct in a consistent or dependable manner, validity refers to the extent to which a set of items appear to accurately represent or reflect the construct. Therefore, a scale may be reliable (that is, measure something in the same way over time, or over repeated measures), but not necessarily valid (that is, it can measure something in a completely "off" way that is consistent over time).

In the selection of constructs for assessment we cannot make the assumption there is a universal shared meaning across ethnocultural groups. For example, consider the concept of stigma. Stigma may have some universal aspects (sensitivity to the negative perceptions of others) but the experience of stigma is also highly population- and issue- specific. Scales created for one population (HIV population versus formerly incarcerated women with drug addiction) should not be applied to other populations without careful attention to adaptation processes, including extensive consultation and pilot testing with the population of interest.

When conceptualizing stigma, evaluators need to be careful not to make assumptions about (a) whether secrecy and shame are part of the stigma experience, (b) whether participants perceive stigma about seeking help, (c) what conditions are experienced as stigmatizing, and (d) the difference between whether participants internalize stigma and feel badly about themselves and their consciousness of how others view them (which can be attributed to the ignorance of others, not a limitation of self).

Further, we must be careful not to make assumptions about cultural homogeneity within the diverse population of people in California who share a common African ancestry. There is considerable ethnic diversity (e.g., Caribbean, continental African, southern, Latin) and as Neighbors et al (2007) have aptly noted:

> *"The few studies that have examined help seeking among Caribbean Blacks have been conducted in the United Kingdom. As a result, many questions remain unanswered regarding whether Caribbean Blacks and African Americans actually differ in mental health service use." Neighbors et al (2007) p. 486*

Finally, it is not enough to merely include African Americans in a sample and from that determine treatment efficacy or gain direction for policy and programmatic decisions. Burlew et al (2009) very useful guidance on matters related to measurement and data analysis for conducting valid research with ethnic minorities. These include:

1. Measures standardized on other populations need to be evaluated to determine their appropriateness with a specific ethnic group. CFAs, IRT, and regression are all tools that may be useful empirical approaches for assessing measurement equivalence. In addition, pilot studies, expert panels, and focus groups may play an important role in assessing the appropriateness of a measure.
2. Researchers are encouraged to review the characteristics of the standardization sample before blindly applying cutoff scores to an ethnic minority group.
3. Clinical trials provide rich opportunities for examining the effects of the race of the interviewer or the race of the coder (rater) on measurement.
4. Race-comparison designs may not address the most important issues for understanding treatment effects for ethnic minorities and may even lead to misleading conclusions. Ideally, studies are needed that focus on the efficacy of specific interventions with specific ethnic minority groups. In addition, a number of alternative within-group (e.g., moderator and mediator variable studies, studies of engagement, and retention) or between-group studies (group differences in variability, groups differences in mediators and moderators) may provide more information for understanding treatment issues in ethnic minority samples.

5. Sample sizes may be a daunting challenge for understanding treatment efficacy within ethnic minority samples. The researcher may address this issue by targeting specific ethnic minority groups, evaluating effect sizes when the sample is not large enough for other analyses, and considering the use of other statistical techniques appropriate for small samples. (Burlew et al, 2009, p.41)

Community-based Participatory Evaluation

Evaluation efforts should be community based and contextual (based on local circumstances and issues). Community-based participatory research methods have been defined as a systematic inquiry with the collaboration of those affected by the issue being studied (Israel et al., 1994). It is an egalitarian process where the perspective of program participants is as valued and recognized as those of the evaluators. It is also concerned with compiling results that are relevant and useful for program improvements and future actions. Community-based participatory methodologies should inherently capture what is important to the community and should have the capacity to provide insight into how to measure outcomes that reflect successful intervention and wellness for African people.

Community-based research isn't research about the community; it is research ***with*** the community (Cooke and Thorme, 2012). As such it is:

- Collaborative, seeing the community as partners
- Respectful of multiple ways of knowing
- Asset-based
- Oriented towards social change/social justice (Strand et al., 2003)

Community-based participatory approaches with African Americans must be grounded in contextual realities; the social, political, historical, and economic realities within which African Americans are situated in the United States broadly, and California locally. In other words, evaluation strategies for African Americans must begin with a frame that understands and incorporates the broader social context. Evaluation strategies must be flexible in defining "what" [variables] are examined, what measurement tools are used, and what methods of data collection are employed. For example, once culture is taken into consideration attention may need to be given to assessing benchmarks or correlates of mental health and well being – benchmarks that are considered precursors to any viable sense of health and well being. For African Americans such benchmarks include relational hardiness, spirituality, resiliency, and sense of ethnic identity.

Expanding the Parameters of What Is Evaluated in the Delivery of Treatment and Prevention Services to African Americans

To the extent culture and context play a central role in determining behavior, evaluations of interventions with African Americans should incorporate personal, environmental and cultural elements (King & Nobles, 1997). For example, King, Nobles, and James (1995) culturecology" model of African American mental health there outcome study incorporated the extent to which participants evidenced cultural realignment - the shift from "individualism and selfishness" to "collective worth and mutual responsibility" (Nobles, et al., 2010). African centered and Black Psychology have provided a number of culturally anchored variables that can and should be included in mental health evaluations. These include: level of cultural identity and affinity, cultural mistrust (Watkins et al (1989), exposure to racial microaggressions and other forms of racial stress (Solorzano et al., 2000), the superwoman syndrome imposed on many

African American women (Wallace & Constantine, 2005), the invisibility syndrome (Franklin & Franklin-Boyd, 2005) and spirituality, communalism and interdependence, sense of purpose, self-determination, harmony, sensitivity to emotional cues, oral communication, relationship to time, the special role of elders, interest in one's history and culture, sense of humor, resilience, critically addressing race, class, and oppression and defending against an "anti-Black" social realities, policies and practices (Hartling, 2008; Lambert & Smith, 2010; Boyd-Franklin, 2003; Grills, 2002, 2003, 2004, 2006, 2009; Nobles, 1998, 2007; Nobles et al, 2010; Myers, 1998; Parham, 2009; Akbar, 2003; Watts & Serrano-Garcia, 2003; Potts, et al, 2003; Thompson and Alfred, 2009; Jones & Shorter-Gooden, 2003; Foster, et al, 1993; Utsey et al, 2007; Genero, 1998; Gordon, 2004; and Peres et al, 2008; Wallace and Constantine, 2005; Belgrave and Allison, 2010; Kambon, 1999; Garvey, 1987; Yeh, et. al, 2004; Grills, 2002; Akbar, 1989; Parham & Helms). Evaluation strategies, therefore, should be able to capture important nuances and manifestations of behavioral expression among African Americans including cultural values and precepts.

Given the individual centered nature of western psychology, research, and evaluation it is important to meet this cultural disconnect with a broader lens and variables for assessment. One could ask of the evaluation, can it track and resonate with community-centric needs and strategies that capture the significance of and assess the presence of:

- a sense of community
- a desire to give back to the community through service
- cultural awareness and sense of identity expressed through activities like music, art, dancing and rituals, mentoring and celebrations
- critical analysis of the race narrative in American society, media, pop culture.

Does the evaluation determine the extent to which interventions reflect a culturally responsive strategy? A holistic model will incorporate relevant aspects of a person's life including their community, educational, physical, environmental, religious and socio-historical context. For example:

- does it connect youth development, mental health & education
- is it culturally grounded
- is it holistic
- does it promote well-being and wellness
- does it create community safety nets
- do services occur in natural spaces and places
- is resilience emphasized (in classroom, school, work environment, community & home environments)
- is it accessible

Snowden (1996) offered a preliminary guide to administrators and policy makers in which he identified a number of useful culture-related characteristics of relevance to outcomes research in mental health with ethnic minority populations. They include:

- The expression and interpretation of symptoms as folk idioms in terms of indigenous systems of belief
- A willingness to use alternative providers, including religious figures and folk healers
- Somatic complaints to express mental health suffering

- Personal and family perceptions of mental health problems as highly stigmatizing
- Interpersonal sensitivity and specialized norms regarding respect, trust, and authority
- A common sociopolitical and sociocultural background
- Culturally distinctive patterns of family burden, responsibility, and satisfaction

Illustration of a Culturally Responsive Model and Assessment

There are promising models of culturally syntonic interventions and accompanying community based participatory evaluation strategies. A rising star among these is ***"The PEaCE Model of Human Adaptation and Transformation"*** developed by Shelly P. Harrell, Ph.D. and the Harrell Research Group at Pepperdine University Graduate School of Education and Psychology.

Congruent with biopsychosocial, community-clinical, and culture-centered approaches to mental health (e.g., African, Native American, Latino, Buddhist), Harrell (2011) created a culture- and context- conscious conceptual model to serve as a foundation for the development and evaluation of local, evidence-based interventions. Such local evidence-based practices are designed to be implemented, disseminated, and evaluated collaboratively with the communities that they serve. (It is currently being piloted in South Los Angeles, SPA 6, as a community driven process to defend against the forced utilization of evidenced based practices in prevention and treatment programs in South LA).

As described by Harrell (2011), the Person-Environment-and-Culture Experiential (PEaCE) Model of Human Existence, Adaptation, Resilience, and Transformation (HEART) is grounded in the theoretical assumption that the person cannot be meaningfully separated from culture and context and that the focus of conceptualization and psychologically-based interventions should be on the "fit" between and within the dynamic elements of the Person-Culture-Context (PCC) transactional field. PCC represents the ongoing transactions between Bio-Experiential (BE) "self" processes (i.e., bio-physiological, perceptual-cognitive, emotional, spiritual, cultural) and Cultural-Ecosystemic (CE) "contextual" processes (i.e., interpersonal, group, community, organizational, institutional-sociopolitical, and macro-temporal) that occur within the Person-Culture-Context field. The nature of the dynamic BE-CE transactions determine Adaptational and Transformational Outcomes (ATOs) for individuals, families, groups, and communities.

This model therefore allows for measurement of change across several dimensions, not just individual change. ATOs include indicators of both wellness and illness. Central to the PEaCE model is the co-existence of both healthy and unhealthy adaptations at all times for all people. We are neither ever at a perfect state of wellness nor a total state of illness. Moreover, the relative absence of illness is not equivalent to optimal health, and optimal human functioning occurs in the context of personal and life challenges. We are in a constant process of adapting to our biopsychosocial limitations and maximizing our strengths.

Thus, the central goal of interventions based on the PEaCE model is optimal functioning and well-being in the unique PCC field of the individual or group reflecting salient BE and CE processes. The PEaCE Model proposes that the nature of Person-Culture-Context fit in a particular temporal and environmental context can be modified by three primary processes and resources that comprise Ameliorative interventions (emphasizing relief from distress and dysfunction), Protective interventions (emphasizing adaptation and resilience), and Transformative interventions (emphasizing growth and change). The specific

objectives of interventions based on APT should specify both wellness-promoting and symptom-reducing elements. A core requirement for APT interventions is that they must be **culturally-syntonic**, that is they must be resonant and attuned to the salient cultural contexts and expressions of the client and community.

Specific interventions can place relative emphasis on personal, cultural, or contextual processes as appropriate to the client, culture, and setting, however it is maintaining attention on the PCC transactional field and the nature of PCC fit that is critical.

Two instruments have been developed as measures of psychosocial functioning that are recommended for evaluating the effects of PEaCE-based interventions: The Multidimensional Well-being Assessment (MWA) and the Broad Assessment of Distress, Disorder, and Dysfunction (BADDD). The MWA measures well-being (wellness) in five dimensions: Physical, Personal, Relational, Collective, and Transcendent. The BADDD is a general measure of psychosocial problems and is not meant to diagnose specific mental illness, but rather provide a broad indication of problematic psychosocial functioning. Harrell recommends that **both** assessments be administered at intake, after approximately 4-6 sessions, and at termination. Psychometric research is in process and preliminary indications of the quality of these measures are promising. The model and the intervention framework are consistent with the types of issues identified both in this report and in the literature on intervention and evaluation with African American populations.

In conclusion, below are examples of population-based community outcome measures. We recommend evaluation approaches that triangulate outcome measures by individual, community and systems levels using research methods and measurements derived from community-based participatory approaches. The following are examples identified by people of African heritage living in California which may yield promising outcome effectiveness measures.

1. Increase in use and seeking of mental health services.
2. Increase in multi-generational mental health programming models.
3. Increase in mental health programs that care for the whole family.
4. Increase in funding to provide African-Centered services.
5. Increase in Black families talking about mental illness and reduction of fear and stigma.
6. Increase in talking about mental illness at church by the pastor and faith leaders.
7. Decrease in institutionalized barriers
8. Increase in cultural milieu for diverse people of African ancestry related to mental health
9. Increase in service provider's access to trainings and certifications.
10. Increase in reports that service providers are trusted by community members who exhibit culturally competent behaviors.
11. Increase of cultural brokers in higher education to provide mental health services.
12. Increase in percentage of diverse African people groups who provide mental health services.
13. Increase in holistic mental health programming models.
14. Increase in access to preventative services at an early age diagnosis, etc. from teachers and schools.

15. Increase of dealing with people from the position of strength versus deficit.
16. Increase in holistic mental health community models.
17. Increase in multi-generational mental health programming models.
18. Increase of dealing with people from the position of strength versus deficit.
19. Increase of individuals blossoming within their community. Individuals won't have to leave their community to become healthy.
20. Increase in openness about mental health needs, no stigma.
21. Increase in visibility of African-American celebrities with mental illness and recovery.
22. Healthier perspective from the media.
23. Actions for individual behavior changes toward healthy lifestyles

Community-base Participatory Evaluation Strategies
Evaluation strategies, therefore, should be able to capture important nuances and manifestations of behavioral expression among African Americans. For example:

Culture Elements - Can it accommodate such cultural elements as:

- interdependence (encourager community and familial support),
- spirituality,
- understanding the African holocaust (Maafa) experience
- current forms of racism,
- collective responsibility,
- purpose, self-determination,
- affirmation of African identity as the "real self,"
- reclaiming cultural heritage and
- self-affirmation (Africentic values, customs, etc.),
- defending against an "anti-Black" orientation (Kambon, 1999; Garvey, 1987; Yeh, et. al, 2004; Grills, 2002; Akbar, 1989; Parham & Helms)

Culture Principles and Expressions - Can it accommodate cultural principals and expressions such as:

- nuances in African American language
- Oral patterns
- People orientation
- Kinship Patterns
- Interaction vs reaction
- Thought processes (intuition/hunches)
- Spontaneity
- Respect for elders
- Generosity
- Cooperativeness/Mutual Help
- Community
- Centrality of Spirit and the Divine

Community-centric - Can it track and resonate with community-centric strategies. Community-centric strategy would

- Provide and foster a sense of community as a whole by involving elders
- Develop and encourage a desire to give back to the community through service
- Develop cultural awareness and sense of identity through activities like music, art, dancing and rituals, mentoring and celebrations. (Vontress, 1991)
- Improve identity and mental health via redefining history from African point of view.

Culturally Responsive - Can it determine the extent to which interventions reflect a culturally responsive strategy? A holistic model will incorporate relevant aspects of a person's life including their community, educational, physical, environmental, religious and socio-historical context.

- Connects youth development, mental health & education
- Culturally grounded
- Holistic
- Promotes well-being and wellness
- Health-promotion
- Creates community safety nets
- Services in natural spaces and places
- Resilience emphasis (in classroom, school, community & home environments)
- Accessible
- High quality

Community-based Psychometric Instruments

Two instruments have been developed as measures of psychosocial functioning that are recommended for evaluating the effects of PEaCE-based interventions: *The Multidimensional Well-being Assessment (MWA) and the Broad Assessment of Distress, Disorder, and Dysfunction (BADDD).* The MWA measures well-being (wellness) in five dimensions: Physical, Personal, Relational, Collective, and Transcendent. The BADDD is a general measure of psychosocial problems and is not meant to diagnose specific mental illness, but rather provide a broad indication of problematic psychosocial functioning. It is strongly recommended that both assessments be administered at intake, after approximately 4-6 sessions, and at termination. Psychometric research is in process and preliminary indications of the quality of these measures are promising.

"The ultimate goal for Black people on this earth is to regain the stolen wealth that was taken from them. What is that stolen wealth? Answer, education, health care, home ownership, and family structure. What we see is when we help Black people we help all people. When we reach out to the Black people with mental illness living in Skid Row (one of the neediest populations in our state) with entrepreneurship skills, we give hope to other Blacks. Black people then find their true selves and the ones who absolutely cannot participate for certain reasons will get taken care of. This can be a great beginning to healing the mind and emotion of a people with rich history. So today I say let's do what we know is right, and is the best contribution we can make to our American communities."

Public Forum: King Howard, Skid Row resident, Downtown Los Angeles

D6. STRENGTH-BASED PROMISING AND EMERGENT PEI PRACTICES FOR BLACKS

In addition, to models and programs, diverse approaches (i.e., African Centered, Faith Based, Ecological/Community, and Wellness, Recovery, and Resiliency), must be considered when attempting to meet the mental health needs of people of African ancestry. There are various activities used by the Black community to facilitate and maintain health and healing. The examples presented in our CRDP were reported by the community.

We believe there are many, many more different types of activities and regular programs conducted by residents in Black communities across California that were not brought to the attention of the CRDP. With limited resources, our CRDP was unable to travel to every county to investigate and discover their practices. This section on strength based practices is reported directly from communities listed. There has been no attempt to leave out anyone's recommendations. If the information was shared, it has been included in this report.

We did not use any specific inclusion criteria except the community believed the activities work to bring mental, emotional, spiritual, or physical healing, and that the practice demonstrated positive outcomes in the Black community. Below are examples of some promising practices as demonstrated in numerous Black led agencies throughout California.

Inland Empire Region

Knotts Family and Parenting Institute (KEPI)-San Bernardino County: Since 1992, *KFPI* has provided services to recruit, train and support certified foster parents to care for children who have been removed from unsafe home situations, placing them in a loving, safe environment; serving over 800 children and families annually. This work has resulted in an increase in the number of African-American families becoming foster parents. *KFPI* has a transitional age youth independent living skills program fostering the development of programs for children, youth and adults in natural settings. *KFPI* uses an innovative concept of villages to address the needs of the families it serves creating 22 Villages throughout the county – churches, housing communities, schools, health clinics, probation sites, and welfare centers – as models for service delivery. These services are provided through a Family Resource Center. Family Resource Centers provide Black parenting classes, Rites of Passages Programs, and other helpful resources. Through this community-based PEI approaches *KFPI* reaches and brings human services annually to a population of hard to reach clients (i.e., homeless, addicts, ex-offenders), positively impacts personal mental and behavior health, increases resiliency in children and youth, and creates a sense of family and belonging to reduce risky behaviors.

Inland Behavioral Health Services, Incorporated (IBHS)-San Bernardino County: *IBHS* is a Federally Qualified Health Center that has been addressing health disparities in the city of San Bernardino for more than 30 years. The mission of the organization is to help the community achieve and maintain general good health, education and welfare through commitment in providing excellent service in the areas of physical health care, substance abuse treatment, mental health improvement, homeless services and prevention education. The corporation provides substance abuse treatment, diabetes education, individual and group counseling, prevention and outreach programs,

CalWORKS Program, PC 1000 Drug Diversion Program and youth drug prevention and diversion programs. *IBHS* provides culturally competent services and address the health needs of African-American populations in San Bernardino. *IBHS* has an aggressive outreach program with dedicated staff that interfaces with multiple service providers to ensure culturally relevant services across the life span, especially to African American children, teens, and transitional age youth (TAY), adults, and older adults. Staff clinicians act as a community resource to mental health service providers, some of their services include applying behavior modification techniques, conducting psychosocial assessments, and providing clinical assessments, diagnostics, and treatment services to diverse populations.

IBHS uses grassroots PEI specialists. One PEI specialist is Linda Hart, who has more than 15 years experience in community engagement, specifically with African American populations addressing physical and mental health disparities. Her work involves developing and maintaining contact with community-based, grassroots groups and churches in San Bernardino, and connecting them to services available at one of *IBHS'* three health centers located in the city of San Bernardino. In 2006, Ms. Hart, Mrs. Gwen Knotts, Mrs. Veatrice Jews, Ms. Wilma Shepard, and Ms. Leah Cash came together to create the African American Mental Health Coalition (AAMHC). The mission of the Coalition is to advocate, educate and promote culturally relevant activities by providing workshops, research, training and stigma awareness, to create public policies that assist in reducing health disparities and to promote a more comprehensive approach to early intervention to allow for individuals and families to care for themselves. This model of community collaboration creates a strong grassroots network to address mental and behavioral health issues.

The Rose Program (San Bernardino County): Ms. Hart created the *Rose Program* in 2008. *The Rose Program* uses fashion design and good business skills to increase the self-esteem and personal development in young African American women who are at risk for gang involvement and other deviant behaviors. These young women learn to be creative, develop marketable business skills, and to make positive choices instead of a drug, alcohol, and gang culture.

California Institute of Health & Social Services, Incorporate (CIHSS) – San Bernardino County: *CIHSS* is a social service agency developed to decrease the number of children being put in out-of-home care, preserve the family structure and increase quality of care services to youth and adults identified as at-risk in the Los Angeles and surrounding communities, including San Bernardino County. *CIHSS* strategies include recruiting, training and supporting resources for families, finding and maintaining foster and kinship families in their own neighborhoods, building community partnerships, and sharing love. They provide several relevant services for children and youth. The Children's Way Foster Family Agency that recruits, trains, monitors, and supports Certified Foster Parents in providing nurturing home environments to children who have been abused, neglected, or have no caregiver. The Alafia Mental Health Institute is designed to provide access to mental health services to children who have been identified as having mental issues to decrease placement disruptions, and increase stability and functioning of children. The Children's Way Adoption Services is a fully licensed adoption services for children in out-of- home care, with resources to certified foster families and biological parents. *CIHSS* prepares the family with supportive services, pre-finalization, crisis intervention and individualized attention. From 2005 to 2010, *CIHSS* has served approximately 1000 African American families in Los Angeles, San Bernardino and Lancaster.

The Brightest Star (San Bernardino County): In 2005, *The Brightest Star* a non-profit organization is dedicated to providing culturally relevant services to abused, abandoned and neglected children in multiple residential treatment settings and foster homes in the Inland Empire. *The Brightest Star* provides mentoring, educational assistance K-12, counseling/mental health services, celebrity motivational appearances, building dreams and self-esteem supportive services to "aged out" and "emancipated youth." This organization also partners with other organizations to locate, recruit and assist individuals of famous and/or celebrated status including city, county, state and national community service leaders to serve as positive outstanding role models to *empower, uplift and inspire* children and teens living in residential treatment centers and foster care systems. These role models work with a team of educators, administrators, residential counselors, and mental health professionals to create, reinforce and normalize positive messages and outcomes designed to build self-esteem and self-confidence in children and teens.

Northern California Region

Clinicians for Change (San Francisco County): In San Francisco four enterprising African American professionals, two psychiatrics, social workers – who provide MHSA funded TAY services, a high school math teacher, and a public Defender, started *Clinicians for Change* a group whose purpose is to develop effective interventions, procedures and policies that result in transformative change for TAY African Americans.

Children's Hospital & Research Center Oakland: Comprehensive Sickle Cell Center (Alameda County): This program is a co-location model that applies integrated holistic principles to the treatment of those with sickle cell disease (SCD) and related problems. The disease occurs in 1 out of every 400 Americans of African ancestry while the trait occurs in 1 in 14 Americans of African ancestry. This chronic disease can be characterized by significant pain and potential organ damage across the life span.

Children's Hospital & Research Center Oakland offers the largest program for sickle cell care and research in the Western United States. More than 450 children and 300 adults from Northern California are seen annually. The Comprehensive Sickle Cell Center operates from an integrative health perspective for inpatient and outpatient care. The center seeks to establish a medical home for all patients that provide a primary care interface with behavioral health, education, and vocational components. Patients also receive additional services funded through the Network of Care grant. Services funded through the Network of Care grant include patient support activities through case management/peer education, increased access to genetic counseling and sub-specialty care, patient education/advocacy, and education of health care providers.

African Immigrant Mental Health Family Outreach and Engagement Program (Santa Clara County): The vision of the *African Immigrant Mental Health Family Outreach and Engagement program* is to have a community where there are no barriers or stigma associated with any form of mental illness, where there exists a strong sense of family in support of one another and to improve the quality of the lives of individuals and their families affected by mental illness. To accomplish this purpose, an Ethnic Cultural Communities Advisory Committee was created. The African component is the African Immigrant ECCAC and serves the Eritrean, Ethiopian and Somali Communities in Santa Clara County. The mission of the African Immigrant ECCAC is to provide support to consumers and family members experiencing mental illness and promote wellness through education, support groups, advocacy, outreach and training. Services and activities offered are: one-on-one and phone support, group support, multi-

lingual (Arabic, Amharic, Tigrinya, Somali, and Orominya), workshops, mental health advocacy, outreach/education, and mental health first aid (MHFA).

Los Angeles County Region
In Los Angeles the following interventions are implemented in Service Areas 1 and 6 where the African American population is 12.8% and 28.2% (respectively). All of the following services are implemented by the Los Angeles County Department of Mental Health. Contact the Los Angeles County for information on where the interventions are located.

- Cognitive Behavioral Intervention for Trauma in Schools (CBITS)
- Child Parent Psychotherapy (CPP)
- Functional Family Therapy (FFT)
- Group Cognitive Behavioral Therapy (CBT) for Major Depression
- Incredible Years (IY)
- Multisystemic Therapy (MST)
- Positive Parenting Program (Triple P)
- Trauma-focused Cognitive Behavioral Therapy (TF-CBT)
- Seeking Safety

Ministry, Mental Illness, and Communities of Faith
Persons with mental illnesses are our neighbors, our coworkers, our siblings, and our friends. They are even members of our churches, synagogues, mosques, temples, and other faith communities. Unfortunately, both ignorance and fear continue to play leading roles in perpetuating stigma that those with these "no-fault brain disorders" face. Religious communities are in a unique position to combat stigma and provide a message of acceptance and hope. Proclaiming the values of social justice, respect for all persons, and non-discrimination, faith communities can reach out to individuals and families affected by mental illness in many helpful ways. Sharing the message that all persons are worthy in the eyes of God, a faith community may be the only place where a person with a mental illness truly feels accepted, valued, and loved.

For people who find no other welcome in the larger community, being welcomed in a house of prayer by a concerned and caring community can make a critical difference for consumers with mental illnesses and their families. Churches, synagogues, mosques, temples, and other places of worship can spread the message that serious mental illnesses are "diseases of the brain" and help families understand that "it's not their fault." They can open their doors and their hearts to consumers and be a supportive presence in their on-going recovery.

Addiction counselors, mental health parishioners, cultural-specific natural healers, clergy and other pastoral ministers operate on parallel tracks as they work to help church and community members or clients. Yet many do not understand how collaboration of these practices and professions work together toward the same goal. Examples of faith-based approaches are:

Deep Level Healing (DLH): Ventura County - One faith-based/cultural-specific strategy often used by trained and experienced ethnic pastors and lay counselors integrates faith, prayer, & lay counseling with church discipleship and traditional mental health treatment.

Pastors on the Premises: Inland Empire Concerned African-American Churches (IECAAC): San Bernardino County - In March, 2002 *IECAAC* implemented the "Pastors on the Premises" program in the San Bernardino City Unified School District, where pastors conduct prayer-walking at schools. Pastors are on the school grounds interacting with the students, providing emotional, spiritual, and academic support. The purpose of this program is to provide supportive caring environment that connects school, faith and community with the goal of preventing incarceration and recidivism. Pastors give counseling in the school with the intent to give students positive ways to deal with aggression, to prevent violent and acting out behaviors, and to provide mentoring and guidance. Students were less likely to engage in negative behaviors, self-esteem increased as well as school attendance, a decrease in gang activity was observed, and nearly eliminated the drop-out rate. This approach has grown into a model for other school districts.

Principle Based Lifestyle Training (PBLT): Merced County – As a ministry of Valley Harvest Church, Harvest Park Educational Center is serving the community by providing multiple subjects tutoring for children grades 1st through 8th. This is a character developing and confidence building program in a safe and friendly environment, with training that is beneficial both inside and outside of the academic arena. *PBLT* is a Biblically-based supplemental education program that is complete with curriculum and workbooks, that was introduced into the local community, schools, and the church by its founder an author, Gloria J. Morris. It has been impacting lives favorably in both the public and private arena, wherever it is used. When *PBLT* is used and applied to our thinking, choosing and acting processes, we can expect to experience positive and successful changes and outcomes in our lives.

Life Lines to Healing: City of Berkeley – Pastor Michael McBride, The Way Christian Center and the Berkeley Organizing Congregations for Action (BOCA), offers a multi-cultural approach to prevention and early intervention for violent offenders. This is a multi systems community approach where violent offenders are identified in the community and letters are sent to invite them to a "Call" meeting with city officials and victims. The intent of the program is to keep offenders out of trouble, to prevent reoccurrences, to help offenders develop social and relationship skills, and to make sure they get the mental and behavioral help needed to change and live productive lives.

Statewide and National Initiatives

Integrative Behavioral Health

As mentioned in our disparity data, mental illnesses and physical illnesses often have interactions that contribute to conditions that are related to complex cycles of multiple systems, such as with asthma, obesity, diabetes, cardiovascular disease, chronic pain, and fibromyalgia. These multilayered conditions are driving healthcare entities to promote and adopt more collaborative approaches to behavioral health in medicine (Davis, 2011; Blount, 2003, 2010; Pomerantz & Sayers, 2010; Peek, Baird, & Coleman, 2009; U.S. Dept. of Health and Human Services, 2001; Burt, Aron, Douglas, T., et al., 1999; Unützer, Schoenbaum, Druss, & Katon, 2006; Strosahl, 2001).

Wang, Demler, Olfson, et al., (2006) note that there has been a major shift towards the provision of mental health care services within primary care settings. However, primary care physicians are rarely prepared to diagnose, treat, and provide follow-up care to individuals with significant behavioral health care problems. Part of the reason for the absence of preparation is the lack of training in psychiatric diagnosis, medications,

and models of care. Although the increase in mental health care episodes occurring in primary care has been evident for a number of years, the models that have been employed have not all been subjected to rigorous study. To date, only the collaborative care model has been subject to a number of studies that have demonstrated its efficacy with persons with behavioral health disorders. A number of these investigations have included African Americans in the samples, (Sanchez, 2011). Collaborative care has the most research evidence showing its effectiveness with those who have mild to moderate behavioral health disorders. (Alexander, 2008)

These integrative approaches incorporate the emotional, mental, physical, and social aspects of patient care. Davis (2011) suggests that various models of integrated care have the following characteristics: 1) co-location of service providers, 2) collaborative care, 3) physician training in behavioral health care, 4) screening and referral services, and 5) school-based services.

In California and nationwide, initiatives are underway that have the potential to close disparity gaps for African Americans when they promote relationship-centered best practices through the integration of primary care and mental health services. An example of this trend is the use of medical family therapists in hospitals, primary care, endocrinolgy, and neurotrauma clinics (Hanna, 2007; Hanna & Antle, 2000; Hanna, Walker, Walker et al., 2004; McDaniel, Hepworth, Doherty, 1992). The role of the medical family therapist is often labeled as a "family health consultant" to de-stigmatize their positions and emphasize the collaborative nature of their work between all relevant systems in healthcare settings. They become consultants to primary care clinicians by brokering the doctor-patient relationship, family-doctor-patient interface, patient-disease relationship and patient-family relationships. We recommend that family health consultants are closely matched to the culture and ethnicity of the individuals who are being served by primary care clinicians. More mental health professionals who are Americans of African descent should be trained to be medical family therapists.

The California Endowment/
Tides Foundation, Integrated Behavioral Health Project

From 2006-2010, the Integrated Behavioral Health Project (IBHP) was a Tides Center project funded by The California Endowment to speed the integration of behavioral health services into primary care settings in California. The ultimate goals were to enhance access to behavioral treatment services, improve treatment outcomes for underserved populations, reduce the stigma associated with seeking such services and expand access to quality health and mental health services.

There were three phases to the project and a variety of agencies that participated in each phase. In Phase I, IBHP funded nine initial demonstration projects: seven based in primary care clinics and two in regional consortia to see what components of integrated care correlate with successful results. In Phase II, IBHP awarded 16 grants to primary care clinics and clinic consortia to foster innovative projects that not only further their own integrated care programs, but offer the possibility of becoming a best practice to be replicated by others. In Phase III, specialized projects proposed by six clinics and one clinic consortia studied aspects of integrated care that could advance the field.

In Phase III, the agency serving a predominantly minority community was St. John's Well Child and Family Center located in Los Angeles County. It is a network of federally qualified (FQHC) and school-based health centers whose goal is to address the unmet needs of low-income, uninsured and under-insured residents by providing access to

patient-centered, culturally appropriate primary care, dental services, and behavioral health services, regardless of the ability to pay. Their patients are Hispanic (83%) and African American (14%).

Although the California Endowment/Tides Center Project produced resources related to a number of the recommendations above, no material on cultural competence targeted African Americans. For African American disparities to decrease, it is imperative that integrated behavioral health initiatives incorporate consumer data that is population-specific into programs and training materials.

Just Therapy: A Therapy of Social Justice (Waldegrave, 2009): *"Just Therapy"* is a reflective practice model developed by family therapists in Wellington Aotearoa/New Zealand. A fundamental feature of *Just Therapy* is the use of broad cultural, gender, social, spiritual, economic and psychological contexts underlying problems experienced by people. The premise is that the context of social and therapeutic problems is critical to their resolution, and that many of the problems find their roots in historical and structural injustices. The author believes the onset of many family problems are located in events external to the family, such as unemployment, bad housing, and racist, sexist, or heterosexist experiences, thus causing extreme depressing ongoing experiences. Those chronic experiences will cause parents and children to enter into a state of stress that leads to physical and mental illnesses. The *Just Therapy* approach addresses the injustices related to the sources and solutions of endemic social problems. Waldegrave (2009) recommends deconstructing institutional power in our public, private, and voluntary services in a manner that honors diversity and enables sensitive therapy, and other forms of service deliver and policy making that genuinely reflect the range of cultural, gender, and socioeconomic experiences of citizens.

D7. DISCUSSION OF FINDINGS

Actions express priorities.

After review of all the data and information collected, the collective cry from across the State of California is that Black people have been "severely neglected" by the system established to help all people. It is the strong belief and perception of the population that there is a cover up of the sever needs of the Black population. The CRDP have purposefully collected all the facts possible related to prevention and early intervention of mental issues, and even the review of the facts created despair within a population that is continually plagued by negative assaults (micro-aggressions) and a seemly lack of compassion or understanding from those who are there to help. Data collected is the best information that has been shared or, made available to the CRDP. SPW members strongly believe that there is more information that could be shared related to the Black population but, for some reasons outside of the control of the CRDP the information was not shared.

A gripping fear among CRDP participants was that this effort would be like other county planning efforts where Blacks had willingly shared information and suggestions as to what would be helpful programs and interventions but, there recommendations were not accepted, funded or established into programs. So the fear expressed is that factual information shared by the Black population would again not be accepted, funded, or put into programs and interventions. Societal level mistrust of this magnitude by an entire population could be indicative of maladaptive behaviors that contribute to mental "dis-ease." Thus, may develop into learned helplessness and lack of self-efficacy. Our society and the Black population needs healing from these perpetual micro-aggressions which are contributing factors and exposure factors for risk of getting post traumatic stress disorder (PTSD). Society needs to re-direct its thought processes away from negative ideas and expressions toward Black people. Initiating a massive environmental change from negative to positive values and equality, the Black population can and will experience significant healing. Our CRDP findings indicate that the caring response to provide a nurturing environment for Black people to grow and flourish is severely lacking.

It was difficult to obtain factual information about the Black population. We asked direct questions about what programs and interventions have been developed and are currently in place that are specifically tailored for the Black population. We were not given direct responses from the current local mental health delivery system. If programs and interventions exist specifically for Blacks, then it should have been shared. SPW members believe information has been purposefully with held; sadly to say based on our assessments very scarce programs and interventions have been designed and implemented for Black people in the State of California. We have written this report from the perspective of what the community said they wanted and needed to prevent mental issues and to intervene early when something happens. Some call it community-defined practices; the population calls it "getting the help they need." Many, many factors affect PEI in the African American population that the CRDP could not give justice to, or present all the details about the factors. We have presented a sampling to the best of our ability and resources to obtain the information. The issues are extremely complex and convoluted, both systemic and pervasive.

Evidence in the MHSA plans demonstrates a gross lack of priority efforts toward the African American population. Programs and initiatives are **NOT tailored** to the expressed needs of Black people, even after Blacks willingly participated in county stakeholder meetings and shared the information. The current system wide approach is passive and detached, which demonstrates a true misunderstanding of what is needed in the Black community at this point to bring about health and healing, and how to work with a population that is suffering from intergenerational unresolved trauma, co-morbid conditions, and multi-level environmental systemic and perpetual injustices. **Tailored African American** programs are missing from the local county DMH service provision system. Yet, data that is available from the county DMH indicate that the African American population is in CRISIS and in need of crisis level interventions. There is a serious disconnect between reality as perceived by the population and what the system "gives to the population based on what the system wants them to have."

The crisis mental health condition in the Black population is exacerbated by what project participants described as a mental health system of care delivery that was neither compassionate nor responsive to their needs, nor provided services they needed. They expressed that diagnoses were not accurate and were inconsistent with their expressed needs. This information suggests that urgent intervention is needed with the Black population in California.

But, data is missing that would clarify how "persons" use the system, and the actual level of care received which makes it impossible to know the severity of the intensity of the crisis. A major issue repeatedly expressed by participants, that negatively impacted good mental health in Blacks, and also precipitated mental illness, was the perceived "falsification of records." In addition to misdiagnosis that lead to wrong treatment and over medication. Participants felt these service practices maintain a cyclic crisis state within the Black population. Therefore, for prevention and early intervention (PEI) actions must be implemented with urgency and at crisis levels, to interrupt this negative cycle.

The Black community can no longer be ignored, misunderstood, marginalized, labeled, pushed to the side, or treated less than human. The Black population needs healing. During our data collection process, Black people expressed that they are 100% human, just like any other people group. From our findings, it is the perception that Blacks are devalued by society. It is insulting to insinuate that Blacks cannot make decisions for themselves, or to imply that they "do not understand," or cannot process "high level thinking." All of which are stereotypical ideas that permeate the American society. These misconceptions of Blacks are absolutely wrong and serve to perpetuate micro-aggressions and psychological distress and intergenerational traumatic experiences.

Strength of the Black population was demonstrated in the successful engagement of diverse people of African ancestry in the CRDP; over 1000 statewide. Significant to the engagement is that the population took time to identify what was meaningful to them based on their lived experiences. It was not a casual, passive participation. On the contrary, it was thoughtful and specific. Engagement of this level refutes the idea that Black people do not care about themselves, or their families, or their communities, or that they are not actively doing something to improve their conditions. The diversity of the engagement process also demonstrated that Blacks can successfully participate in multiple levels of public planning. Black people wanted to share information about what is currently working in their communities, and to make sure their expressed desires were clearly articulated.

During the 30-day public review of the draft African American Population Report, Blacks expressed they desired to have more elaboration on information in the report, even when the report was already at 249 pages. The population expressed they have been doing so much work in their communities for so long, and have not been financially supported by the local DMH, neither have they been recognized for the good and excellent work they have provided for years. The CRDP was the opportunity to share information with other Blacks and to create a statewide network to enhance efforts of the Black community to care for its own.

A major area of concern related to PEI, was the expression that DMH outreach for education and early intervention **was not visible or present in their communities**. A lack of education and awareness was noted as major barriers to reducing disparities and enhancing mental wellness of Black people. This included knowledge of African-centered modalities that define proper human behavior, and detail remedial approaches to restore proper functioning. Critical findings of the CRDP was the identification and cataloging successful culturally grounded scientifically tested interventions (see *Table 53*), listing of over 125 community practices, (see *Table 48*) and the identification of current successful tailored community-based projects and programs (see *Table 54*). All together the population articulated 274 recommendations, practices and strategies. Of extreme significances is the Skid Row Positive Movement, where Black residents over the past five years have created and implemented an ecological design for community rehabilitation (an inside out approach) that is not funded by DMH (or any other significant funders), and before the CRDP the Skid Row resident efforts were not even recognized by anyone. The Skid Row Positive Movement is an exceptional example of "self-help."

The Black population believes the DMH system has turned a death ear and blind eye to the needs of the population and current planning is not sufficient to meet the needs of the Black community. There is strong expectation that the recommendations in this CRDP Population Report will be adopted and incorporated in the re-designed integrated system of care. The population believes with examples and resources (such as the African American Mental Health Providers Directory) there is NO EXCUSE to not use tailored African American programs, projects, interventions, and culturally proficient professional providers. It appears the current DMH system planning has not incorporated the impact of multigenerational traumatic issues within the Black community. Black people in California are living traumatized lives. There must be trauma based crisis level interventions that are tailor made to provide the help that Black people need. The help should come directly from incorporating what is already working in the Black communities as listed in this report.

Local DMH continues to promote evidence based-practices for African Americans over community practices and the investment in tailored strategies and programs that are valued by the population, and work within the Black community to bring healing, self-sufficiency, and to help people become contributors. Research is clear, and the National Institutes of Health (NIH) and the Centers for Disease Control and Prevention (CDC) recommend "tailored" programs and interventions as identified by the affected population is what works best to reduce disparate outcomes and to bring and sustain healing among people groups. What is needed for the Black population is massive population-based intervention that value people and provide equity. Research on community-defined practices need to be tested to grow new evidence for mental health disparities from what the community knows works for them. There is the need to grow new strategies based on the community and populate the new evidence to bring new learning, and produce significant change in outcomes.

It is inappropriate, and unethical to use the same intervention for one group of people without the consideration of tailoring modalities based on an assessment of the population using a representative sample. For example, Blacks were brought to this country as enslaved people. Our current societal invisible bars continue to maintain an enslavement framework, which is restrictive and repressive. Black people in America will never be assimilated into society because of physical characteristics; we can only acculturate. Therefore, imposed programs and interventions will never work to bring health and well being to Black people based on inappropriate labels (such as bipolar, schizophrenia, drug addiction). There must be complete and thorough assessments. When seeking to provide PEI for a community of Blacks, there must be consideration in taking the views and perspectives of the population not just "a chosen few." There is Black culture but, Black people vary in preferences and must be asked, and prefer to be equal partners in decision-making regarding their health, the health of their families and their communities.

Repeatedly, the population expressed that prevention and early intervention (PEI) activities that are sponsored by DMH are not visible in Black communities. The local county DMH is not perceived as making a significant impact into the Black community to bring the changes needed for good mental health. When CRDP participants were asked to identify programs that were meaningful to the population, immediate response was to name PEI programs sponsored by the grassroots community organizations, or the Black church. And, most of the grassroots Black organizations stated they were not funded by the county DMH.

Of the data collected from community participants, over half of the participants self-identified as consumers, clients, or client family members; however, we believe the number was much higher. Participants stated that stigma, shame and the fear of being labeled "crazy" keeps Black people for seeking help for mental issues, and from acknowledging if they (or their families) are consumers. Likewise, many LGBTQI individuals did not self disclose, 10% self- identified with LGBTQI population for the same reason, fear of rejection and fear of not getting the help needed, and fear of being further marginalized. Blacks observe that other people groups are respected, and expect to receive the same care and consideration as others irrespective of economic status, gender preference, or cultural beliefs and practices.

When asked to identify ethnicity, over 35 different ethnic mixtures were reported with a common Black or African American heritage; except for people born on the continent of Africa who all identified by nationality. Important to the process was to allow the population to self-identify ethnicity, the question of "how do you identify with a certain people group." How Blacks living in America perceives self is a critical factor in determining belonging. Belonging is relative to cultural identification and how one has been socialized. It is not surprising that Black people freely respected their heritage, and identified multiple combinations of people groups, that were not necessarily based on "physical" or obvious characteristics. However, there are Blacks with unresolved issues relating to African culture. This could be a lack of understanding ones heritage which most likely contributes to the expressed "identity confusion;" as stated by several TAY, "we do not know who we are." This uncertainty creates frustration, isolation, anger, and other stresses. Attempting to acculturate into a society, that perpetuates a negative image of Black people creates and sustains continual micro-aggressions that lead to mental distress. Additionally, Dr. Leary (2005), in Post Traumatic Slave Syndrome, attributes the attitudes and behaviors of American Blacks are related to the sequela of slavery, especially the phenomena of low self-esteem, racist socialization, and

'Black rage'. Sequela is a pathological condition from a disease, injury or other trauma. Another example, PTSD may be a psychological sequela of rape.

Participants were from 28 of California's 58 counties, representing 106 different cities. Of particular interest is 73% of the Black population in California lives in six counties, Los Angeles (37.8%), Alameda (8.7%), San Bernardino (7.7%), San Diego (6.5%), Sacramento (6.4%) and Riverside (5.6%); and we were successful in engaging 72% of the project participants from these counties. Distribution of all CRDP participants by regions included 27.84% Los Angeles area; 26.81% Inland Empire; 25.30%Northen & Bay area; 11.14% Central and 8.91% Southern California. The voices from Black people are clear, "We are not getting the help we need to live healthy balanced lives." In all counties the expression is, "They say they are helping us, but they are not." The collective response from the Black community is, "Every person deserves to be treated humanely. We are humans, too. Will somebody do the right thing and help all people equally."

It has been our attempt to do the right thing and present the facts. We have made no excuses for individuals, the community or the system. And, the facts are that Black people all over the State of California are working with and within their communities to bring healing and to reverse the negative downward spiral of the population. There was a tremendous acknowledgement of community-based organizations that provide on-going activities, programs and services in the Black community. Great appreciation was extended to those organizations that work with little or no financial resources or staff. Because of their un-relinquishing efforts to help the Black community, people trust them and look to them in time of need.

However, the shame is that millions of dollars are provided by the mental health system, but hardly any significant money is awarded to Black community-based organizations to continue their respectful work with Black people. This is unfair allocation of financial and human capital that has been appropriated to help the community. The population has called for a **statewide accountability system** that works and that there are published systematic reports that provides documentation of the wellness status and progress toward independence and self-sufficiency. These reports are not just counting fiscal management of resources but direct correlation between intervention and outcomes. Additionally, there needs to be implemented immediately a vetting of "all" organizations that claim to provide culturally appropriate services and interventions to Black people. It was beyond the scope of this CRDP to vet organizations that report they are providing culturally appropriate services.

The recommendations from our CRDP are in concert with national reports. For example in the document, *Pathways to Integrated Health Care: Strategies for African American Communities and Organizations (Davis, 2011)*, four consensus statements emerged from this national dialogue of forty-five experts from a variety of relevant professions. They are:

1. A long-term response to health disparities in African American communities has been the development of informal or practice based evidence as well as the use of healers. For behavioral health care and related problems, African Americans often seek services from their houses of worship. However, there is a need to assess these interventions to determine the effectiveness of their outcomes and how the interventions can become evidence-based practices.
2. Reductions in disparities are partially dependent on the quality, quantity, and skills of the health and behavioral health workforce and the type of

integrated care applied. There is a need for a more diverse workforce that utilizes culturally and linguistically proficient and competent interventions that are developed within African American communities in addition to those that may also involve adaptations of evidence-based practices from other communities.

3. There is a pressing need to develop and measure a core set of practice standards and criteria that focus on holistic health, wellness, and community based standards.
4. A significant number of the health and behavioral health conditions in African American communities co-occur with other socio-economic conditions. These co-occurring conditions include substance disorders, severe mental illness, HIV/AIDS, poverty, diabetes, heart disease, low income, unemployment, and homelessness as examples. The presence of multiple conditions increases overall health risks, stigma, costs, and health outcomes.

Retrospective review of California data and information as collected and presented in this CRDP Population Report reveals clear evidence that the African American population is not a priority. From the perspective of the population, evidence is overwhelming that the mental health and overall well-being of Black people are declining drastically due in part from a sever lack of the County DMH not investing resources into targeted specific interventions. The perspective of the Black population is that the "melting pot" approach, which is "everybody gets the same treatment" has not worked and has not proven to drastically improve the mental health of African Americans.

Culture remains a major factor for meaningful interaction with the population and defines relevant community practices. It appears that community-based efforts in ethnically- and culturally-matched communities are the most desirable. Programs for Blacks need to be created, implemented and replicated in communities across the State of California. In those counties where tailored cultural programs are in place experience tremendous positive results. These programs **MUST** continue and be significantly financed, supported and sustained in order to make a "meaningful" difference in mental health outcomes. Supporting community-based networks that are currently in place and those that need to be established is advantageous to a newly re-designed mental health system given the severe shortage of professionally trained workforce. A monumental consideration would be the training of individuals at the community level that would provide ongoing PEI activities in a manner that is valued and meaningful to the population.

From the perspective of Blacks, there is a quick acknowledgement that change must take place at the individual, community and especially the systems level. A lack of investment by the County Department of Mental Health in tailored programs and interventions does not provide demonstrated evidence of what is working to significantly meet the mental health needs of the Black population. Community grassroots programs and interventions that work to keep the African American population healthy have not been financially supported by the County Department of Mental Health. Results from "everyone gets the same" approach have not generated evidence of what is working for "good mental health" in Blacks, and or to sustain or expand what is working.

"We keep talking, but it appears nobody is listening."

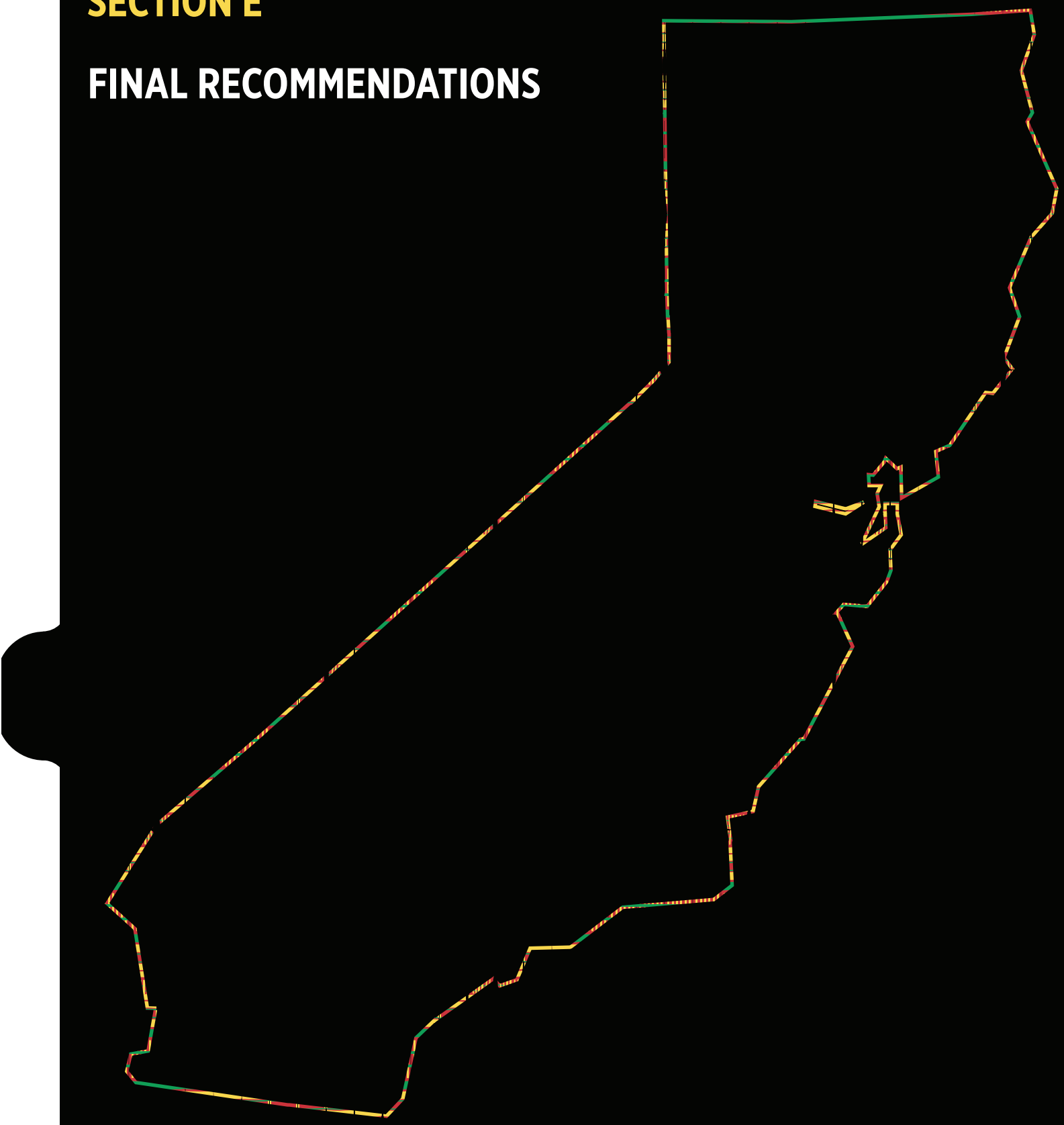
“CULTURALLY SENSITIVE ASSESSMENTS.”



nityrespecthopecompassiondignityfamilycouragepeacetogethernessculturefaithloveu

SECTION E

FINAL RECOMMENDATIONS



E. FINAL RECOMMENDATIONS

Pathways into the Black population for eliminating mental health disparities calls for a bold and radically different and alternate way to deliver mental health PEI services that is culturally grounded and proficient in African American reality. We must seek to heal the whole person instead of addressing various symptoms as they arise. Participants were clear when articulating 274 PEI practices that could be helpful at the individual, community and systems levels to bring needed change and foster permanent healing and restoration of the Black population. If practices are implemented in counties, they could help to improve and enhance the existing mental health system, as well as assist in re-designing the system to align with culturally congruent practices for PEI in people of African heritage. Complex, aggressive, and urgent actions are needed.

Community-defined practices as reported by people of African ancestry are recommended for prevention and early intervention are:

- To increase the wellness and the health of individuals and communities through taking action for social change strategies to restructure the mental health system to be recovery-oriented, community-based, and to bring systemic transformational change to correct dysfunctional systems dynamics that will support emotional emancipation and healing for Black people
- To protect our civil and human rights
- To exercise our power of choice in health approaches
- To build more accepting, inclusive, and diverse organizations and communities in broad-based population efforts for prevention and early intervention of mental issues in people of African ancestry
- To provide a focused approach on what will bring significant healing there must be a protection of the family, support for children, provide skills for mothers, jobs for men, training for young men, eliminate root causes of disparities, create a community career system, and a re-employment system

The Black community already has in place systems and networks that heal and support individuals and families. These systems need to be supported and funded for sustainability, continual outreach, and ongoing development of organizations and agencies. The efforts of the **California Reducing Disparities Project (CRDP)** has required a dynamic approach that is unrelenting surrounding a complex interplay of issues of disparity reduction, availability, quality and outcomes for the unserved, underserved and inappropriately served.

Radically different and alternative ways to deliver mental health PEI will require us to engage in the direct application and interrogation of African American culture. Culturally congruent PEI practices call into question the idea of culture as more than simply culturally relative "add-ons" or programmatic adaptations in the name of diversity. Culture is a skill set and paradigmatic guide facilitating both the cultural capacity enhancement of existing services and programs serving African American clients and directly allow for the development of new culturally authentic practices and service programming in line with the African American cultural reality.

The new integrated culturally grounded PEI techniques designed specifically for African American people will require psychological practices allowing for new and distinct "areas of interest," "rules of evidence," "classificatory integrity," "independent

nosology," and "precise diagnostic methodology." It will require mental health cross training for and by African American mental health practitioners, including traditional/ indigenous healers, and the joint creation of materials that involve interdisciplinary and trans-disciplinary approaches.

The CRDP African American Population Report calls for recommendations that are ***SMART*** - **Strategic** (specifically targets African Americans); **Measurable** (allows for cultural vetting of programs and services); **Achievable** (monitored against real indicators of African American mental health); **Required** (will address both necessary and sufficient conditions desired by African-American community) and **Timely** (allows for concrete and guided action now).

The African American PEI ***SMART*** recommendations clearly and concisely positions the State of California as the leader in national actions to reduce disparities for the African American population with permanent, long-term solutions that generate immediate positive impact on individual, community and system wide investment. The following are individual, community and systems level recommendations that work and promising community cultural practices (see page 217) that have the potential to make a significant difference in mental health for people of African ancestry.

We, therefore, recommend:

#1: Crises Care: Immediately implement culturally focused short term population-based crises care.

#2: Service Delivery Change: Immediately respond to the mental health crises in the Black population by shifting emphasis of service delivery away from diagnosis and prescriptions to screening, accurate assessment and identification of immediate needs.

#3: Establish a Black Care Paradigm: Immediately change the provision of services to Blacks by first conducting mass population-based screening and trauma-based assessment for crisis level interventions conducted by trained African American providers. Support African American mental health service providers (see *California African American Mental Health Providers Directory*), promote and use the expertise of this statewide interdisciplinary African American network as consultants for integrated health services for "whole persons" care, with special emphasis on young children, youth, older adults, the blind/deaf, and LGBTQI. Adopt a culture based approach for all service delivery, especially PEI, such as The Culturecology Model© (Nobles and King, 2000) which recognizes that (1) "the nature of the person" and "the nature of the environment" are inextricably connected, (2) both the environment and human beings are cultural phenomena, and (3) the "cultural grounding" and meaning of each (person and environment) must be culturally understood in order to fully understand the interactive relationship between persons and health and disease. It, in effect, requires the simultaneous examination of the forces that promote and prevent disease in the African American community. The model has been successfully applied in prevention , i.e., the **African Centered Behavioral Change Model© (ACBCM)** [Nobles et al, 2009] with the implementation of the **Healer Women Fighting Disease** project, which has been designated as an evidenced-based best practice and listed in the Substance Abuse and Mental Health Services Administration (SAMHSA) National Registry of Effective Programs and Practices (NREPP).

#4: The State should Establish Culturally Congruent Mobile Intervention Teams: Significantly fund and organize statewide county level mobile intervention teams utilizing trained interdisciplinary integrated African American clinical psychologists (i.e., the Association of Black Psychologist), clinical social workers (i.e., the Association of Black Social Workers), and marriage and family therapists to stabilize and unify the Black family unit and community.

#5: The State should Fund Neighborhood Health Efforts: The State should provide significant financial resources directly to Black led community-based organizations to continue providing meaningful programs, interventions and activities for long-term positive community wellness and growth. Significantly fund, support, and replicate comprehensive family, community resources and wellness centers that are directed and administered by Blacks that provide wholistic (i.e., wrap-around) services to the Black community which includes a broad base network of ***"Neighborhood Health Check Stations"*** for prevention and early identification of services needed. Examples are *"The Village Project"* in Monterey County, the *"Skid Row Resident Positive Movement"* in downtown Los Angeles, and the *"GENESIS Program"* in Venture County, the *"ISOJI"* (e-so-gee) Project in Marin County, *"Harmonious Solutions"* in San Diego County, and *"African Immigrant Ethnic Cultural Communities Advisory Committee"* (ECCAC) in Santa Clara County.

#6: The State should Fund Existing Culturally Congruent Integrated Programs: Examples are G.O.A.L.S. for Women an integrated model that provides culturally competent mental health counseling, mentoring, coaching, peer counseling, high-risk case management, TAY services, and advocacy to underserved women of color and their families since 1997 in Oakland (Alameda County). Also, the *"GENESIS Program"* in Ventura County, a program model that serves all ages across the lifespan and integrates spirituality, lay counseling, cultural ambassadors, and culturally congruent mental health therapy. The program is administered by the Cyrus Urban Interchurch Sustainability Network (CUISN) and is currently conducted at Oxnard Community College, Saint Bonaventure High School in Ventura, and the First Samoan Pentecostal Church of Oxnard. Volunteers participate from a variety of disciplines including psychology, business and banking, religion, the Black American Political Association of California, Ventura County Behavioral Health & AOD, the African American Reading Room, and other community entities.

#7: The State should Fund Community Healers Support Network: Critical to integrated care across service domains of behavioral health, mental health, substance abuse, and public health is the establishment of a statewide network of community healers & indigenous/traditional healers (These are local residents that work continually using various ways to heal their communities.) and fund 6 pilot projects at least one in each region; test and evaluate the efficiency of alternative mental health integration across domains. Significant funds should go "directly" to neighborhood healing efforts (e.g., the *"Skid Row Resident Positive Movement"* in downtown Los Angeles), community defined solutions (e.g., *"Black Men Speak"* in Alameda County), the cultivation of local leadership and grassroots homegrown agencies (e.g., *"The Gardens"* in Sacramento County), and advocacy to address interrelated threats to Black health including substance abuse, mass incarceration, youth and domestic violence, and a deficit of culturally trained community mental health workers.

#8: Immediate Process of "Cultural Vetting": The MHSOAC should immediately develop and implement a due diligence process of "cultural vetting" (examination

and evaluation) to determine the utility and effectiveness of programs and services ability and/or capability in working with people of African heritage. There must be a transparent accountability process to ensure that providers and programs are responsive to the needs of the Black population.

#9: The State should Establish a Continuum of Healthcare and Education Systems: A systemic transformational change is required, if a more effective mental health system is redesigned to be more responsive to ethnic population needs, and to correct dysfunctional systems dynamics that create fragmented care and perpetuate disparities in health, education, and community well-being. Create a continuum that links Federally Qualified Health Centers (FGHC) community clinics and School Based health Centers (SBHC) with integrated physical health, mental health, and substance abuse services at single site facilities (The Inner City Industry Model by Bruce Wheatley in Los Angeles) and a similar model by Dr. Henry Hendrix in the Fresno Unified School District. The continuum of systems establishes a point of healthcare entry for children, youth, and transition age youth actively enrolled in K-16 education institutions and establishes fundamental ethnic guiding principles such as all teachers should be experts in "cultural pedagogy."Therefore, the continuum system can be and must be sustained by culturally congruent workforce education training to employment program. The program provides part-time employment for transition age youth as peer mentors and wellness coordinators, and healthcare coordinators for the adult population.

#10: Establish Mental Health Service Community Commissions: In every county (or combination of small counties) the Mental Health Services Oversight and Accountability Commission (MHSOAC) should establish culturally congruent community commissions. These community commissions will report directly to the MHSOAC. Accountability of MHSA funds should be strictly enforced. And, mandated compliance should be governed by the people served. MHSA funds should be utilized to establish community governance to collaborate with the MHSOAC in providing culturally congruent community-based participatory research and programming with social service agencies in establishing evidence of the effectiveness of programs funded. With the national trend toward integrated health models, ***mandated Countywide African American Health Oversight Commissions*** (and other culturally congruent community commissions) will ensure that African American issues related to total health and well-being are appropriately addressed using culturally appropriate approaches as valued by local county residents. Each commission is composed of local county residents from a broad spectrum/representation of people of African ancestry including clients, client family members, consumers, and other interested/invested community-based residents. Annual benchmarks and status reports should be generated for county level accountability of appropriate services rendered and the wellness status of residents.

#11: Fund Culturally Congruent Community Evaluation Programs: To assist the MHSOAC with its state mandated responsibility of monitoring and evaluating MHSA fund usage, provide funds for community-based organizations to conduct community participatory evaluation of programs providing services to people of African heritage. This will ensure accountability of programs, not just fiscal accountability but including manner and method of delivery of services. The process of using a "one size fits all programming approach" does not product the level of significant change needed for the Black population in the State of California. Black people are traumatized, stigmatized, marginalized, and neglected. Passive programming and interventions do not produce significant healing and health. Program success outcomes should not be limited to "evidence-based programs" but should be given equal weight with community-defined

practices. We have highlighted the expert community-based evaluation work of Dr. Cheryl Grills in our CRDP, who is the PI for a 22 site national community-based program evaluation project in communities of color. We recommend that culturally congruent evaluation modalities and measures used in this project be adapted and tested in recommended tailored PEI programs funded by the MHSA. Efficacious program outcome measures in the Black population should be based on the client desired practices as measured by quality of service delivery, wellness state and satisfactory client progress toward independence and self-sufficiency.

#12: Establish Prisoner Re-entry "Places of Compassion": Work with the Criminal Justice System, local police departments, district attorneys, faith/community-based organizations to develop alternative sentencing and housing options (*"Places of Compassion"*) for the mentally ill entangled in the system and returning home under the *"re-alignment program"*(California AB 109). The majority of incarcerated adults & youth are Black. Each county re-entry plan should be vetted by the community to prevent recidivism and further perpetuate escalating crises. Important is to significantly fund existing grassroots PEI programs in the Black community working with the formerly incarcerated and preventing recidivism (e.g., *"Pastors on the Premises"* in San Bernardino; *"Life Lines to Health"* in the City of Berkeley; *"Harmonious Solutions"* in San Diego).

#13: Culturally Congruent Population-based Education: Provide alternate education programs designed to educate, restore and revitalize the Black family unit and population (i.e., create "Community Healing Circles"). Extensive education program for people of African heritage to learn about mental health to eliminate the stigma associated with mental illness (i.e., the NAMI family training model and ***Peer to Peer Program***). Public education campaign on the nature of mental illness so family, friends and community members can recognize early warning signs and know how to take action and how to access resources to prevent a major episode. Utilize the Black media to promote a public education campaign designed like the national heart attack or stroke campaign.

#14: Statewide CRDP Implementation Workgroup: Appoint an implementation workgroup for the recommended community-defined practices of all CRDP Population Reports. Respect and work with all diverse communities, especially the American Indians, Asian/ Pacific Islanders, LGBTQI, Latinos, and the African Americans who make up the majority of the citizens of the great State of California. All people are important. All people deserve to live at peace and to experience "good mental and overall health" as defined by the people group.

#15: Stabilize the Black Family Unit: The Black family is in crises as a result of intergenerational traumatic experiences and ongoing micro-aggressions that continue to exist today. Only holistic services to the community, using the natural family support system will assist the family unit to stabilize. Black families need full opportunities to recover and to establish stable environments that are nurturing and supportive of "good health." The state should financially support approximately 6 African American Culture Centers and evaluate the effectiveness of a holistic cultural-based community-level approach to mental health.

#16: Establish a Network of Community Healers & Indigenous/Traditional Healers: This is a suggestion for an alternate way to deliver mental health services that is culturally grounded. This allows the mental health system to become community-based, going to the people for assertive outreach, to foster the natural support system

of cultural healing that fosters relationships that are naturally in the community and are respected by the community. When structured correctly this recommendation will greatly improve the mental health workforce and extend the professional staff outreach. It will require cross-training in helping people, capacity building for healing, and accepts and acknowledges "community preferred practices." This approach is a long-term solution, with immediate impact on individual, community and system wide investment. To implement correctly, mandates must be established in the RFP contracting process, mental health training for professionals as well as community healers, and the creation of materials that involve interdisciplinary and trans-disciplinary approaches. The State should fund 2-4 pilot projects, test and evaluate the efficiency of alternate means to mental health that is integrated across domains. Create and provide professional development opportunities for non-licensed workers (local community persons, lay-ministers, para-professionals, etc.) to obtain enhanced culturally-grounded mental health training in order to increase the number of service providers capable of providing culturally congruent services to African American clients

#17: Conduct Statewide Therapeutic Training Sessions on Racism: Therapeutic training sessions on racism will educate mental health practitioners about the historical and contemporary mistreatment of people of African ancestry. Using the resources located in the family system and community, training of clergy and lay persons in African American communities (Molock, Matlin, Barksdale, Puri, & Lyles, 2008) and education of parents, with school-based interventions (Brown & Grumet, 2009) could address reduction in at least one serious public health concern—Black teen suicide prevention, but certainly can and should measure effectiveness over multiple domains of living and well being.

#18: Ongoing and Directed Training for First Responders such as Faith Community (Clergy) and Law Enforcement (Officers): We acknowledge there are current trainings available for both groups. This recommendation comes forth from the community to identify what is "meaningful" for Black people to experience good mental health intervention from first responders. First there needs to be a statewide task force established that includes "indigenous healer and community leaders" from every region within the State of California. The suggestion is to develop an RFP and contract to determine and develop the curriculum. The curriculum should include an overhaul of language used to address mental issues, allow for individual regional approach tailored to community, include multilevel approach to respect diverse faith community practices, approaches that will address stigma, provide resources that can be used by the clergy and law enforcement to share with the community, and should include an evaluation component. During the directed training participants should obtain information on resources, county options, and crises.

For the law enforcement, training is needed for immediate assessment so that the **person is not treated like a criminal** when the person is in fact sick, hard of hearing, deaf or legally blind. Law enforcement must be trained on how to deal with "micro-aggression" in the Black community. In the police academy specific training MUST be offered on mental health. Particularly, training should be on the same level as "hostage negotiation" when dealing with Black men. Officers must be proficient in how to de-fuse the behavior of a Black person. There needs to be established an "officer hotline" for immediate assistance of a mental health professional to assist with assessment. Recommendation supported by the California Judicial Council Task Force for Criminal Justice Collaboration on Mental Health Issues: Final Report, issued April 29, 2011.

#19: African American Culturally Sensitive Services Program: Create a unique category of early intervention practice services that could potentially be a part of the African American Culturally Sensitive Services Program (AACSSP). This category will improve on better wrap-around services, and at a minimum should include the following:

- Stipulated number of days to follow seriously mental ill (SMI) client after residential treatment center (RTC) release Federal/State Legislation to require documented follow-through of consumer client from RTC hospitalizations primary care practitioner to the next level of care practitioner.
- Partnership between Private Insurance and Public Health Insurance collaborative partnership for smooth transition regarding Level of Care. Make this an end product of the Mental Health Parity Law of 2009.
- Alternative Treatment Options should be embraced by medical community and should also be embraced by insurance companies. These treatment programs options can be a component of the African American Culturally Sensitive Services Program (AACSSP) and can include the following:

- **Pet Therapy Program**
  Fostering a Pet
- **Family Life Program**
  Financial Literacy
  Parenting Classes
  Purchasing a Home
  Having and Maintaining Good Credit
  Maintaining Marriage & Personal Partnerships
- **Spiritual Exercise Programs**
  Meditation Exercise Courses
  Tai Chi Exercises
- **Brain Exercise Programs**
  Reading
  Board Games
  Video Games
- **Physical Exercise programs**
  Gym memberships
  Spa Membership
  Organized sports programs
  Organized dance programs
  Alternative New Age stress reduction programs
  Chinese medicine, (acupuncture, acupressure)
- **Fine Arts programs**
  Theatre, Music, Drawing, Painting, Sculpture
- **Vocational Arts Program**
  Auto Mechanics
  General Contractor Training Program (Carpenter, Electrician, Plumber)
- **Home Economics Program**
  Cooking
  Cleaning
  Parenting (Child Rearing & Elder Parent Care)
  Guiding principles for AACSSP

- Define African American Culturally Sensitive Services that are unique and wanted by the population. Develop these services so that they can be implemented singularly or bundle them together in-like minded modules. Establish African American Culturally Sensitive Services Program (AACSSP) based on the unique services requested (GIVER)
- Create Community Program Partners (CPP) that receives these culturally sensitive unique services (RECEIVER)
- Identified African American Culturally Sensitive Services Program (AACSSP)work through Community Program Partners (CPP), who identify the needs in their communities that our services can help them address. We provide services to the partners, and work with them to plan and implement distributions and activities in their communities. This helps reduce the immediate need.
- The identified African American Culturally Sensitive Services Program (AACSSP)help Community Program Partners enhance the local programs where they work. By volunteering with us, the partners learn how to work with outside resources, organize and advertise events, and recruit and coordinate volunteers. Their volunteers also build skills and confidence. This learning benefits all programs in the long run.
- The African American Culturally Sensitive Services Program (AACSSP) will give preference to the mentally challenged with limited access to transportation and services. Many mentally ill consumers do not have transportation. Additionally many of them live in zip codes that have been identified as being below the national poverty level. This is the target group that we will prioritize for service.
- When a group is selected for services, the African American Culturally Sensitive Services Program (AACSSP) will serve everyone in the group. In addition to need, a group may be further defined by age, location, the Community Program Partner's service area, or other factors. These criteria make clear who is eligible to receive the service. Using this system helps to avoid any feeling of unfairness or partiality within the community that could undermine the effectiveness and credibility of the African American Culturally Sensitive Services Program (AACSS) or our Community Program Partners.
- The African American Culturally Sensitive Services Program (AACSSP) program delivers only needed services. We work with Community Program Partners to understand what products are needed and in what quantities, then strive to match those needs with high-quality products. In other words, we do not "dump and run." Dumping services merely because they are available doesn't guarantee a benefit. Some services are unwanted or inappropriate. Delivering the wrong thing at the wrong time or to the wrong place can create a problem for the community. Thus, the African American Culturally Sensitive Services Program (AACSS) program only delivers to the Community Program Partners (CPP) and only delivers services that will help address the Partner's need.
- The African American Culturally Sensitive Services Program (AACSSP) program gives clear, written expectations to its Community Program Partners. We rely heavily on the Community Program Partners and other volunteers to make our program work. We clearly outline expectations as to what the community needs to do and what the African American Culturally Sensitive Services Program (AACSSP) will do for them. Building this line of communication makes our services more effective because everyone's expectations are clear.

- We will insist upon program accountability. We expect our Community Program Partners to care as much about the services provided as we do. Services must go only to the defined group and be reported on by the Community Program Partners in a timely fashion. We fulfill our obligations to our Community Program Partners, and we expect our Community Program Partners to fulfill their obligations to us.
- We will insist that the program will also be accountable to our donors. We take seriously the management of resources that donors entrust to our care. We work efficiently and effectively year-round, to achieve the maximum reach and impact from available resources. This enables us to be a constant resource to our People and to the Community Program Partners who are counting on us.

#20: Certified African American Providers: All licensed mental health service providers must be certified by the Association of Black Psychologists in order to improve the skills of service providers to better provide culturally competent service to diverse African Americans.

#21: Cultural Proficiency Training: All mental health service providers should be provided cultural competency training in African American cultural orientation by African American trainers and providers in order to improve the delivery of services to African American clients.

#22: Community-based Practice Research: Develop opportunities for local health departments to attain enhanced awareness of Community Defined Evidence-Based Prevention and Early Intervention Programs (i.e., homegrown).

#23: Culturally Competent Curricula: Create and provide opportunities for adoption and inclusion of culturally competent curricula developed by African Americans based on Community Defined Evidence in a way that better serves diverse African Americans.

#24: Funding for African American Practice Models: Develop funding opportunities for Community Defined Evidence-Based Prevention and Early Intervention Programs (i.e., homegrown) to provide mental health services to African American clients.

#25: Test African American Program Efficacy: Utilize the recommended community practices and organizations associated with this CRDP African American Population Report, to conduct research to test their efficacy for sustainability and expansion, see *Table 54.*

#26: Advocacy and Financial Support for Positive Image of Black Culture: Develop social marketing plans and outreach with Black media to expand and enhance understanding of Black culture with an emphasis on positive imagery for improved mental health and to destroy erroneous ideologies about the population.

#27: Appropriate Data Collection and Reporting: To address the need for more appropriate data collection on the Black population, mandate culturally congruent methods that document individual and community (ecological approach) positive actions for what is working well toward personal improvement, progress toward independence, and toward becoming a contributor. Progress reports and data outcomes must be reported on a regular base to ensure program fidelity and return on MHSA financial investment

#28: Mandatory analysis of all assessment and screening tools used on African American / Blacks for all mental health issues and standardized culturally adapted screening instruments and tools

#29: The State should Fund Community-based Culturally Congruent Prevention Research: For example, the role of diet in regulating mental wellness must be considered and further explored with an emphasis on traditional food combinations and dietary principles of people of African ancestry. Many traditional African American dietary practices were African cultural retentions passed down through generations. These culinary traditions should be examined and any interventions should be culturally relevant. Consideration should also be given to the medicinal use of food such as the incorporation of bitter foods (kola nuts, bitter leaf, etc.) in the diet, as well as the use of raw foods, organic foods, vegan, and vegetarian diets and the effect on psychological and emotional moods. This process can create intergenerational partnerships and promote cultural sharing among people of African ancestry.

#30: The State should Fund the creation of Tailored PEI Outreach Materials on the nature of mental health and well-being for social marketing and education on the community level, that can be implemented by traditional mental health providers and non-traditional agencies (i.e., community based organizations, churches, barber shops, beauty salons, professional athletes, entertainment industry, food industry, etc), as well as the development of social marketing/networking plans and outreach based on the internet and social media to expand and enhance understanding of mental health for African Americans.

Summary

In summary, the African American population in California wants to be part of a thriving, self-sufficient, productive community that can care for its own people in meaningful, creative, and traditionally collective ways. We will collaborate with the State of California to implement initiatives as an investment in the future well-being of our children, youth, families, neighborhoods and state, for the greater good.

We have grouped our final 30 recommendations into five strategic action categories to strengthen the investment in the Black population for a unified community-building initiative to eliminate disparities. It is our belief that this approach has the potential to ultimately save the state millions of dollars in integrated cost-effective strategies, mental health prevention and early intervention care, decrease further deterioration of those with mental illness, and create a more efficient whole person service delivery system.

Category 1: Local African American Prototypes
Recommendation #15 African American Cultural Centers can and should become a hub for several recommendations such as:
#1: Crisis Care
#2: Service Delivery Care
#4: Mobile Interventions
#5: Neighborhood Health Efforts
#7: Community Healers Support Networks
#12: Places of Compassion
#16: Certification of a Network of Community Healers & Indigenous/Traditional Healers as Prevention Care Providers

Category 2: Community-County Partnerships
#10: Mental Health Services Community Commission
#11: Culturally Congruent Community Evaluation Programs
#18: Culturally Congruent First Responders Training
#22: Community-based Participatory "Practice" Research
#27: Data Collection and Reporting

Category 3: State Specialized African American Program Prototypes
#3: Black Care Paradigm
#6: Existing Culturally Congruent Programs and Projects
#19: African American Culturally Sensitive Services Program (AACSSP)
#24 & 25: Test Efficacy of African American Practice Models

Category 4: Partner Alliances with the State on Accountability Mechanisms
#8: Cultural Vetting
#10: Mental Health Services Community Commissions
#11: Culturally Congruent Community Evaluation Programs
#14: CRDP Implementation Workshops
#20: African American Mental Health Providers Certification Program
#21: Mandatory Analysis of all Assessment and Screening Tools Used with African Americans

Category 5: Statewide Culturally Congruent Education
#13: Population-based Education
#17: Therapeutic Training Sessions on Racism
#21: Proficiency Training
#23: Culturally Competent Curricula
#26: Social Marketing Campaign for Positive Black Images
#30: Prevention and Early Intervention Outreach Material

Additionally, we have summarized below key "community practices" representing what is important to Black people and what they believe is needed to promote good mental wellness. *Table 54* is a combination of community practices, resources and examples.

Table 54 A List of Identified Community Practices, Resources, and Examples

Community Practice	Example	Goal	Contact
Culturally Congruent African American Services	***The Village Project***	To provide community-based culturally appropriate services to African American population for unmet needs; services include mental health counseling for children, adults, families, couples; Black parenting classes; groups for girls and boys; after school tutoring program; plant propagation program; psycho-educational support groups for youth; guidance in establishing healthy African American identity; youth leadership training; life skills training; **Started May 2008**	**Mel Mason, MSW, LCSW** Executive Director & Clinical Director 1069 Broadway Ave, Suite 201 Seaside, CA 93955 (831) 392-1501 www.thevillageprojectinc.org Monterey County
	ISOJI (e-so-gee) Project	Nigerian for "rebirth, or revitalization, or renaissance" To facilitate the process of building community from within through social justice, advocacy, and effective communication by offering programs that support family resiliency, early childhood education, mental health, health & wellness **Started in 1999**	**Ricardo Moncrief, Ex Director** (415) 883-1757 hnef@aol.com Elberta Eriksson, BCD, LCSW Leslie Johnson, MSW, PPSC Marin County
	Operation Give-A-Damn (OGAD) Project	Community grassroots wrap around system to provide care to African American families; project started in a church and offered integrated services across multiple collaborations to address psycho-social issues, developmental issues, mental and health related services, peer support, relationship building, economic assistance, health literacy, ethnically matched mentoring programs, and	**St. Andrews Presbyterian Church** Drake and Donahue Marin, CA 94965 **Elberta Eriksson, BCD, LCSW** And others are working to restart the project - ***Operation Give-A-Damn²***

Table 54 A List of Identified Community Practices, Resources, and Examples

Community Practice	Example	Goal	Contact
		other needs as identified by individuals and families; program success is demonstrated by the positive contribution and independent well being of participants; **Started in 1967 and ended 1995**	***(OGAD) Project*** **(415) 383-2073** eneriksson@comcast.net Marin County
	Coalition of Mental Health Professionals (CMHP), Inc. **African American Wellness Centers**	CMHP provides to a multiethnic & multi-lingual community, using professionals who represent the communities they serve; Afrocentric approach used to provide services that include group & family therapy, psychological evaluation, psycho-education assessment, parenting classes, domestic violence & anger management classes, critical incident stress debriefing, conflict resolution, HIV/ AIDS information, awareness, prevention counseling, and referral services **Started in 1992**	**Sandra E. Cox, Ph.D.** Executive Director 9219 South Broadway Los Angeles, CA 90003 (323) 777-3120 **sandilane4@aol.com** Los Angeles County
	G.O.A.L.S. for Women	Provides culturally-competent mental health counseling, mentoring, coaching, peer counseling, high-risk case management, TAY services and advocacy for increased community access to culturally competent mental health counseling to underserved women of color and their families **Started in 1997**	**Gwen Wilson, MSW** (510) 985-0500 www.goalsforwomen.com Alameda County

Table 54 A List of Identified Community Practices, Resources, and Examples

Community Practice	Example	Goal	Contact
	African Immigrant Ethnic Cultural Communities Advisory Committee (ECCAC)	To provide support services, including **mental health first aid (MHFA)** to consumers and family members experiencing mental illness, as well as promote wellness through education, support groups, advocacy, outreach, and training; serving the Eritrean, Ethiopian, & Somali Communities; services offered – one-on-one & phone support, group support, and multi-lingual workshops	**Mohammed Ali** Business (408) 792-2153 Cell (408) 712-7555 **Semert Haile** (408) 775-3783 Santa Clara County
	Progressive Life Center (PLC)	PLC provides behavioral and mental health services that combine core principles of ancient African worldview with techniques of humanistic psychology targeting children, youth and families who have experienced negative life events and challenges. Services include treatment and traditional foster care, kinship care, youth diversion, family preservation, and cultural diversity and team building training to educate and empower families, organizations and communities to realize and utilize their inner power to achieve healing using culturally competent and spiritually-based human services practices. **Started in 1983**	**Dr. Frederick Phillips** Progressive Life Center, Inc. 1704 17th Street NE Washington, DC 20002 **Tel:** 202-842-4570 **Fax:** 202-842-1035

Table 54 A List of Identified Community Practices, Resources, and Examples

Community Practice	Example	Goal	Contact
Community Programs Based on African American Culture	**Afterschool Rites of Passage**	African American boys transition from boyhood to manhood; creative arts, math, science, college prep, fitness, and monthly family empowerment dinners	**Dr. E.M. Abdulmumin** The DuBois Institute (951) 686-9930 Riverside County
	Afrocentric Youth and Family Rites of Passage Program	African American boys 11-15 years of age; mentorship, tutoring, college prep, creative arts, and the seven principles of Kwaanza	**Tinya Holt, Director** Perris Valley Recovery Program (951) 657-2960 Riverside County
	Effective Black Parenting Program	Parenting program with an African American frame of reference, pyramid of success, family rule guidelines	**Dr. E.M. Abdulmumin** The DuBois Institute (951) 686-9930 Riverside County
	Cognitive-Behavioral Intervention	African American boys and girls ages 10-14; to reduce symptoms related to physical or emotional trauma; build resistance/strength, increase peer and parent support	
	Effective Black Parenting Program	African American parents to teach methods of disciplining children using effective praise and a reward point system	**Tinya Holt, Director** Perris Valley Recovery Program (951) 657-2960 Riverside County
	Cognitive-Behavioral Intervention for Trauma in Schools	African American children in middle and high schools; provide counseling in the schools based on Cognitive Behavior Therapy principles	

Table 54 A List of Identified Community Practices, Resources, and Examples

Community Practice	Example	Goal	Contact
	Resilience Promotion in African American Children	To build resiliency and prevention behaviors in African American students	**Patrick McKinstry, Director** The LaBaron Group (951) 675-2750 Riverside County
	Harmonious Solutions	African American young males (10-17 years) culturally compassionate conflict resolution program based on African-centered values and practices; counseling and community education -male imagery, trauma, cultural influences; support groups and community forums; mental health stigma forums	**Charles Kahalifa King, MS** IMF 52740 Harmonious Solutions (619) 266-1181 info@harmoniouslifesolutions.org San Diego County
	Family/Youth Partner Program Harmonium, Inc.	Essential life supporting linkages and advocacy for children, and Transitional Age Youth (TAY) with serious mental illness. Interventions and collaborative partnerships aimed at reducing disparities in access to mental health services for Africa-Americans.	**Andrea M. Stewart, LMFT Program Manager** (619) 254-1148 (619) 857-6799 San Diego County
	The Grandparents Connection	Assists “parenting” grandparents and their families with care-giving needs such as food, clothing, counseling, advocacy, spiritual self-help, and other essential support services.	**Shearl Lambert, Founder/CEO** (619) 931-9548 info@grandparentsconnection.org shearl@grandparentsconnection.org San Diego County

Table 54 A List of Identified Community Practices, Resources, and Examples

Community Practice	Example	Goal	Contact
	Black Men Speak!	A speaker's bureau that seeks to inform and enlighten the community about issues concerning African American males with mental health and substance abuse challenges; provides positive role modeling, support to women, and skills to end the cycle of sexual violence and other traumas	**PEERS** Oakland , CA 94621 (510) 832-7337 Alameda County
	"Hip Hop Therapy"	Interactive program for at-risk youth embracing the Hip Hop genre as a positive means for therapy using self-style expressions for reflection on the Hip Hop lyrics as they relate to life experiences; creative expressions, increases self-esteem, and enhances cultural development	**T. Tomás Alvarez, MSW, ASW** Beat, Rhymes & Life (BRL) Founder & Executive Director Oakland & San Francisco (510) 452-9011 (415) 828-4694 tomas@beatsrhymesandlife.org Alameda County
	CASASTART[SM]	African American students (high risk elementary, middle and high school age) and their families, alcohol and other drug prevention	**Christine Bierdrager, PhD** Inland Behavioral &Health Services (909) 881-6146 www.ibhealth.org San Bernardino County

Table 54 A List of Identified Community Practices, Resources, and Examples

Community Practice	Example	Goal	Contact
	Knotts Family Resource Center & Knotts Family Parenting Institute	Playback: Digital Storytelling Effective Black Parenting Program	**Gwen Knotts, NP** Jean Kayano (909) 880-0600 jkayano@kfpinstitute.org www.knottsfamilyagency.org San Bernardino County
	***GENESIS* Program**	A program model that serves all ages across the lifespan and integrates spirituality, lay counseling, cultural ambassadors, and culturally congruent mental health therapy. The program is administered by the Cyrus Urban Interchurch Sustainability Network (CUISN) and is currently conducted at Oxnard Community College, Saint Bonaventure High School in Ventura, and the First Samoan Pentecostal Church of Oxnard. Volunteers participate from a variety of disciples including psychology, business and banking, religion, the Black American Political Association of California, Ventura County Behavioral Health & AOD, the African American Reading Room, and other community entities.	**Jim Gilmer, MA** Cyrus Urban Interchurch Sustainability Network (CUISN) P.O. Box 8122 Oxnard, CA 93030 (805) 228-2386 **gilmer@roadrunner.com** **jimgmcv45@gmail.com** Ventura County

Table 54 A List of Identified Community Practices, Resources, and Examples

Community Practice	Example	Goal	Contact
	The Gardens - Family Care Community Center, Inc.	Community-based program; (Not funded by DMH) Target African Americans TAY – "Project Cease Fire" addressing mental health issues in TAY 18 to 25 years old, such as PTSD, counseling, intake & referrals, skills building; goal is to intervene, prevent reoccurrences, and to get MH services needed	**Ron T. King** Business (916) 427-1593 Cell (916) 410-6888 thegardens@sbcglobal.net Sacramento County
	Guardian Knights Drum Corps	African American youth, 8 to 21 years old; increase self-esteem, mentoring, drug, alcohol & pregnancy prevention; address issues that lead to mental illness by using a family approach and connect to performance arts	**Ron Norman** (530) 752-9497 http://guardianknightsdrum.com Sacramento County
Places of Healing in the African American Community	**African American Family Culture Center**	To empower and embrace African American families and community by reclaiming, restoring, and revitalizing cultural heritage, values and identity; to bring about healing	**Youth For Change** (530) 877-1965 Butte County
	Neighborhood Health Check Stations ***"Houses of Compassion"***	Comprehensive family, community resources and wellness centers that provide wholistic (i.e., wrap-around) services to the African American community, that would include a broad base network of ***"Neighborhood Health Check Stations"*** for prevention and early identification of services	For Future Development

Table 54 A List of Identified Community Practices, Resources, and Examples

Community Practice	Example	Goal	Contact
	Community Healing Circles ***"Houses of Compassion"***	Using the ***"Community Healing Circles Model"*** developed by the National Community Healing Network and enhanced by the Association of Black Psychologists, healing circles can address racial stressors and internalized racism that can negatively impact health and mental health. The significance for the Black community is to increase psychological hardiness and sense of ethnic identity, strengthen community ties, increase sense of community, and address social problems through organized community networks of residents and clients.	**Cheryl T. Grills, Ph.D.** President, National Association of Black Psychologists African American CRDP SPW Advisor, Los Angeles (310) 748-9755 cgrills@lmu.edu
	Time For Change Foundation ***"Houses of Compassion"***	Help for homeless women and children achieve self-sufficiency by using a strength-based approach to address their needs. Programs and supportive services help to provide tools necessary to recover from the effects of homelessness, drug addiction, family separation, mental and physical abuse, and incarceration; on-site case management, emergency shelter, transitional housing, independent living skills, financial education & money management, family reunification, leadership development, and parenting education	**Kim Carter, Founder/CEO** P.O. Box 5753 San Bernardino, CA 92412 (909) 886-2994 www.TimeForChangeFoundation.org **San Bernardino County**

Table 54 A List of Identified Community Practices, Resources, and Examples

Community Practice	Example	Goal	Contact
Positive Imagery of Blacks/African Americans **"Value-based Initiatives" to promote societal paradigm shift from negative imagine to positive image of Black people**	**Skid Row Resident Positive Movement** **Statewide Positive Media Campaign**	Environmental change movement that engages Skid Row residents into self-help activities to create positive livable spaces; opportunities to return to be productive contributors to community, proactive involvement in community decisions-making; proactive mass media positive image making; social justice advocacy; movement for equality; integrated collaborative partnerships with the community; community capacity skills development toward self-sufficiency Work with California Black media to create statewide positive mass media efforts Work with celebrities and entertainment business Goal: to eliminate negative, inaccurate information about population	**General Jeff, Founder** ISSUES AND SOLUTIONS (323) 445-0723 issuesandsolutions@yahoo.com Los Angeles County **To Be Developed**
Community Mobilization Efforts that Reinforce Positive African American Cultural Values	**Skid Row Photography Club and Skid Row Films**	Recreational social activity focused on highlighting the beauty of Skid Row; provides cameras for club members & instruction on how to create media and digital story telling for positive self expressions of emotions and to facilitate inner healing; opportunity for self-supporting entrepreneurship and financial independence; provides outlet to give positive contribution to the healing of the Black community	**Michael Blaze** Skidrowfilms@yahoo.com Los Angeles County

Table 54 A List of Identified Community Practices, Resources, and Examples

Community Practice	Example	Goal	Contact
	3 on 3 Street Ball League (Gladys Park)	Social and recreational forum for all ages in Skid Row; games on Saturday; meetings on Wednesday; practices throughout the week; a forum for the Skid Row artists collective; all activities create healing spaces in the mind, allow for self-growth, positive development, self-discipline, positive relationship building skills; teambuilding skills to help rebuild the Black community and cultural values	**Manuel Compito** Ognservicela3@yahoo.com Los Angeles County
Culturally Appropriate Education	**Institute for the Advanced Study of Black Family Life and Culture**	Education, training and research; reunification of the Black family, reclamation of Black culture; revitalization of the Black community	**Wade Nobles, PhD** (510) 836-3245 www.iasbflc.org CRDP SPW Advisor Alameda County
	Araven Holistic Mind Institute	TAY - Target 13 years and older with mental illness and learning disabilities; education; mental health prevention; life management; promoting holistic lifestyle	**Dianne Ross, RN** (916)391-2464 www.ahmi4u.org Sacramento County
	SANKOFA	Using African and African American culture to increase student achievement & self esteem in Rio Vista Elementary School and Dr. M. L, King, Jr. Middle School; student mentoring and parenting program	**Tanya Fisher, MS** (909) 891-1009 Tanya.fisher@sbcusd.com San Bernardino County

Table 54 A List of Identified Community Practices, Resources, and Examples

Community Practice	Example	Goal	Contact
	Solomon Ujaama Center	Parenting Education F.R.E.E. (Family Resilience Education Empowerment) program, a parent education & bonding program; Motherread/Fatherread program; Center for the Improvement of Child Caring (CICC) program; Effective Parenting program; Nurturing Fathers program	**Pastor Owusu Hodari** sucinc@yahoo.com (909) 880-3200 San Bernardino County
	Harvest Park Educational Center - Principle Based Lifestyle Training	African American character development and confidence building program for children grades 1 -8;	**Gloria Morris** Valley Harvest Church (209) 723-4344 vhcofmerced@yahoo.com Merced County
	TSI-Total Self Insight, Inc	Anger/stress management; parenting and family conferencing; domestic violence treatment	**Valerie K. Anthony** (209) 384-7606 vanth357@aol.com Merced County
	Mental Health Education/System Navigation Support for African American Health Conductors	120 African American Families in Bay Point, Pittsburg; culturally appropriate education on mental health topics through "Soul to Soul," "Mind, Body, and Soul," "Body and Soul," support groups ; Youth-Senior Peer Outreach Project to decrease older adult feelings of isolation and increase self-efficacy	**Cynthia Garrett** Center for Human Development (925) 431-2321 cgarrett@hsd.cccounty.us Contra Costa County

Table 54 A List of Identified Community Practices, Resources, and Examples

Community Practice	Example	Goal	Contact
	Child Abuse Prevention Council of Contra Costa	Providing African American parents residing in Western Contra Costa County with evidence-based curriculum of culturally, linguistically, and developmentally appropriate parenting classes	**Carol Carrillo, MSW** (925) 798-0546 capccarol@sbcglobal.net Contra Costa County
	Continuum of Culturally Congruent Healthcare and Education Systems	To create a continuum that links Federally Qualified Health Centers (FGHC) community clinics and School Based Health Centers (SBHC) with integrated physical health, mental health, and substance abuse services at single site facilities. The continuum of systems establishes a point of healthcare entry for children, youth, and transition age youth actively enrolled in K-16 education institutions; is sustained by culturally congruent workforce education training to employment program; and provides part-time employment for transition age youth as peer mentors and wellness coordinators, and healthcare coordinators for the adult population. This PEI combines education and workforce development, eliminates stigma associated with mental health through the promotion of health and social emotional wellness in K-12, and creates an organic college to career pathway to eliminate poverty	**Bruce Wheatley** President/CEO Inner City Industry, Inc. 7100 S. Western Ave. Los Angeles, CA 90047 (323) 501-7553 **brucew@innercityindustry.org** Los Angeles County

Table 54 A List of Identified Community Practices, Resources, and Examples

Community Practice	Example	Goal	Contact
	Continuum of Culturally Congruent Healthcare and Education Systems	The Fresno Unified School District model is similar to the Inner City Industry model but incorporates asset mapping for potential employment, as well as integrating more public agencies to help create a multi-level integrated delivery system, such as mental and behavioral health, drug and alcohol, public health, social services, probations and education.	**Dr. Henry Hendrix** President, State Coalition of Black School Board Members and Board of Trustees Washington Unified School District (559) 647-3425 HanHark1@aol.com Cynthia Sterling Cass2011@ymail.com Fresno County
	Project Return	***Project Return Peer Support Network*** is a empowerment and integration network with involvement in self-help groups, "warm line," community integration program, "Bill's Corner", employment, advocacy, community involvement and training; peers run groups and consumers function well on their own; meetings are once a week; Los Angeles County specific program	**Keris Jan Myrick, Ph.D.** Executive Director 6055 E. Washington Blvd, #900 Commerce, CA 90040 (323) 346-0960 http://prpsn.org Los Angeles County
Community Resources	**United Coalition East Prevention Project**	Provide prevention programs; health promoting recreational and social activities; cultural study group, improve neighborhood; volunteer driven; host cultural celebrations; engage the most vulnerable populations of Central City East (skid row) to challenge systemic conditions and social disparities that threaten a healthy environment.	**Zelenne Cardenas** zcardenas@socialmodel.com 213.622.1621 Los Angeles County

Table 54 A List of Identified Community Practices, Resources, and Examples

Community Practice	Example	Goal	Contact
	Prevention and Early Intervention (PEI) Services (Los Angeles Downtown) New Services	PEI services are short-term therapy treatments to help someone experiencing mild or moderate symptoms of anxiety or depression, trauma, or recent difficulties or problems in their life which are not long-term or permanent in nature. A variety of therapy treatments are available under PEI, and staffs who provide these services receive special training. **Anyone can be referred to these services.**	**Marcie Gibbs, LCSW Supervisor** Los Angeles, CA 90013 (213) 430-6719
	Community Wellness Center (SHARE Downtown)	Host numerous support group meetings as part of their wellness center. Their goal is to empower people to change their own lives and provide them a loving, safe, non-judgmental place where they can find community, information and support.	**Jason Roberts** Jason@shareselfhelp.org 310.846.5270 Los Angeles County
	Weingart Center for Community Health	Medical facility providing integrated care through a variety of medical services (including substance abuse and mental health) under one roof	center@weingart.org (213) 627-9000 Los Angeles County
	Emanuel Baptist Rescue Mission	To meet spiritual as well as physical needs; increase self-esteem; meals, clothing, & free lodging for the men of Skid Row.	**Mike Davis** mikedavis@baptistrescue.org (213) 626-4681 Los Angeles County
	Avalon Carver Community Center	Cares for the physical, mental and spiritual needs of individuals and families in South Central Los Angeles whose lives have been severely disrupted by the use of alcohol and	**Darnell Bell** kofi@sbcglobal.net (323) 232-4391

Table 54 A List of Identified Community Practices, Resources, and Examples

Community Practice	Example	Goal	Contact
		other addictive substances; behavior change to productive/satisfying roles within the community; full range of direct and supportive services that holistically address the needs of clients, their families and the community	Los Angeles County
	Central City Community Church of the Nazarene	Neighborhood church in Skid Row that hosts numerous social activities; decrease isolation; inspire hope	**Rev. Dr. Jeffery Thomas** annoited2000@yahoo.com Los Angeles County
	Downtown Women's Center	medical and mental health centers for women on Skid Row; provide permanent supportive housing and a safe and healthy community; foster dignity, respect, and personal stability; advocate ending homelessness for women	**Lisa Watson, CEO** (213) 680-0600 Los Angeles County
	Los Angeles Community Action Network	Advocacy, civil rights, neighborhood empowerment	**Pete White** or **Becky Dennison** Beckyd@cangress.org (213) 228-0024 Los Angeles County
	Frank Rice Safe Haven LAMP Art Project	Skid Row LAMP Community; mental illness; recreational options; housing	**Shannon Murray,** Deputy Director shannonm@lampcommunity.org (213) 488-9559 x 140 Los Angeles County

Table 54 A List of Identified Community Practices, Resources, and Examples

Community Practice	Example	Goal	Contact
	Volunteers of America Drop-In-Center	Supportive services and social activities, housing, host annual Black History Month celebrations	**Jim Howat CEO** jchowat@voala.org (213) 305-9658 Los Angeles County
	Movies on the Nickel (James Wood Community Center)	Free social entertainment forum on the weekends	**Wendell Blasingham** Wendellbx1@netzero.com Los Angeles County
	Hospitality Kitchen of The Catholic Workers (Hippie Kitchen)	Free meals and supportive services for the homeless, garden courtyard social area	**Jeff or Catherine** House: (323) 267-8789 Kitchen: (213) 614-9615 Los Angeles County
	Set Free Ministries	Services inside and outside of Skid Row for those most in need	**Pastor Ron** (213) 909-1915 Los Angeles County
	Los Angeles Public Library Central Library	Provides safe social, educational, & recreational space for many Skid Row members	(213) 228-7000 Los Angeles County

Table 54 A List of Identified Community Practices, Resources, and Examples

Community Practice	Example	Goal	Contact
	Los Angeles Public Library Little Tokyo Branch	Provides safe social, educational, & recreational space for many Skid Row members	(213) 612-0525 Los Angeles County
	The Mental Health Hookup	Multiple services to provide assistance with mental health problems, assessment, assist with finding and coordinating community and educational resources, early intervention, phone and in-person professional assistance	**Barbara B. Wilson, MSW, LCSW** Newhall, CA (877) 572-0955 www.mentalhealthhookupcom Available 24-Hours Daily Los Angeles County
	School on Wheels	Provide educational (tutoring, school supplies, uniforms) and social support for homeless and low income youth & children in Skid Row	**Matt Raab** Mraab@shcoolonwheels.org (213) 896-9200 Los Angeles County
	Say Yes **(Central City Community Outreach)**	Youth program, after school care, meals; neighborhood school created to meet needs of homeless and very low income children	**Sophia** Sophia@lacentralcity.org (213) 689-1766 Los Angeles County
	TAY Resource Center	Provides mental health consultation to TAY at an existing youth center	**Youth Uprising** Oakland, CA 94605 (510) 777-9909 www.youthuprising.org Alameda County

Table 54 A List of Identified Community Practices, Resources, and Examples

Community Practice	Example	Goal	Contact
	North County Senior Homeless Program	Multidisciplinary team engages homeless seniors and provides housing with community supports. Provides linkage for family members and offers peer support	**Bay Area Community Services** Oakland, CA 94612 (510) 271-8844 www.bayareacs.org Alameda County
	Life Link Resource Directory	Developed by, **Dr. Karen Gunn** for the County of Los Angeles Department of Mental Health to provide the African, Caribbean & African American communities with information for over 330 resources in 16 categories: - Mental Health - Health Services - Wellness Centers - HIV/AIDS Testing Programs - Mutual Aid/Diplomatic Services - Domestic Violence - Developmental Disabilities - Addiction/Substance Abuse - Employment - Housing - Faith-Based Organizations - Family Services - Children & Youth Assistance - Senior Services - Veterans Services	**County of Los Angeles Department of Mental Health Program Support Bureau, Planning Division** **(213) 251-6801**

Table 54 A List of Identified Community Practices, Resources, and Examples

Community Practice	Example	Goal	Contact
	Marin City Health & Wellness Center	State of the art culturally sensitive health center in Marin City; provides medical dental, mental health and case-management; offers prevention strategies that reduce the presence and severity of disease while encouraging lifestyle choices that promote health and wellness such as individual and family counseling, child and adolescent counseling, stress and anger management, parenting skills training, and many prevention services	**Terrie Green** **(415) 336-6421** **Terriegreen1@comcast.net** Marin City Health & Wellness Center 630 Drake Avenue Marin City, CA 94965 (415) 339-8813
	Daily Mood **"Self-help tool to track mental health progress toward healthy lifestyle and independence"**	**Daily Mood** is an interactive mental health assessment tool that helps you develop insight into the relationship between your mental health treatment, medications, medical conditions and your overall quality of life. Chose the care providers to receive progress reports that include quick glance graphs and summary tables; developed by Dr. Richard T. Kotomori, who has worked in private practice outpatient settings, inpatient settings and public mental health settings since 1994.	**Richard T. Kotomori, Jr., MD** Child & Adolescent Psychiatry Board Certified Psychiatrist Quality of Life, Inc. 6529 Riverside Ave., #133 Riverside, CA 92506 (951) 684-1944 http://QualityLifeGroup.com/ **African American CRDP/SPW**

Table 54 A List of Identified Community Practices, Resources, and Examples

Community Practice	Example	Goal	Contact
	Inland Empire Veterans Stand Down	To rebuild, restore and reunite homeless veterans back safely with their families and communities through restorative resources and services for mental health, medical, re-entry skills training, re-entry into society and community life, supportive shelter and housing; other information, referrals and resources based on individual needs	**Kismet Evans, Co-Founder** **Leroy Huff, Co-Founder** Inland Empire Veterans Stand Down P.O. Box 338 Riverside, CA 92506 (951) 531-7113 www.ievsd.org
Access to Professionally Trained African American Mental Health Providers	**African American Mental Health Providers Directory for California Residents**	A statewide listing of licensed clinical mental health professionals; African American professional resources to provide culturally appropriate services within the established system and consultations To ensure that a diverse African American professional service providers are utilized by county department of mental health to provide culturally matched & culturally congruent services	**Resource created by African American CRDP/SPW**

Table 54 A List of Identified Community Practices, Resources, and Examples

Community Practice	Example	Goal	Contact
Information and Broad Based Training on Effective Practices for Addressing Mental Issues in the African American Population	Association of Black Psychologists, California Affiliates Association of Black Social Workers, California Affiliates	To make accessible efficacious research, tools and resources to those providing services to African Americans, and should also permeate strategic Black social networks	**Cheryl T. Grills, Ph.D.** President, National Association of Black Psychologists 7119 Allentown Road, Suite 203 Ft. Washington, MD 20744 (202) 722-0808 www.abpsi.org **CRDP Consultant** ##### **Joe E. Benton, Jr., M.S.W.** President National Association of Black Social Workers 2305 Martin Luther King, Ave SE Washington, DC 20020 (202) 678-4570 www.nabsw.org Harambee@nabsw.org
Culturally Congruent Statewide Education Campaign for the Black Community on Prevention and Mental Health		To ensure that Black people throughout the State of California receive standardized culturally grounded services irrespective of county of residence	**To be funded and developed**

Table 54 A List of Identified Community Practices, Resources, and Examples

Community Practice	Example	Goal	Contact
Statewide Support Systems for Black Mental Health		To ensure accountability for Black people throughout the State of California for receiving standardized culturally grounded services irrespective of county of residence	**To be funded and developed**
Connect Africans, Caribbean & American Blacks		To facilitate unity and coalition building healing to promote culturally congruent healing practices and modalities	**To be funded and developed**
	Mental Health America of San Diego County: Breaking Down Barriers Program	Provides Mental Health Education through outreach services, community education, and certified Mental Health First Aid Instruction. Services are designed to reduce barriers and disparities which impede African-Americans from accessing and benefiting from culturally appropriate mental health services.	**Tondra Lolin, B.A.** **(619) 543-0412, ext 106** **tlolin@mhasd.org** Outreach Services Coordinator African-American Communities San Diego County

Table 54 A List of Identified Community Practices, Resources, and Examples

Community Practice	Example	Goal	Contact
	National Alliance of Mental health (NAMI) San Diego	Comprehensive grass roots mental health education, advocacy support, peer recovery services, support groups, and mental health diagnosis education. Promotes learning in multicultural advocacy, cultural competence, and multicultural outreach mental health education. Develops education materials designed to increases connection with the African-American population.	**Anita Fisher** **Education Director** (619)-398-9851 anitafisher@namisd.org San Diego County
	Neighborhood House Project Enable: A Mental Health Program	Outpatient specialty mental health services to adults 18 years of age and older affected by serious and persistent mental illness and/or co-occurring disorders. Provides cultural specific outreach services to African-Americans.	**Sheila Willis** **Rehabilitation Specialist** (619) 266-2111, ext. 113 San Diego County
	Pazzaz, Inc. Educational Enrichment Center	Customized academic and enrichment programs designed to promote self determination and personal development. Accompanies parents to school meetings for support, and advocates for parents to access educational rights and social enrichment services for their children. Parent support groups and teen character building.	**Zoneice Jones** **Co-Founder/President** (619) 264-6870 zoe@pazzaz.org San Diego County

Table 54 A List of Identified Community Practices, Resources, and Examples

Community Practice	Example	Goal	Contact
	Project New Village **People's Produce Market** **Community Gardens Projects**	Supports the Health & Well-being of the African-American community. Advocates for healthy food choices, community gardens development, and farmers markets. A central goal includes encouraging health food choices which contribute to reducing incidents of chronic health conditions known to affect African-Americans.	**Diane Moss, B.A. Founder/Director** Phone: (619) 262-2022 Email: d.moss28@yahoo.com San Diego County
	Project Ujima **Harold J. Ballard Parent Education Center**	Offers a series of free evening classes for parents and guardians of African-American students. Topics include strategies to address disparities in education, social, legal, mental health, and advocacy services which impact African-American children and families. The entire community is welcome to participate.	**Elneda Shannon** **Program Manager** (619) 293-4431 eshannon@sandi.net San Diego County
	UPAC **Elder Multicultural Access and Support Services (EMASS)**	Provides outreach, education, advocacy, peer mentoring support and transportation services for adults and elderly population with mental health illness. Inclusive of EMASS is designated staff committed to outreaching and serving the African-American population. Family friendly services are provided.	**Stephanie D. Wilson** (619) 208-3016 San Diego County

Table 54 A List of Identified Community Practices, Resources, and Examples

Community Practice	Example	Goal	Contact
Culturally Appropriate Community-based Research	**African American Health Institute in San Bernardino County (AAHI-SBC)**	Provide culturally grounded and congruent community-based research, educational and outreach engagement materials and tools, community collaboration and policy advocacy	**V. Diane Woods, Dr.P.H., M.S.N.** Founding President & CEO P.O. Box 12083 San Bernardino, CA 92423 www.AAHI-SBC.org (909) 880-2600 **San Bernardino County**

MENTAL HEALTH SYSTEM CHANGE RECOMMENDATION

A final recommendation is for the new re-designed Behavioral Health System for California. SPW members believe there is a critical need for a new system that is community driven and a strong accountability system that ensures all fiscal and human resources are maximizing the return on investment (ROI). Specific suggestions for health system changes were identified by respondents in this study as:

- Need culturally designed health facilities in the community
- Need for culturally proficient providers
- More caring and culturally sensitive people to work with the population
- Better community-friendly payment system
- Culturally engaging and designed education, awareness, and information
- People in the community to spend time with residents to address mental issues
- Mental health prevention advertisement
- Better care for the poor and general population
- Immediate access to prevention services in the community, not the clinic
- A "dedicated" branch of state government just for community prevention services

We are recommending a process systems model (see *Figure 50*), for health system change. This is an open system that allows input from the public regarding their interest and needs. It is also a schematic design operationalized to find solutions. We have operationalized our model (see *Table 55*), and graphically portrayed where data fits with sequences and patterns of interactions. This model provides a guideline to improve the healthcare delivery system. Our model can be adjusted to any population of people. This social environmental model requires inputs from all those affected by the problems.

Inputs: Includes all available data from the targeted people, community organizations, state and national organizations about the problem(s).

Conversion: Information in Phase I will impact the process to bring about change. This includes the task, people, structure to be effected, and available technology to bring change and to be utilized in the changed system. Phase II is the implementation process which depends on the health systems under change. The mode of implementation is determined by how fiscal resources are received into the system. There is always overlapping of financial systems, so more than one of the modes of implementation may be chosen at given points in the process.

Outcome: Results are determined by targeted outputs, impact of output on the system, and the effectiveness of the desired outcome. These activities are measured by short term (1-2years), intermediate (3-5 years), or long term (6-10 years) outcomes. Specific goals should focus primarily on the client, and secondarily on the organization.

Feedback: The expected progress is evaluated continually by specific evaluation criteria and established standards according to the prevailing science. The evaluation data becomes input for adjusting the process and defining directions to accomplish the expected goals.

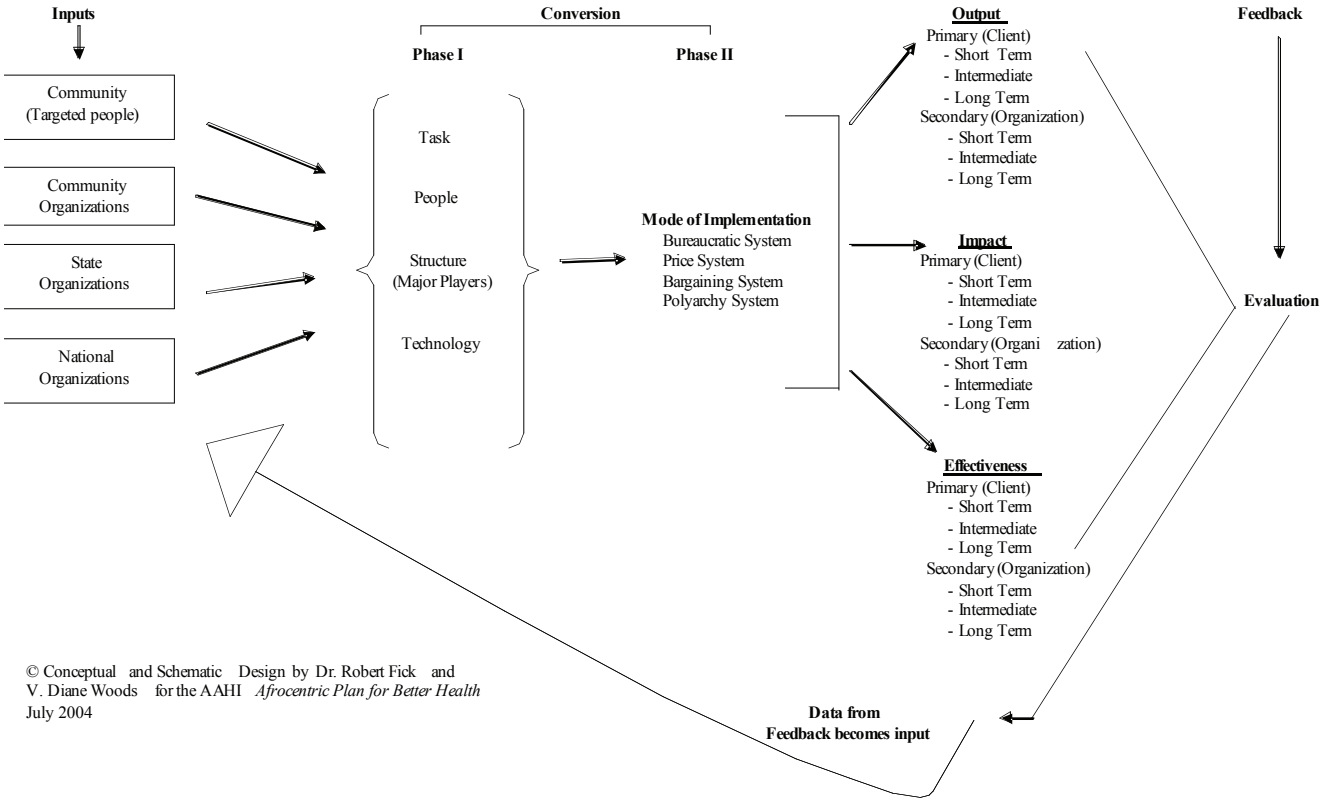


Figure 50: *A Health System Structural Change Model*

Table 55: *Operationalized Health System Structural Change Model*

Inputs	Conversion		Outputs/ Impact/Effectiveness	Evaluation
	Phase I	**Phase II**		
Community Level Organizations 1. Health Dept. 2. Physicians -Individual -Group 3. Professional -ACS -AHA -ALA -HIV/AIDS -All Black Orgs. 4. CBOs 5. Hospitals -Public -Private -Clinics 6. Others	**Task** Primary: Goals of Clients Secondary: Organizational Goals **People** - Targeted Clients - Public Health Policy Makers - Medical Staff - AAHI Staff - Health Professional **Structure – Major Players** - Public Health - HMOs - CBOs - Hospitals - AAHI **Technology** -Communication mechanism - Levels of technology education - Technology equipment	**Modes of Implementation** [Choose one] Bureaucracy [Traditional System] Price System [Contract] Bargaining [Negotiation] Polyarchy [Collaboration with accountability]	**Measurable goals and objectives** - Primary goals are client centered - Secondary goals are organizational - Short term goals = 1 - 2 years - Intermediate goals = 3 – 5 years - Long term goals = 6 – 10 years	Evaluation criteria Tracking/ monitoring systems Epidemiological data Patient satisfaction data Community health status indicators Social health status indicators Organizational performance standards National standards of care
Entropic Functions	**Entropic Functions**	**Entropic Functions**	**Entropic Functions**	**Entropic Functions**
Fall out	**Fall out**	**Fall out**	**Fall out**	**Fall out**

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STRATEGIC ACTIONS NEXT STEPS

We realize Black people had a lot to say, and the CRDP provided the opportunity for expression. Outlining policy prescriptions alone is not sufficient for the pressing task of preserving and restoring health to the Black population and to their communities. A collective approach requires a catalyst to shift the policy debate. There must be due diligence to implement policies effectively and equitably.

The California mental and behavioral system must adapt a human rights approach to health. There must be respect for shared rights and responsibilities to truly transform the mental health system in the State of California. There must be honest and careful efforts to remove stereotypical and dehumanizing views regarding the Black population, as well as unhealthy silo-based approaches.

To bring wholistic healing to the Black population and to accomplish the recommendations in the *CRDP African American Population Report*, the next community-based strategic action steps include:

1. Mobilizing for action through planning and partnership
2. Building strategic statewide alliances with Black organizations and faith-based entities to create an infrastructure to address all recommendations using "out of the box" strategies that are culturally grounded in the unique Black experience
3. Convening a statewide integration meeting to implement integration of services across parties of interest including Black "end users", community organizations, professional disciplines, and state and county agencies
4. Creating a statewide African American/Black Mental Health Commission
5. A call to action and accountability for the State of California to demonstrate equity across ethnic and cultural groups

The **CRDP African American Population Report** is not the end. It is not a "magic" bullet. This CRDP has been true to engaging the Black population in identifying what is meaningful to them. Program and practice examples in this report are not perfect. Some programs examples are more culturally appropriate than others. All programs, practices, and services offered to Black people need to be immediately vetted against community identified and agreed upon standards of practice that are helpful to those served. This report represents the collective wisdom of California's Black population and serves as a starting point to move forward toward true healing of our people by using practices valued by the people and for the people.

We give special honor and praise to staff in the California Department of Mental Health (DMH) Office of Multicultural Services (OMS) for their vision, wisdom, determination, endurance and tenacity in the creation of the CRDP and overseeing its implementation, development and completion. You have demonstrated true commitment to ethnic and cultural diverse communities.

Thank you DMH Office of Multicultural Services staff!:
Rachel Guerrero
Autumn Valerio
Marina Augusto
Kimberly Knifong
Claire Sallee
Shayn Anderson

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UC RIVERSIDE UNIVERSITY OF CALIFORNIA

Banche Project

Demographic Profile of People of African Ancestry Living in CA

AAHI

By completing this survey you are giving your consent to willingly participate in this project. This project is a simple data collection effort to identify what people of African ancestry live in California, and in what county. The information will be used to develop target specific programs to increase access to care for people of African ancestry. This project is directed by ***Dr. V. Diane Woods, President & CEO*** of the African American Health Institute of San Bernardino County. You may contact her at www.CorporateOffice@AAHI-SBC.org or call (909) 880-2600 for additional information.

1. What country where you born in? _____
2. Where is your permanent resident city? _____ Resident Zip code? _____
3. What is your gender? ☐ Female ☐ Male
4. What is your age in years? _____
5. Are you a current student? ☐ Yes ☐ No
6. What is the highest level of education you have received?
   - ☐ Less the high school
   - ☐ High school (GED)
   - ☐ Some college
   - ☐ 2 year collage associate degree
   - ☐ 4 year collage bachelors degree
   - ☐ Masters degree
   - ☐ Doctoral degree
   - ☐ Professional degree (MD, JD)
7. What type of job do you have? _____
8. What African country's culture do you identify with? (check no more then two)

☐ Algeria	☐ Gambia	☐ Nigeria
☐ Angola	☐ Ghana	☐ Reunion
☐ Benin	☐ Guinea Bissau	☐ Rwanda
☐ Botswana	☐ Guinea	☐ São Tomé and Principe
☐ Burkina Faso	☐ Ivory Coast	☐ Senegal
☐ Burundi	☐ Kenya	☐ Seychelles
☐ Cameroon	☐ Lesotho	☐ Sierra Leone
☐ Cape Verde	☐ Liberia	☐ Somalia
☐ Central African Republic	☐ Libya	☐ South Africa
☐ Chad	☐ Madagascar	☐ Sudan
☐ Congo	☐ Malawi	☐ Swaziland
☐ Dem. Rep. Congo (Zaire)	☐ Mali	☐ Tanzania
☐ Djibouti	☐ Mauritania	☐ Togo
☐ Egypt	☐ Mauritius	☐ Tunisia
☐ Equatorial Guinea	☐ Morocco	☐ Uganda
☐ Eritrea	☐ Mozambique	☐ Zambia
☐ Ethiopia	☐ Namibia	☐ Zanzibar
☐ Gabon	☐ Niger	☐ Zimbabwe

9. Do you know of other people of African ancestry that live where you go to school or your permanent resident city, if so, what city? _____and which African country are they from? _____

Thank You

Banchamlak Shita

Abysinian Student Union

Revised April 21, **2010**

APPENDIX A: BANCHE PROJECT SURVEY

California Department of Mental Health (DMH)
Reducing Disparities in Populations (CRDP) Project
African American Strategic Planning Workgroup (SPW) Survey

The African American Strategic Planning Workgroup of the California DMH CRDP Project is currently working to identify all of the practices that African American and other people of African descent have used to yield positive behavioral health, wellness, or resiliency outcomes over time. The information collected will become an inventory of diverse practices. The SPW goal is to promote effective mental health approaches and solutions (both traditional and non-traditional) serving African Americans and other **p**eople of African descent.

We invite you to participate in this short survey by **identifying organizations and people you believe use cultural specific practices** targeting African Americans and other people of African descent in the State of California. **Please complete** this brief survey by March 30, 2011, and return to Jim Gilmer, AAHI-CRDP/SPW, *Greater Los Angeles Regional Consultant*. You may **Email to** gilmerj@roadrunner.com or, Fax to (805) 382-2618 or mail to P.O. Box 8122, Oxnard, CA 93031-8122.

TYPE or PRINT:

1. Please provide a name and key contact person for the program or organization (include telephone and email) : _____

2. When was this program/organization established? _____

3. What is the target population(s) served by this project? (i.e. African American, African Immigrant, Black Latino, Black Filipino, etc..), list all groups if more than one
   _____

4. Please estimate the percentage served of each target group identified above.
   _____

5. Please describe cultural-specific mental health services provided (prevention, early intervention or treatment).
   _____
   _____

6. Do the cultural specific services identified target specific groups? Check all that apply:
   ___ Under 12 years ___12-15 Years ____ 16-19 TAY ___Families
   ___ Adults (20-69 years) ___ Elders (above 70 years) ____ LGBTQI ___Across Lifespan/All the above

7. Have the cultural specific services been evaluated? ____ Yes ___ No

Your name and title: _____

Telephone_____Email_____

Thank you for your time!

For questions about this survey please call Jim at (805) 754-2933.

APPENDIX B: EMERGENT PROMISING PRACTICES SURVEY

DMH CRDP Project: African American Workgroup

African American Health Institute of San Bernardino County
P.O. Box 12083
San Bernardino, CA 92423
(909) 880-2600

Focus Group Participant Survey

Date: _____

Age in years: _____

Gender: _____

Location of Focus Group: _____

1. Have you sought mental health services in the last 2 years?	**Yes**	**No**
2. What is your preferred ethnicity of a mental health provider?		
3. Are African Americans more prone to mental health issues/problems than others?	**Yes**	**No**
4. Who is most likely to have mental health problems?	**Males**	**Females**
5. When you have mental health troubles who do you want to go to?		
6. Where do your people come from?		

V. Diane Woods, August 2010

APPENDIX C: FOCUS GROUP PARTICIPANT SURVEY

Reducing Mental Health Disparities

Focus Group Guide
Conceptual Development

Conceptual Framework

Social-Ecological Model

The influence of social factors on mental health has been well documented. Historical social policies including racism, subjugation and marginalization of Africans in America and the resultant inequities in housing, education, and income support are not easily disentangled from the policy challenge represented in disparities in mental health access, treatment and outcome.

The Social-Ecological Model social considers the complex interactions (mesosystems) between macro and micro-level factors: individual, family, community, and societal factors. Conceptually, the model will allow us to consider the interplay between factors and to critically address the potential for additive and multiplicative interactions among contributing factors in elucidating mediators of mental health disparities among Africans in America.

General Research Questions

Mental Health Policy
1. What defines the elements of the U.S. mental health policy that has resulted in the observed mental health disparities among Africans in America?
2. What changes in the U.S. mental health policy are required to begin to decrease disparities in mental health outcome and improve effectiveness of mental health services to Africans in America?

Mental Health Treatment
1. How do Africans in America characterize "good" mental health? What attributes of "being" defines good mental health?
2. What characteristics of the treatment system, including provider and system characteristics are effective among African people in America?

Focus Group Philosophical Framework

Epistemology – Way of Knowing – Method of Obtaining Knowledge

- Distinguishing belief from opinion
- Elucidation of ideas, concepts and theoretical constructs from lived experiences of Africans in America

Ontology – Dealing with the specification of the characterization of the "nature of being"

- Feelings regarding process of care
- Perceptions regarding the responsiveness of the care

Axiology – Nature of values, judgment, worthiness

- Characteristics of the care that "define" its orientation
- What concessions are made to receive or benefit from the care
- Evidence of practice that makes it "Africentric, Eurocentric, Culturally consistent"

Methods

1. Focus Groups
2. In-depth Interviews of selected participants to follow focus groups

A. Focus Group Methodology

Question Asking – Opened Ended – Naturalistic Setting, allowing for responses that may include:

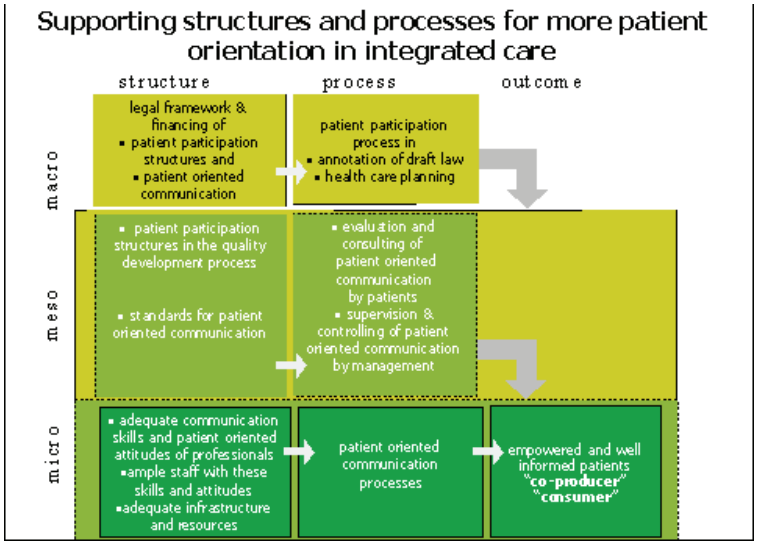
- Storytelling
- Case histories
- Symbolism
- Relational Issues (being, belonging, becoming)

Question: Will explore the:

Potential for Exosystems
(Additive and Multiplicative Models and Effects)

MetaSystems
(Indirect impact of events or factors on individuals and family members, from the direct impact on others in the family)

Macrosystems – Mesosystems – Microsystems
Evaluation of proximal and distal factors. Emotional and behavioral needs include families, cultural norms and values, and service sectors such as schools, health centers, specialty mental health systems, justice systems, protection services, and substance use treatment systems.



Christa Peinhaupt, Mag., et al

Theoretical Constructs and Theory
Daramöla A.T.N. Cabral, DrPH

What influences Structure, Process and Outcome

Historical/Social and Public Policy
Community (Culture and Values)
Social Institutions (Culture and Values)
Interpersonal/Family/Social Networks
Individual Self-Efficacy and Resiliency
(Skills, Abilities, Cultural Realignment)

Questions to be developed for each of the Sub-Domains to examine factors that influence and mediate Mental Health Policy and/or Treatment Access and Outcome.

- Development of additional domains, as needed based on our theoretical model.
- Our task is to develop questions below domains.

B. Mediators of Access and Utilization of Mental Health Services

Three Domains – Perceptions; Treatment Delivery; Policy

Perceptions of disease and Needs

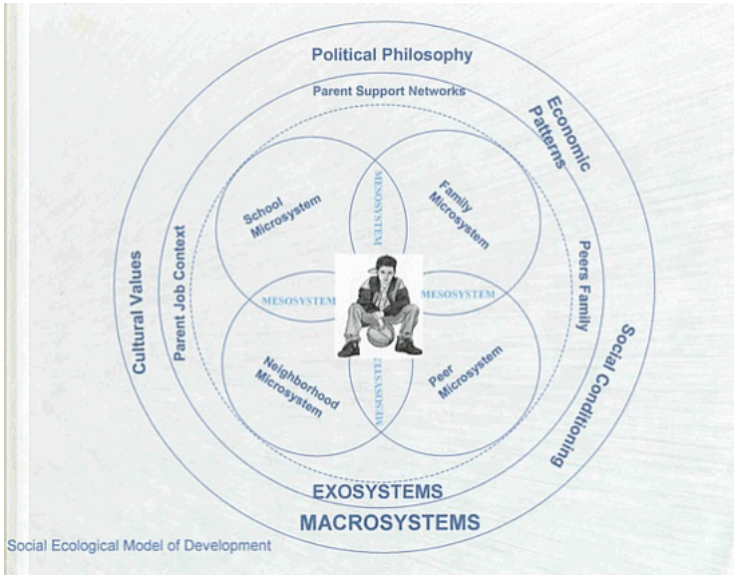
- Functioning
- Culturally-specific definitions of disease
- Social Support

Mental Health Treatment Delivery

- Quality of Care from the Clients Perspective
- Improving Treatment Outcomes
- Culturally Concordant and Successful Treatment Models
- Mental Health risk factors unique to Africans in America

Mental Health Policy

- Mental Health Provider Factors
- Cultural Competency & Quality of Care



http://www.aspe.hhs.gov/HSP/connections-charts04/figa.gif

AAHI

REDUCING DISPARITIES IN MENTAL HEALTH

FOCUS GROUP GUIDE

OPENING
WE ARE COLLECTIVELY IDENTIFYING AND DEFINING WHAT SERVICES BEST MEET THE NEEDS OF AFRICAN PEOPLE. YOUR COMMENTS WILL HELP US TO BETTER IDENTIFY AND UNDERSTAND THE MENTAL HEALTH NEEDS OF AFRICAN AMERICANS

SECTION 1

PROXIMAL FACTORS

"Going off – Crazy – Functioning"
Characterization of good mental health (GMH) compared to mental health disease (MHD)

RQ What attributes of "being" - what defines good mental health (GMH)?

Focus Group Questions

1. What does it mean to be able to function in life?

- Functioning
- What is it to be well?

2. What do you call it "___MHD____" when a person can not function in various areas of their life?

- Culturally-specific definitions of disease
- Social Support

3. What do you think causes "_____MHD_____" to happen?

- Individual factors
- Family factors
- Historical / Societal factors

4. When "_____MHD_____" happens, what matters the most?

- To "you" the individual
- To the "Communal" you
- To the "you" in the Community / social network / peer group

5. Who is the source of support for (you, your clients, your friends, etc) when "_____MHD_____" happens?

- Mental health risk mediators
- Social support / family systems

SECTION 2

PROXIMAL – MEDIAL FACTORS

RQ What characteristics of the treatment/delivery system, including provider characteristics have helped when "_____MHD_____" occurs?

Focus Group Questions

1. When "_____MHD_____" happens, what has helped or made a difference, even if for a little while?

- Individual level – Self-efficacy/resiliency
- Family level – Culture/Values
- Community level – Social Institutions
- Societal – Service Provider(s)

2. In your experience, either for yourself or someone else - what has not helped or made matters worse?

- Process of care – registration, fees, insurance, hours of operation
- Mental Health Service Provider factors
- Perceptions of disease – Individual level
- Stigma associated with diagnosis – Cultural Norms/Societal

3. In what ways do any services you have received meet your (or your clients) needs?

- Quality of Care from the Clients Perspective
- Improving Treatment Outcomes
- Culturally Concordant and Successful Treatment Models
- Mental Health risk factors unique to Africans in America

SECTION 3

PROXIMAL – MEDIAL – DISTAL FACTORS

RQs **What changes in the U.S. mental health policy are required to begin to decrease disparities in mental health risk and outcome. What is needed to improve effectiveness of mental health services to Africans in America?**

Focus Group Questions

1. In what ways do the services you receive (or provide) not meet your needs (or the needs of your clients)?

- Mental Health Provider Factors
- Cultural Competency & Quality of Care

2. What changes would you recommend to improve the care you receive (or care/services) you provide?

- Mental Health Provider Factors
- Cultural Competency & Quality of Care

3. What would help the most?

- Quality of Care from the Clients Perspective
- Improving Treatment Outcomes
- Culturally Concordant and Successful Treatment Models
- Mental Health risk factors unique to Africans in America

STATEMENT TO GIVE THANKS FOR PARTICIPATION

DMH CRDP for African Americans: Focus Group Probing Questions

Major Question: What do people of African ancestry need to get help for mental health.

The following questions were generated from discussions by:
Dr. Erylene Piper-Mandy, Dr. Carolyn Murray, and Dr. V. Diane Woods, on August 11, 2010.

How do you define your community?

What is mental health?

What is mental illness?

How do you know when someone has mental problems?

What is the community's response to a person with mental problems?

What are most important mental health issues?

What are some of the other issues specific to this area?

What happens within the family when a member has a serious mental health need?

What about the role of prevention?

Do most people in the community prefer health providers of their same ethnicity?

What services do mental providers provide?

Do community mental providers deliver appropriate services?

Do community mental providers deliver effective services?

In what ways do the services provided not meet the need of the community, family, and individuals?

What do you see as biggest mental health issues?

What do you see as biggest mental health diseases?

Are there specific racial/ethnic issues specific to (a) mental health? (b) how to seek health?, (c) services provided?

Given the context, what interventions are most likely to be effective in reducing health disparities?

What are the most appropriate available resources, information, etc?

Who are the most appropriate to deliver services within our community?

Self-medication…?

Where do patients come from and why?

V. Diane Woods, August 11, 2010

APPENDIX D: FOCUS GROUP GUIDE

Consumer, Client, Client Family Member Survey

DMH California Reducing Disparities Project (CRDP) African American SPW

County: _____ **Resident City:** _____ **Date:** _____

Ethnicity: _____

Circle ALL Credentials that apply:

ASW	AA
LCSW	BA
MSW	BS
IMF	MA
MFT	MS
DMFT	MPH
LEP	DrPH
LCPsy	RN
PsyD	MH CNP
PhD	Psy Tech
MD	EdD
Other:	

By completing this survey, I give my verbal consent to participate.

I understand the information recorded on this survey will be used to complete the Department of Mental Health (DMH) California Reducing Disparities Project (CRDP) African American Strategic Planning Workgroup (SPW) Population Report, contract #09-79055-006, as administered by the African American Health Institute of San Bernardino County (AAHI-SBC).

Dr. V. Diane Woods, Project Director
Office: (909) 880-2600

DEMOGRAPHICS		
Age:		
Gender:	Female	Male
LGBTQI:		
Marital Status:		
Married		
Single		
Specify Other:		
Insurance:	Yes	No
Mental Health Affiliation:		
Client (list diagnosis):		
Client Family Member (list family and diagnosis):		
Consumer (specify):		
Other (list):		

INFORMATION	SUMMARY RESPONSES
Identify at least 3 major mental health problems for Blacks	1. 2. 3.
List 3 solutions to major mental health problems for Blacks	1. 2. 3.
List critical community practices for mental health prevention and early intervention (PEI) for Blacks	

2nd Administration/vdw/August 2011

CRDP Report - *African American*

State of California Department of Mental Health

Statewide Strategic Planning Workgroup Member Assessment Tool-PC1b

Proposed Workgroup Member's Name: _____

Recommended by: _____

Goal of the Statewide Workgroup:

To write a California Reducing Disparities Population (CRDP) Report for African Americans living in California to address mental health issues according to an African-centered framework

Screening Survey

Characteristics Needed	Selection Criteria	Specify
Broad representation of the people of African ancestry population (self identified)	African American Continental African Afro-Caribbean Afro-Latino African Mixed	
Diverse adult age range	Age (in years)	
Gender representation (self identified)	Male Female LGBTQ	
Diverse faith-base	Self-identified	
Diverse social status	Persons with disabilities No/low income Laborer Technician Professional (degree/certificate/licensure)	
Diverse geographical region (identify county)	Northern CA Southern CA Central CA LA County San Bernardino/Riverside Counties	
***Demonstrated knowledge of mental & behavioral health within the population**	Lived experiences Work related experiences Professional/expert	
Ability to work within a group process	Previous experience	
Speak/write in English	Must affirm	
Function within a strategic timeline and produce deliverables	Must affirm - previous examples	
Make a 12 month commitment	Must verbalize - affirm	
***Demonstrated African-centered skills**	Academic/Publications Research Provider	

*Must complete the Knowledge & Skills Assessment Questionnaire

African American Health Institute (AAHI) of San Bernardino County under California DMH Contract #09-79055-006

|April 19, 2010

Survey Completed by: _____Date: _____

AAHI-SBC Staff: _____ Date: _____

APPENDIX F: SPW PRE-SELECTION SCREENING TOOL A

CRDP Report - *African American*

State of California Department of Mental Health
Statewide Strategic Planning Workgroup Member Assessment Tool-PC1b

Proposed Workgroup Member's Name: _____ **Recommended by:** _____

Knowledge & Skills Assessment Questionnaire

Please identify level of knowledge and provide supporting documentation. Place a check in all columns that apply.

Mental & Behavioral Health Knowledge	Risk Factors	Protective Factors	Prevention	Primary Care	Substance Abuse	Maternal Health	Pediatric & Adolescent	Older Adult Health	Forensic System	Provide Examples	Submit Resume or CV
Lived Experiences											
Work Experiences											
Professional Expert											

African-Centered Skills	Programs	Interventions	CBO	Training	Materials	LGBTQ Approaches	Outreach & Engagement			Provide Examples	Submit Resume or CV
Research											
Academic/Publications											
Provider											

African American Health Institute (AAHI) of San Bernardino County under California DMH Contract #09-79055-006
| April 19, 2010

APPENDIX G: SPW PRE-SELECTION SCREENING TOOL B

CRDP Report - *African American*
State of California Department of Mental Health
Statewide Strategic Planning Workgroup Member Assessment Tool-PC1b

Selection Matrix by Region and Category of Workgroup Membership

	Consumers & Other Community Stakeholders (2 per Region)	Mental & Behavioral Health Providers	Psychologist Anthropologist Psychiatrist	Social Workers	Other Groups LGBTQ, Youth, Older Adults
Northern CA ***Valerie Edwards*** Regional Consultant					
Southern CA ***Stephanie Edwards*** Regional Consultant					
Central CA ***Edward Lewis*** Regional Consultant					
San Bernardino & Riverside Counties ***Wilma Shepard*** Regional Consultant					
Los Angeles County ***Jim Gilmer*** Regional Consultant					

African American Health Institute (AAHI) of San Bernardino County under California DMH Contract #09-79055-006
|April 19, 2010

APPENDIX H: SPW PRE-SELECTION SCREENING TOOL C

African American Health Institute

of San Bernardino County



Calling all people of African ancestry

"For tomorrow belongs to the people who prepare for it today"
-African Proverb

Workgroup Structure

California Department of Mental Health
Reducing Disparities Project(CRDP):
African American Strategic Planning Workgroup
March 1, 2010 to February 29, 2012

V. Diane Woods, DrPH, CRDP Director

Track our progress.
Join our efforts.

For more information please visit
www.AAHI-SBC.org
(909) 880-2600

APPENDIX I: STATEWIDE AFRICAN AMERICAN SPW STRUCTURE

African American Health Institute of San Bernardino County

Harambee

"All Pull Together"
Swahili



CRDP African American Strategic Planning Workgroup (SPW)

Harambee is a Kenyan tradition of community self-help events, e.g. fundraising or development activities. *Harambee* literally means **"all pull together"** in Swahili, and is also the official motto of Kenya and appears on its coat of arms.

Harambee events may range from informal affairs lasting a few hours, in which invitations are spread by word of mouth, to formal, multi-day events advertised in newspapers. These events have long been important in parts of East Africa, as ways to build and maintain communities.

Following Kenya's independence in 1963, the first Prime Minister, and later first President of Kenya, Jomo Kenyatta adopted "*Harambee*" as a concept of pulling the country together to build a new nation. He encouraged communities to work together to raise funds for all sorts of local projects, pledging that the government would provide their startup costs. Under this system, wealthy individuals wishing to get into politics could donate large amounts of money to local *Harambee* drives, thereby gaining legitimacy. Encyclopedia, 2010

So it is with the ***California Department of Mental Health Reducing Disparities Project (CRDP)***. We the people of African ancestry (including African Americans, Continental Africans, Afro-Caribbean, Afro-Latinos, and Africans any other nationality or country of birth) living in California are coming together, using the resources we have to create a system that provides culturally appropriate services for those who need it. *Join the effort!*

APPENDIX I: STATEWIDE AFRICAN AMERICAN SPW STRUCTURE

California Department of Mental Health
Reducing Disparities Project (CRDP)
Contract Deliverable
Program Component 2: Convene Strategic Planning Workgroup

African American Health Institute

A: Meeting Structure

Using a participatory process in the past has been very successful working with people of African ancestry. Due to the nature of this project, several types of meetings will be necessary, such as telephone conference calls, in-person meetings, online meetings at the ***Office Meeting Center***, and the exchange of emails. The project contract and deliverables mandate **at least one** meeting per quarter. Identified quarters are:

1st Quarter=March, April, May 2010
2nd Quarter=June, July, August 2010
3rd Quarter=September, October, November 2010
4th Quarter=December 2010, Jan, February 2011
5th Quarter=March, April, May 2011
6th Quarter=June, July, August 2011
7th Quarter=September, October, November 2011
8th Quarter=December 2011, January, February 2012

All meetings must utilize the following items:

1. A written agenda
2. A start time and end time
3. Minutes summarizing discussions and actions taken
4. Minutes submitted to AAHI-SBC office in electronic format
5. Attendance record
6. Meetings scheduled based on group consensus
7. Confirmation of meeting date/time should be sent by email to all participants
8. Confirmation of email will be followed by a telephone call

Office Meeting Center is an online web-based program created for this project. Access: **http//: SharePoint.AAHI-SBC.org/default.** The preferred method for meeting and interacting with SPW members and project partners is the ***Office Meeting Center***. Each workgroup member will be assigned a personal password to enter. The program will create standard forms and formats for the agenda, minutes, scheduling, and keeping data. Each person is assigned to his/her selected group and will be able to work only with that group. If there is interest in other group activities, access is granted to view activities but, not enter or manipulate any items in the group working space.

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California Department of Mental Health
Reducing Disparities Project (CRDP)
Contract Deliverable
Program Component 2: Convene Strategic Planning Workgroup

Advantages of the ***Office Meeting Center*** are: available 24 hours, multiple members can be online at the same time, all conversation is documented in writing, all written information is permanently recorded and can be viewed at anytime, the flexibility of meeting times are optimal, and efficiency is high because of standard forms and record keeping. Meetings documented at the Office Meeting Center are official and reportable as a project deliverable. AAHI-SBC office staff can download minutes and meeting information for the office records.

Conference calls are also official meetings. A free conference center is available by dialing: 1-507-726-4200. A group member must be assigned to keeping the records and emailing copies to the AAHI-SBC office (CorporateOffice@AAHI-SBC.org).

In-person meetings are not the most efficient method for workgroup members to meet because members are in diverse parts of the state. Time and travel would be cost prohibited.

Email exchanges between group members are encouraged.

All decisions during group meetings will occur by consensus. Webster defines consensus by "an opinion held by all, or most; general agreement." The final decision should be recorded in the minutes, and stated clearly.

B: Leadership Structure

We recognize that there is not one right, but rather a diversity of leadership styles. With a mixed group of people from diverse backgrounds, the leader must be accepted and respected by the group. Leadership structure deemphasizes individualism and promotes a communitarian perspective. "Communitarian perspective" values sharing what is in common; what is best for the whole, not one individual.

The African American Strategic Planning Workgroup is organized into three levels of participation. All three levels make up the workgroup; **statewide workgroup members = 42.**

Level 1: The African American Health Institute of San Bernardino County (AAHI-SBC) staff
Level 2: The AAHI-SBC project consultants
Level 3: The Workgroup volunteer statewide members

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California Department of Mental Health
Reducing Disparities Project (CRDP)
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Program Component 2: Convene Strategic Planning Workgroup



Level 1: Workgroup participants in Level 1 are the administrative team. AAHI-SBC has the day-to-day management of the project, must make sure the contract deliverables are on time, and the project is successful.

Level 2: The AAHI-SBC consultants (Level 2 participants) provide input regarding project development and implementation according to mental health best practice models. The AAHI-SBC staff and consultants worked together to submit the application to the DMH, and will work on the project according to identified and approved roles as stated in the executed contract from the DMH.

Level 3: Strategic Planning Workgroup statewide members are volunteers. There are 26 individuals who signed a Workgroup Agreement to voluntarily serve on the CRDP Report project. Each member identified personal priority areas for working on the CRDP Report. AAHI-SBC staff and consultants will work with workgroup volunteer statewide members to produce the final product of this project, a ***CRDP Report for African Americans*** based on an African-centered framework.

AAHI-SBC staff will interact in every aspect of the project. Office staff, expert consultants and select representatives of the workgroup membership will refine the CRDP Report before it is submitted to the DMH. Participation in refining the final product is based on what is "efficient" and "effective" utilization of project resources to meet deliverable deadlines.

Title	Staff
President & CEO	V. Diane Woods, DrPH, MSN, RN
Program Coordinator	Nacole Smith, MPH
Prevention Specialist	Denise Hinds, DrPH
Office Assistant	Linda Williams

AAHI-SBC consultants have specific assignments, namely:

Regional Consultants: Responsible for project recruitment and to identify the best project input from each region within the state. See project regional map of identified counties in each region. Regional consultants are:

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Reducing Disparities Project (CRDP)
Contract Deliverable
Program Component 2: Convene Strategic Planning Workgroup

African American Health Institute

Region	Consultants
Northern California	Valerie Edwards, LCSW
Southern California	Stephanie Edwards, MPA
Central California	Edwards T. Lewis, MSW
Inland Empire	Wilma L. Shepard, LCSW
Los Angeles	Reverend James C. Gilmer, MA

Subject Matter Expert Consultants: Level 2-AAHI-SBC Project Consultants provide specific input related to expertise. Each consultant will work with workgroup members on specific assignments to successfully create and produce the CRDP Report. Subject matter expert consultants are:

Expertise	Consultants
Utilization & Cultural Competency	Daramöla Cabral, DrPH, PA
Adolescent & Adult Mental Health	Suzanne Hanna, PhD, MFT
Psychiatric Medicine	Richard Kotomori, MD
African Immigrant Health Services	Walter Lam
Behavioral Health Provider Services	Temetry Lindsey, DrPA
Psychological Anthropology	Erylene Piper-Mandy, PhD
African-Centered Psychology	Carolyn B. Murray, PhD

Workgroup Statewide Members*:* All 26 members bring together the diversity of expertise from the mental and behavioral health arena. The role of the workgroup members is to create the CRDP Report. Each member will have specific assignments and products to deliver according to pre-established times and due dates.

Expertise	Member
Consumer/Stakeholder Transitional Aged Youth	Maceo Barber, MFT Intern
Mental Illness in African People	Yewoubdar Beyene, PhD
Marriage and Family Therapy	Marva M. Bourne, DMFT
Consumer/Stakeholder	Gregory C. Canady
Stakeholder/Provider, Mental Illness Services	Nancy Carter
Stakeholder/Provider, Behavioral Health Care Services	Gigi Crowder
Ethiopian Consumer/Provider, African Assist Services	Alemi Daba

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African American Health Institute of San Bernardino County under contract with California DMH #09-79055-006

APPENDIX I: STATEWIDE AFRICAN AMERICAN SPW STRUCTURE

California Department of Mental Health
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Program Component 2: Convene Strategic Planning Workgroup



Counseling Psychology	Terri Davis, PhD
Consumer	Don Edmondson
Psychiatry & Neurology	C Freeman, MD
Nurse Psychotherapy	Sabrina L. Friedman, EdD, NP-C
African-Centered Sociology	Lawford L. Goddard, PhD
Clinical Social Work	Tracie Hall-Burks, LCSW
Stakeholder/Provider, Forensic MH Clinical Services	Melvora (Mickie) Jackson, MPA
Stakeholder/ Social Support	Phyllis Jackson
Consumer	Luvenia Jones
Consumer	R. B. Jones
Stakeholder/ Ministerial Council	Bishop Ikenna Kokayi, MA
Social Work	Lana McGuire, ACSW
Clinical Psychology	Gloria Morrow, PhD
Consumer	Musa Ramen
Consumer	Linda Redford, LVN
African-Centered Psychology	Daryl M. Rowe, PhD
Provider/ Mental Illness & HIV/AIDS	Madalynn Rucker, MA
Clinical Social Work	Essence Webb, ACSW
Provider/ California Institute of Mental Health	Doretha Williams-Flournoy, MS

CRDP Report Section Development

There are five sections of the final CRDP Report. Each person is assigned to a specific section based on personal preference, ability to provide constructive input toward the deliverable, diversity of perspective, category of workgroup members, and regional representation.

CRDP Section Leaders

Leaders for each section will be identified based on standardized criteria, such as (1) previous experience with the subject matter, (2) demonstrated ability to lead the group to success, and (3) demonstrated time and availability commitment to meet pre-established deadlines. The Section Leader is responsible for moving the group forward to developing three drafts of the CRDP Report. The drafts must be developed and submitted according to standard criteria identified by the project and the established project work plan.

California Department of Mental Health
Reducing Disparities Project (CRDP)
Contract Deliverable
Program Component 2: Convene Strategic Planning Workgroup

CRDP Sections	Assigned Individuals
Section 1: Reducing Disparities (documenting & making recommendations; removing barrier to accessing programs and services)	Richard Kotomori, MD Edward Lewis, MSW Linda Redford, LVN Lawford Goddard, PhD Madalynn Rucker, MA Yewoubdar Beyene, PhD Mickie Jackson, MPA
Section 2: Accessing Programs and Services (recommendations)	Stephanie Edwards, MPA Nancy Carter Walter Lam Musa Ramen Essence Webb, ACSW C. Freeman, MD Marva Bourne, DMFT Terri Davis, PhD
Section 3: Identify Focus Areas for Improved Mental Health Outcomes	Suzanne Hanna, PhD Temetry Lindsey, DrPA Luvenia Jones Phyllis Jackson Georgy C. Canady Don Edmondson Tracie Hall-Burks, LCSW
Section 4: Promoting Effective Relevant Approaches and Solutions (identification & inventory specific community-defined promising practices with strength-based, culturally competent approaches that support improved services, identify effective mental health service models which contribute to the overall health and mental wellness of individuals in the population)	Wilma Shepard, LCSW Reverend Jim Gilmer, MA Maceo Barber, MFT Intern Sabrina Friedman, EdD, NP-C Gigi Crowder Daryl Rowe, PhD Alemi Daba Gloria Morrow, PhD
Section 5: Supporting Community Participatory Evaluation Approaches (recommendations for appropriate methodologies and metrics)	Valarie Edwards, LCSW Carolyn Murray, PhD Bishop Ikenna Kokayi, MA Erylene Piper-Mandy, PhD Daramöla Cabral, DrPH Lana McGuire, ACSW Mr. R. B. Jones Doretha Williams-Flournoy, MS

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APPENDIX I: STATEWIDE AFRICAN AMERICAN SPW STRUCTURE

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Program Component 2: Convene Strategic Planning Workgroup

African American Health Institute

C: Strategies for Inclusive Participation

This first convening will allow members to get to know each other, orient them to the project, and determine their **governance structure for developing the project work plan to complete the CRDP Report**.

Strategy 1: Pre-meeting package. Pre-meeting packages will allow all project participants to have starting point with the same information, and the opportunity to become familiar with project requirements. The pre-meeting package includes: (1) preliminary literature with articles from each of the CRDP Report sections, (2) three overarching articles from leading authors on mental health disparities, measures of unnatural causes of poor outcomes, and racism, (3) pre-assigned sections, (4) data on people of African ancestry, and (5) focus group data collection information.

Strategy 2: Engaging workgroup members in project planning. Each person is given pre-meeting opportunity to decide what section they would like to participate in based on interest and expertise. Engaging individuals and giving them the opportunity to utilize their strengths will hopefully increase productivity and work quality. Each person has individual freedom of expression to include what is valued and important based on perspective and scientific merit. Each person can obtain information, contact individuals, or secure input to ensure project success. Each person will then write their specific assignment and submit for inclusion in the CRDP Report.

Strategy 3: Regional consultants identified and recommended workgroup participants. Each consultant talked to potential members to encourage participation and decision-making regarding project and how project should proceed.

Strategy 4: Inclusion of target specific students. All project participants who have access to students have been encouraged to create opportunities for students to work on the project and receive academic credit. Project development has included seven student interns from local universities in undergraduate and graduate schools. Students are receiving academic credit. All students have projects associated with a specific deliverable. Inclusion of students strengthens the future workforce.

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Program Component 2: Convene Strategic Planning Workgroup

Strategy 5: Target specific selection of workgroup members by categories: consumers, stakeholders, mental health providers, psychologists, sociologist, anthropologist, marriage and family therapist, social workers, nurses, physicians, faith community and community-based organizations, in addition to youth, older adults, LGBTQ individuals, and individual representation of sub-target group populations (African American, Continental African, Afro-Caribbean, Afro-Latino, and African other nationalities).

Strategy 6: Population-based data collection among diverse Blacks. Focus groups will be conducted in each region of the state by specific categories. The primary goal of the focus groups is to hear from the general Black population about what needs to be included in the CRDP Report.

Focus Group (FG) Data Collection

Regional Consultants will conduct target specific recruitment for FG participants. A total of 8-10 individuals are expected for each FG with a total of approximate 320 to 400; (Low End: 8 FG x 8 participants = 64 participants/region x 5 regions = 320; High End: 8FG x 10 participants = 80 participants/region x 5 regions = 400). Standardized focus group protocol will be established by a research design group. All participants will be offered an incentive.

Recommended FG by Regions	
FG 1	**African Immigrants, African Caribbean, African Latino, African Other**
FG 2	**Consumers, Faith Community, Grassroots Organizations, LGBTQ**
FG 3	**Gang Members, Forensics, Substance Abusers, Sex Workers**
FG 4	**Foster Care, Older Adults**
FG 5	**Musicians, Celebrities, Social Media, Artist/ Writers/ Dance/ Drama**
FG 6	**Kids/Youth (students)**
FG 7	**Government Officials, Mental Health Providers, Social Workers, African Mental Health Workers**
FG 8	**Educators, Teachers & Academics**

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Strategy 7: Web-based access to project progress and opportunity for input. A designated webpage has been created to allow the general population to go online and provide input, feedback, and to complete brief surveys. The webpage has a secure access space for workgroup members to utilize 24 hours per day, and for the general public to view for communication exchange.

Strategy 8: Specific regional outreach and recruitment with flyers, posters, radio, newspaper ads, and TV coverage on the local PBS, as well as visits to community meetings, and places where Blacks frequent.

Strategy 9: Online Meeting Center that is open 24 hours to allow all project participants to read communication exchange and to document personal input.

Original document created June 1, 2010; updated September 2010

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Program Component 2: Convene Strategic Planning Workgroup

Each AAHI-SBC project consultants have also agreed to either help facilitate data collection, work the integration process with the other DMH Strategic Planning Workgroups, and to assist with the final completion of the CRDP Report. See consultant assignment in matrix below. This is a tentative list and subject to change after the first statewide workgroup meeting with all members.

Project Task	Project Consultant	Specific Task
Interface with other SPW: **Asian/Pacific Islander** **Latinos** **LGBTQ** **Native American**	Stephanie Edwards, Leader Dr. Richard Kotomori Valerie Edwards Edwards Lewis Reverend Jim Gilmer	✓ Communicate with the other groups on regularly ✓ Develop & write strategy on how project will interface with other groups
Training Focus Group Facilitators	Dr. Carolyn Murray, Leader Edward Lewis Wilmer Shepard Stephanie Edwards Student Intern	✓ Train those who need to facilitate the focus groups ✓ Identify Focus Group instrument to train the facilitators
Data Collection Design	Dr. Daramöla Cabral, Leader Valerie Edwards Dr. Suzanne Hanna Reverend Jim Gilmer Wilmer Shepard Student Intern	✓ Design the Focus Group Guide and procedure ✓ Create the questions ✓ Develop recruitment plan for FG participants ✓ Provide logistics for the Focus Group training
Data Analysis	Dr. Piper-Mandy, Leader Dr. Daramöla Cabral, Co-Leader Walter Lam Dr. Suzanne Hanna Dr. Temetry Lindsey Student Intern	✓ Analyze data and write data report
Final Report Writing	Dr. Piper-Mandy, Leader Dr. Carolyn Murray, Co-Leader Valerie Edwards Dr. Suzanne Hanna Dr. Daramöla Cabral Student Intern	✓ Synthesize all information ✓ **Write final project report** ✓ Work with DMH Writer

Original document created June 1, 2010; updated September 2010

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Reducing Disparities Project (CRDP)
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D: Procedures for Decision Making and Setting Priorities

The process for making decisions will differ at different phases of the project. In the beginning, the group will use a set of criteria for deciding the section group leaders. Scores will be assigned to each criterion. The person with the highest score based on the selection criteria will become the leader. Using standardized processes will help to coalesce the group and build trust.

The next phase of decision-making will be related to developing the work plan for the completion of the CRDP Report. There is a high possibility that we expect to continuously manage challenges due to diversity of participants that despite many similarities and common interest, have different perspectives. The group has decided to agree by consensus. A critical decision will be what is critical to include in each section. Small group brain storming will occur to allow everyone to be heard. To ensure all participants of the group are heard and that the working group together set the priorities, we will use a facilitation tool by the Institute for Cultural Affairs (ICA) called *practical visioning (PV)*. PV involves the whole group in setting priorities by conducting a visioning, followed by small and then large groups organizing and prioritizing the information. The process provides not only the diversity of priorities to surface but the thinking behind them as well. This process ensures that all participants are heard and respected. The group will be expected to keep the vision of where the Black population will be in the next year, three years, five years and beyond.

Another phase of decision-making will relate to the content of each of the three drafts of the CRDP Report submitted to the project director for approval before the honorarium is issued. The AAHI-SBC staff in conjunction with the project expert consultants will review each draft for content approval and guidance for further draft development. Issues of contention are to be supported by documented scientific evidence.

The final report will be reviewed by representatives of the AAHI-SBC staff, expert consultants, workgroup members, and a group of special advisors. The special advisors will be selected at the first statewide workgroup meeting. Special advisors are representatives of the workgroup profile that have not participated in the process and should provide a non-bias review of the final document.

Original document created June 1, 2010; updated September 2010

California Department of Mental Health
Reducing Disparities Project (CRDP)
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Program Component 2: Convene Strategic Planning Workgroup

African American Health Institute

E: Communication Plan

A comprehensive communication plan has been developed that details internal and external communications. This is a separate document. The main objectives of the communication plan are for the stakeholders and constituency to engage in information sharing, to track the movement of the strategic planning process and development, and to decrease confusion and promote transparency. Components of the plan will include the creation of a dedicated page on the AAHI-SBC community website, to include Q & A, opportunities for input, tracking of activities, meeting dates and locations, and other information of interest about the development of the mental health plan for African Americans. Also, information will be released in each region through the California Black Media.

F: Procedure for Addressing Members' Questions/Concerns

We will maintain a group process. Individuals must be acknowledged while in the group meeting before questions or concerns expressed. We will encourage individuals to write questions and share confidentially, or to have a one-on-one discussion with one of the staff. Many people of African ancestry prefer individual time to get their questions answered without embracement. Expressed concerns will remain confidential and not share outside of immediate staff.

G: Procedure for Approaching Conflict Resolution

The group will operate under principles that are respectful of and supportive of an African-centered perspective, such as:

- Shared decision-making
- Diversity of leadership styles, but all are respected
- Participatory, restorative practices
- Seek win/win solutions; this is a collaborative effort. Establishing respectful long-lasting relationships to accomplish the desired objective is the most import issue. Participants will agree to disagree, and disagree respectfully. Both sides of the situation will be discussed, and the group process will define the end results. Time limits will be established on how long participants have to present their position. Afterwards a group vote will decide the outcome. In this strategic planning process, the strength is in the collective effort. People of African ancestry desire their opinions to be heard. This is viewed as respectful of another person and is highly valued.

Original document created June 1, 2010; updated September 2010

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- At the start of our work the participants will draft for themselves a "code of conduct" a set of agreements of what constitutes respectful behavior, what limits we put on time together, what the group expects of leadership in these circumstances, and other aspects of working well together. Additionally, ground rules for participating in the group process will be established by the workgroup at the first meeting. We will also discuss how we hold each other accountable in honoring the agreements we have made to each other. In this strategic planning process, the strength is in the collective effort and wisdom.

H: Quarterly Meetings

Deliverables include: Agenda, Minutes, Attendance and Materials for Meeting

Tentative Schedule

Quarter 1	**April 27, 2010**	***San Bernardino* – Planning Meeting**
Quarter 2	June 1, 2010	***Sacramento*** – Statewide Workgroup Convening Meeting
	August 13-15	***Oakland*** – Statewide Retreat/Planning Meeting
	August 13-30	Start Statewide Focus Group Meetings
	Ongoing	SharePoint Online Meeting Center & Conference Calls
Quarter 3	September 25	***Riverside*** – "Applying African-Centered Concepts" Workgroup Training Meeting –with Dr. Thomas Parham
	September 1-November 15	Statewide Focus Group Meetings
	Ongoing	SharePoint Online Meeting Center & Conference Calls
Quarter 4	TBD	San Diego or Los Angeles - Jan or Feb 2011
Quarter 5	TBD	
Quarter 6	TBD	
Quarter 7	TBD	
Quarter 8	TBD	

Original distributed at Workgroup Convening June 1, 2010; updated September 12, 2010

Original document created June 1, 2010; updated September 2010

California Department of Mental Health
Reducing Disparities Project (CRDP)
Contract Deliverable
Program Component 2: Convene Strategic Planning Workgroup

California Department of Mental Health Reducing Disparities in Populations (CRDP) Report:
African American Strategic Planning Workgroup

Component #1: Establish Strategic Planning Workgroup

a. Membership Criteria Listing
b. Assessment Tools
c. Recruitment Plan
d. Member Agreement Statement
e. Workgroup Member Roster & Community Affiliation

Component #4: Contribute to CRDP Report

a. Regular Collaboration with other RD Workgroups
b. Regular Communication with CRDP Facilitator/Writer
c. Regular Collaboration with MHSA Multicultural Collaborative
d. Promoting of the CRDP Strategic Plan
e. Assist in Developing the Dissemination Plan for CRDP Strategic Plan
f. Review & Comment on Drafts of the CRDP Strategic Plan

PROJECT TIMELINE

PRE-PLANNING MEETING	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8
Nov 2009 to Feb 2010	Mar 2010 – May 2010	June 2010 – Aug 2010	Sept 2010 – Nov 2010	Dec 2010 – Feb 2011	Mar 2011 – May 2011	June 2011 – Aug 2011	Sept 2011 – Nov 2011	Dec 2011 – Feb 2012

Component #2: Convene Strategic Planning Workgroup

a. Meeting Structure
b. Leadership Structure
c. Strategies for Inclusive Participation
d. Procedures for Decision Making and Setting Priorities
e. Communication Plan
f. Procedure for Addressing Member Concerns/Questions
g. Procedure for Approaching conflict Resolution
h. Quarterly Meetings
a. Agenda, Minutes & Materials for Meetings

Component #3: Develop & Finalize CRDP Report

a. Development of CRDP Report:
   a. 3 DRAFTS Section 1. Reducing Disparities
   b. 3 DRAFTS Section 2. Accessing Programs & Services
   c. 3 DRAFTS Section 3. ID Focus Areas for Improved MH Outcomes
   d. 3 DRAFTS Section 4. Promoting Effective Approaches & Solutions
   e. 3 DRAFTS Section 5. Community Participatory Evaluation Approach
   f. FINAL Sections
b. Work Plan for Completion of CRDP Report
   a. Process for Regular Review by:
      i. MHSA Multicultural Collaborative
      ii. CRDP Facilitator/Writer
      iii. California Dept of Mental Health
c. Dissemination Plan for Population Report
d. Implementation of Dissemination Plan for Final Report
e. Delivery of Hard Copies & Electronic copy to DMH

Created by N.S.S., June 1, 2010

Original document created June 1, 2010; updated September 2010

APPENDIX I: STATEWIDE AFRICAN AMERICAN SPW STRUCTURE

California Reducing Disparities in Populations: (CRDP)
Statewide African American Workgroup Profile



First Statewide Meeting

USC State Capital Center
Sacramento, CA
www.AAHI-SBC.org

June 1, 2010

APPENDIX J: LIST OF SPW MEMBERS AND THEIR AFFILIATION

Workgroup Biographical Profile



Maceo Barber is a Marriage Family Therapist Intern graduate of Louisiana Tech University (Psychology); Grambling State University (Sociology); specializes in children/adolescence victims of trauma, severely mentally ill, and crisis intervention. Mr. Barber is a member of NAACP and San Francisco African American Health Disparity Project. He has always been a person committed to serving the underserved population.

Yewoubdar Beyene, Ph.D. is an Associate Professor in the Institute for Health & Aging and the Department of Social and Behavioral Sciences at the UCSF. She holds a PhD in medical anthropology from Case Western Reserve University, Cleveland, OH. Her research areas include women's reproductive health, health care beliefs and practices of traditional cultures, HIV/AIDS, chronic illnesses and immigrant and refugee health.





Marva Bourne, M.S., M.F.T., D.M.F.T graduated from Loma Linda University with a DMFT (Doctor of Marriage and Family Therapy) degree and from California State University with an MS in Educational Counseling. Clinical counseling experience with youth and young adults, couples, and families in a medical family therapy setting, and coordinated a clinic program for young children and their families. Held several leadership positions in her church and interested in ministering to young adults and women and their families.

Daramöla N. Cabral*, Dr.P.H., M.P.H., PA,* is a research scientist and professor of health sciences at JFK University. She earned her Doctorate in Public Health in Epidemiology and MPH in Maternal and Child Health from the University of California at Berkeley. In her research she explores culture and health perceptions as powerful mediators of health behavior, and employees social-ecological approaches in the development of strategies to eliminate disparities in vulnerable populations.



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APPENDIX J: LIST OF SPW MEMBERS AND THEIR AFFILIATION

Workgroup Biographical Profile

Gregory C. Canady is a part of the African American Culture & Family Center in Butte, California. He is a strong advocate for the underserved population.

No Photo Available



Nancy Carter is the Co-Founder and Executive Director of the NAMI Urban Los Angeles affiliate chapter of the National Alliance on Mental Illness. Ms. Carter attended Howard University in Washington, D.C. before heading to New York to pursue a career in front of the camera. Ms. Carter currently lives in Santa Monica, California; she is working on completing her first book, tentatively entitled "Down the Rabbit Hole. A baby Boomer's Tale,"and tongue-and-cheek account of living with depression.

Gigi Crowder, B.S. is the mom of two18 year old twin boys. Gigi is the Ethnic Services Manager for Alameda County Behavioral Health Care Services and has worked in the Behavioral Health Care field for more than 20 years. She is a strong advocate for social justice and serves on several state wide committees; one of the highlights of her career was being inducted in the Alameda County Women's Hall of Fame.





Alemi Daba works for the Alliance for African Assistance in San Diego, California. She is an advocate for patient's rights and refugee health.

Terri M. Davis, Ph.D. is Associate Professor in the John F. Kennedy University Clinical Psychology program. As a clinician, she is committed to the wellbeing and empowerment of adults of color. As a professor, she is committed to developing new generations of culturally competent psychologists.



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APPENDIX J: LIST OF SPW MEMBERS AND THEIR AFFILIATION

Workgroup Biographical Profile



Don Edmondson earned his ***A.A.*** degree from Los Angeles City College in 1997. As a member of the State DMH Client and Family Member Expert Pool, since 1998, he has participated in reviews of County Medi–Cal Mental Health Programs, Mental Health Rehabilitation Centers, and numerous MHSA implementation plans. As a member of an MHSA Implementation Study Team he helped produce several reports that can be found on the State DMH website.

Stephanie Edwards, M.P.A., CAMF, is a native Californian. Ms. Edwards has earned two Masters Degrees; one in Public Administration and the other in Hospital Administration from the University of Southern California; she earned her Bachelor of Science from California State University, Northridge; she continued her studies in the field of fundraising at the Indiana University Center of Philanthropy. Drawing on more than 27 years of experience in fund development and working within non-profit environments, Ms. Edwards founded Community Resource Fundraising Group (CRFG), of which she is president. Ms. Edwards provides hands-on, professional and culturally sensitive resource development and technical assistance to community-based, non-profit organizations.





Valerie Edwards, M.S.W., L.C.S.W. has over 20 years experience in clinical care, innovative programming and oversight of an array of behavioral health, and HIV programs, including management of over 100 FTE staff. She is on the faculty of the School of Social Welfare at UC Berkeley. She is a lifelong community activist dedicated to the concerns of marginalized populations. She received her MSW and her AB in Psychology from UC Berkeley.

C. Freeman, M.D., MBA, earned her BS in Psychology with a minor in Gerontology at Howard University; MBA at Pepperdine University; MD at Howard University. Dr. Freeman is a Psychiatrist at the Los Angeles County Department of Mental Health in Los Angeles, California; and has been a Medical Director, Clinical Faculty Physician, Expert Witness Trainer, Project Manager, Phlebotomist, and Veterinary Assistant.



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APPENDIX J: LIST OF SPW MEMBERS AND THEIR AFFILIATION

Workgroup Biographical Profile



Sabrina Friedman, Ed.D., PMHCNS-BC, NP-C, DAPA is Board-Certified Nurse Practitioner and Clinical Nurse Specialist in private practice providing psychiatric medication management and psychotherapy. She is also an Associate Professor in the Psychiatric Nurse Practitioner Program at Azusa Pacific University. She received her Doctorate from Nova Southeastern University, Master's Degree from the University of Southern California, and Post Master's from Duquesne University.

Jim Gilmer, M.A. (Nonprofit Management/Leadership & Theology) is the Founder and President of Cyrus Urban Inter-Church Sustainability Network/Multicultural Community Ventures Initiative, member of the CA-MHSOAC Services Committee, Plan Reviewer/Evaluator for the MHSAOAC-Prevention & Early Intervention process, Urban Ministry/Multicultural Socio-Economic Development Consultant, and has over 30 years of resource development experience for faith-based-grassroots organizations and ethnic small businesses.





Lawford L. Goddard, Ph.D. is a sociologist/demographer with a broad multi-disciplinary social science background. Dr. Goddard is an expert on Black family dynamics, Black culture, youth development programs, HIV/AIDS, substance abuse and other forms of self-destructive behavior.



Tracie Hall-Burks, M.S.W., L.C.S.W. received her Bachelors degree in Social Work from Tuskegee University and her Masters degree from Norfolk State University in Clinical Social Work. Ms. Hall-Burks spent the last 9 years of her life providing mental health services to children, teens, women, and families. She currently runs her own private practice part time and works full time with a team of professionals in assessing, developing, and making recommendations for future mental health services and placement plans for abused and neglected youth within the foster care system.

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APPENDIX J: LIST OF SPW MEMBERS AND THEIR AFFILIATION

California Department of Mental Health Reducing Disparities Project (CRDP): African American Strategic Planning Workgroup
African American Health Institute of San Bernardino County
Dr. V. Diane Woods, CRDP Director

Workgroup Biographical Profile



Suzanne Midori Hanna, Ph.D. is a senior marriage and family therapist, author, consultant and researcher who specialize in evidence-based practices for African Americans, and others who are underserved and disadvantaged. She believes that many important healing traditions have been ignored during the evolution of mental health treatment in the U.S. In addition to these lost traditions, her current projects emphasize trauma symptom reduction, and the importance of neurobiology in family and cultural relationships.

Denise Renee Hinds, Dr.P.H. received her Doctor of Public Health in Preventive Care at Loma Linda University, CA, 2010; Master of Public Health, Maternal and Child Health, Loma Linda University, CA, 1999; and is a Certified Health Education Specialist. Dr. Hinds has over 10 years of experience in health education and promotion, including planning, implementing, and evaluating community programs.



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Melvora (Mickie) Jackson, B.A., M.P.A. grew up in Milwaukee, Wisconsin. One of seven children; a mom of three children, and two grandchildren; Ms. Jackson received her B.A. degree at New College of California, M.P.A. degree from University of San Francisco, and has a doctoral degree in progress. Mickie is a Forensic Mental Health Clinician.

Phyllis Jackson is the Executive Director of (Karibu) Center for Social Support & Education. Her areas of expertise and focus in working with women include drug addicts, ex-offenders and those with HIV/AIDS. Phyllis' training and education was centered on behavioral science, with emphasis in substance abuse and recovery.



No Photo Available

Luvenia Jones is a Message Therapist Health Educator. Ms. Jones is a part of Bonita House, Inc. Board of Directors, Alameda County Mental Health Board, and POOL of Consumer Champions.

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APPENDIX J: LIST OF SPW MEMBERS AND THEIR AFFILIATION

Workgroup Biographical Profile

R.B. Jones, Certified in Early Childhood Ed **served 13 years on a local school board (5 years as board president). Mr. Jones served 2 years as board president of the California Black School board Assoc. He also served 3 consecutive terms as Mayor of the City of East Palo Alto, CA.**





Bishop Ikenna Anyanwu Kokayi, M.A. Prelate, Christ Church Ministries-in-Community and President/CEO, United African American Ministerial Action Council (UAAMAC), San Diego.

Richard T. Kotomori, Jr., M.D. received his BA in Genetics with a Minor in Spanish Literature at the University of California, Berkeley and his MD at Howard University College of Medicine. Dr. Kotomori specializes in Child and Adolescent Psychiatry and is CEO of the Quality of Life Group. Dr. Kotomori is board certified, a lecturer, has several publications, and is President of the J W Vines Medical Society, Inland Empire (NMA affiliate).





Walter Lam is a refugee from Uganda. In 1989, he founded the Alliance for African Assistance with the purpose of helping fellow refugees from Africa. In the past 22 years the Alliance has expanded greatly, serving thousands of refugees from all over the world. In 2007, the agency launched the Alliance Health Clinic, a non-profit Community Health Center dedicated to the well-being of refugees and other underserved residents of Central San Diego.

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APPENDIX J: LIST OF SPW MEMBERS AND THEIR AFFILIATION

Workgroup Biographical Profile

Edward T. Lewis, M.A., M.S.W., is an Adjunct Lecturer at Sacramento State University teaching Advanced Child Welfare Policy and Child Welfare Practice in the Department of Social Work. Edward has nearly 20-years of social and human services experience with the Departments of Probation, Mental Health and Welfare; Child Protective Services in Butte and Yuba Counties, and California Department of Social Services (CDSS), Children & Family Services Division in Sacramento. In 1991, he realized that his passion and commitment is to work towards resolving issues of disproportionality and disparities, as it impacts African American youth and communities in the areas of health, mental health, education and social services.





Temetry Lindsey, Dr.P.A., has over 20 years experience in the development and management of health and human services. Dr. Lindsey received her BA in Political Science at the University of California, Riverside; MPA at the University of Pepperdine; and her Dr.P.A. at the University of La Verne. Dr. Lindsey is the Chief Executive Officer and President of the Inland Behavioral Health Services, Inc. in San Bernardino, California.

Lana C. McGuire, M.S.W., A.C.S.W. earned a Master's Degree in Social Work from CSU, Chico in 2009 at the age of 45. Ms. McGuire has served children, youth and families of Butte County for 20 years as a group home director, AIDS prevention counselor, drug/alcohol counselor, teen parent social worker and child protection social worker. She has been involved in grassroots efforts to promote education, health and wellness in her local African American community.





Gloria Morrow, Ph.D. received her BS in Psychology from the University of La Verne; MA in Marriage & Child Counseling at Azusa Pacific University; and her MA and Ph.D. in Clinical Psychology from Fielding Graduate Institute. Dr. Morrow teaches a variety of topes that focus on mental and emotional health, and has authored several books. Dr. Morrow is a Diversity consultant at Harvey Mudd College and has appeared on CNN several times providing expert insight into Black psychology. Dr. Morrow integrates Spiritual concepts and principles with her clinical skills to bring healing to the body and soul. Dr. Morrow is co-pastor of the Victory Community Church, and publisher of the Inland Valley News in Upland, CA

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APPENDIX J: LIST OF SPW MEMBERS AND THEIR AFFILIATION

Workgroup Biographical Profile

Carolyn Bennett Murray, Ph.D. is a Full Professor in the Psychology Department at the University of California, Riverside. She received her Ph.D. from the University of Michigan, Ann Arbor in 1979. Dr. Murray was awarded a four year grant from the National Institute of Child Health and Human Development, National Institute of Mental Health (NIH) to conduct a pioneer longitudinal study of the socialization processes of African American families and their children, assessing the normal development processes of African American children and socialization techniques used by their families. Her earlier research and published work is in the area of attribution and affective consequences of negative stereotypic expectations for academic achievement. Her most recent research investigated the role of physician-patient communication in understanding health-disparities.





Erylene Piper-Mandy, Ph.D. received her BA and BS in Psychology and African American Studies from Vassar College; MA in African American Studies from Boston University; and her MA and Ph.D. in Cultural Anthropology at the University of California, Irvine. Dr. Piper-Mandy is Adjunct Professor at Pepperdine University, Graduate School of Education & Psychology; Lecturer at California State University, Long Beach; a consultation in ethnic relations and cultural competence; and the Executive Director of the Center for Cross Cultural Competence in Carson, CA.

Musa Ra Men, A.A., is President of Life Skills Educational & Vocational Inc, a non-profit social change organization; Co-Founder, of the African American Reading Room of Ventura County; and was the MHSA Project Links Youth Council Coordinator for the African American community in Oxnard/Port Hueneme from 2005-2008. Musa is currently employed as a field service technician with the Xerox Corporation.





Linda Redford is a Grandma of 13 and raising 8, ranging from 7-14 years of age. Ms. Redford completed LVN school and was employed by the county as an eligibility worker and caretaker for 5 years.

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Workgroup Biographical Profile



Daryl M. Rowe, Ph.D. is a professor of psychology at the Graduate School of Education and Psychology of Pepperdine University. He teaches courses on socio-cultural influences on human behavior, theories and strategies of clinical intervention and provides clinical supervision to both masters and doctoral students. Dr. Rowe was the National Chair of The African Psychology Institute, the training arm of the Association of Black Psychologists, is a licensed psychologist and maintains a practice emphasizing the psychosocial and communal needs of persons of African descent.



Madalynn C. Rucker, M.A., is founder and executive director of OnTRACK Program Resources, Inc., a nonprofit consulting firm specializing in health and human services since 1997. Previously she served for seven years as a Human Services Analyst III for the County of San Mateo, and six years as a Project Director for a Substance Abuse & Mental Health Services Administration (SAMHSA) grant for the Community Services Planning Council in Sacramento. Ms. Rucker holds a Bachelor of Arts degree in Political Science from the University of Washington, and a Master of Arts degree in Political Science/Public Administration from Stanford University.



Wilma L. Shepard, L.C.S.W., is a Licensed Clinical Social Worker in private practice as well as an Adult Education Teacher who educates and assists individuals and families in solving problems that are interfering with successful adjustment within the family and to life in general. Ms. Shepard has over 25 years of experience in the mental health field specializing in domestic violence and family therapy and is one of the founders of the African American Mental Health Coalition, Inland Empire, which educates, and advocates raising awareness and decreasing the stigma surrounding mental health in the African American communities. A native-born Californian, Ms. Shepard received her B.A. (1986) and MSW (1995) from California State University, San Bernardino and when she is not working, she loves to read, travel and to learn.

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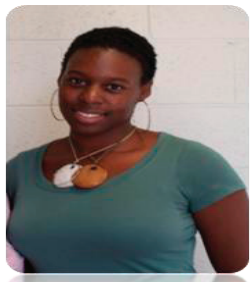
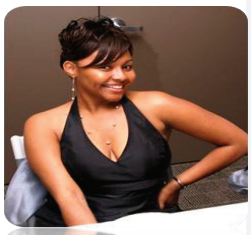
APPENDIX J: LIST OF SPW MEMBERS AND THEIR AFFILIATION

Workgroup Biographical Profile

Nacole Smith, M.P.H. is the Program Coordinator for the African American Health Institute of San Bernardino County, where she spent 2 years as a Graduate Student Intern; she recently finished her Master's in Public Health at Charles Drew University of Medicine and Science; she earned her Bachelor's in Biological Science with a Minor in African Studies at California State University, Sacramento. Ms. Smith has a variety of skills in culturally based cancer research, grants and contracts, health education and prevention programs, is a certified HIV/AIDS facilitator, and has presented her prostate cancer research at the 137th APHA Annual Meeting in Philadelphia, PA in 2009. Nacole is the first in her immediate family to graduate from college and obtain her master's degree, is the youngest of two older twin sisters, and she has two nieces and two nephews.





Essence A. Web, M.S.W., A.C.S.W., is a MSW Supervisor for Sacramento County-DHHS/CPS- Emergency Response Bureau. Mrs. Webb is the President of Sacramento Chapter of CABSW; she is currently on the CABSW State Steering Committee, and works in many social service and community projects throughout Sacramento, such as the Boys & Girls Club of Greater Sacramento, Travelers Aid Emergency Assistance Agency, WEAVE, Family Reunification and Family Maintenance Bureaus of CPS, California Child Welfare Council, and the Sacramento Probation-Neighborhood Accountability Board (NAB). Mrs. Webb is wife to Lamont Webb and mother of two daughters, Taylor (6) and Torri (2) Webb, and active in her children's school PTF (Parent Teacher Fellowship).

Doretha Williams-Flournoy, M.S., has over 25 years experience implementing community based mental health and healthcare services, program planning and administration, and public policy advocacy. She is the Deputy Director for the California Institute for Mental Health. As a Deputy Director and member of the executive management team her portfolio includes the provision of statewide technical assistance and training programs focused on Prevention and Early Intervention, Reducing Disparities, and Integration of Primary Care and Behavioral Health.



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APPENDIX J: LIST OF SPW MEMBERS AND THEIR AFFILIATION

Workgroup Biographical Profile



Linda Williams began volunteering at the African American Health Institute in 2010. Mrs. Williams has worked for Bank of America Specialty Group, GTE Yellow Page Directories and Delta Airlines. She received her BA in Liberal Studies from California State University Los Angeles.

V. Diane Woods, Dr.P.H., M.S.N., RN, received her Doctor of Public Health (Dr.P.H., 2005) in health education and promotion, social policy and social research from Loma Linda University (LLU) School of Public Health; Master of Science degree in community health nursing administration (M.S.N., 1986) Wright State University, Dayton, Ohio; and a BSN (1974), University of Alabama in Huntsville. Dr. Woods is a certified public health nurse (CPHN), holds an academic appointment as an Assistant Research Psychologist at the University of California, Riverside (UCR) Psychology Department, and Founding President and CEO of the African American Health Institute of San Bernardino County (AAHI-SBC, 2006 to 2012). She has over 35 years in public health executive administration, community and clinical nursing, teaching, consultancies, and research. Dr. Woods conducts community-based action research, translational research, and engages in primary prevention health systems development that is community driven and based on a social ecological framework. She has two adult children and three grandchildren.



Created by N.S.S. on May 28, 2010

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Dedicated to the United Nations declaration honoring

2011 INTERNATIONAL YEAR
FOR PEOPLE OF AFRICAN DESCENT

African American Health Institute
of San Bernardino County

Prepared for:
California Department of Mental Health
Under CRDP contract #09-79055-006, funds made possible by MHSA

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May, 2012