STATE OF THE STATE 2010-2011

Reducing Disparities in Mental Health

California Mental Health Services Act Multicultural Coalition

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Acknowledgements

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Executive Summary

Decades of research have documented significant disparities in mental health care for racial, ethnic and cultural communities. In recent years, the California Department of Mental Health (DMH) and counties across the state have engaged in efforts to address and reduce disparities. In this, first annual "State of the State" report, the California MHSA Multicultural Coalition reviewed one of the most relied upon mechanisms by states and counties to identify inappropriate gaps and disparities in care; penetration rate data. After our review we ask ourselves this question: What progress has been made since the implementation of the Mental Health Services Act (MHSA) towards the goal of reducing disparities? The following is an overview of findings:

- The MHSA has provided numerous and varied opportunities to reduce disparities in mental health. By promoting efforts to increase access to services, improve quality of care, and address social determinants of mental health for racial, ethnic and cultural communities, the Act holds tremendous promise for improving the mental health of minority communities throughout the state.

- The recent fiscal crisis in California has dramatically reduced the potential for the MHSA to effect system transformation and to reduce disparities.

- State and county-wide information systems lack infrastructure and reliability to provide adequate and reliable data regarding disparities.

- Even with improved data systems, significant threats to the validity of penetration rates as a measure of data on disparities in access to care, appropriateness of care, and other quality indicators limit the interpretation of findings based on this data.

- Available evidence suggests that disparities in access to care, quality of care, and social determinants of mental health persist, since the implementation of MHSA

Recommendations:

- Efforts must focus on improving data systems and commitment to the collection of racial and ethnic data or proxy indicators. Without accurate, reliable and timely data it is impossible to effectively target efforts to reduce disparities and improve systems so that they better serve racial, ethnic and cultural populations.

- County and state representatives and multicultural advocates should work together to identify a collaborative, feasible, expedient, and accurate way to measure disparities.

Effectively addressing racial, ethnic and cultural mental health disparities requires more than an understanding of penetration rates and the access barriers implicated. In order to objectively establish how many communities are being underserved, we need to know about penetration rates. This report lays out the case for broader collaboration between county agencies and ethnic community-based organizations and the fundamental system-level changes that remain undone to effectively address racial, ethnic and cultural mental health disparities.

Introduction

The State of the State Report

The reduction of disparities in health and mental health for racial, ethnic and cultural groups is a recognized goal of health policy at the national level and at the state level in California. To directly address this goal, the DMH Office of Multicultural Services created the California Reducing Disparities Project (CRDP). The CRDP has several components, one of which is the development of the California Mental Health Services Act Multicultural Coalition (CMMC), a collaboration of community based health and mental health providers, agency leaders, and advocates, which helps guide efforts to reduce disparities on a state level. The primary tasks of the CMMC are to:

1) Produce and annual written "State of the State" report.

2) Produce a series of written reports on topics regarding MHSA implementation, including recurring themes, continued challenges, and potential solutions for the reduction and elimination of disparities for multicultural communities.

This "State of the State" report on mental health disparities is intended to summarize county efforts to reduce disparities and evaluate progress in achieving this goal. Because of the recent initiation of these efforts, county-level data on disparities is limited. Given this consideration, the current report will draw from existing data to provide information on progress made in mental health care for racial, ethnic and cultural populations in California.

History and Background

Proposition 63, the Mental Health Services Act (MHSA) passed in California in 2004, and offers a significant opportunity to reduce disparities through major changes in the state's approach to mental health service delivery. This initiative proposed a 1% tax to be levied on all individuals earning at least one million dollars. The revenues generated as a result of this taxation are to be spent on the expansion, improvement and transformation of mental health services in the state of California. Through a lengthy planning process, the DMH developed a structure for the implementation of the MHSA that involved five components which included Community Services and Supports, Prevention and Early Intervention, Innovation, Capital Facilities and Technology, and Workforce, Education, and Training.

Since implementation of the MHSA, there has been an increased emphasis on enhancing cultural competence and improving access to care for unserved, underserved, and inappropriately served groups. Through efforts such as inclusive planning processes, targeted service provision, increased workforce diversity, and the creation of community partnerships, county mental health departments and the state Department of Mental Health have had unprecedented opportunity to take steps towards eliminating inequities in mental health care for all Californians, including racial, ethnic and cultural groups.

For example, a portion of funding was set aside for a statewide project to address disparities: the Ethnic and Culturally Specific Programs and Interventions project. This component led to the implementation of the California Reducing Disparities Project (CRDP). The CRDP's charge has been to directly address disparities through statewide initiatives that include the development of Strategic Planning Workgroups to identify community defined programs for racial, ethnic and cultural populations and the formation of a statewide cultural competence advocacy committee the California MHSA Multicultural Coalition (CMMC) to produce this annual State of the State reports.

In addition, the MHSA resulted in the implementation of Full Service Partnerships (FSPs). FSPs are programs specifically designed to provide clients with severe mental illnesses "whatever it takes" to promote recovery including employment assistance, housing, alternative healing options, and legal assistance. The designation of funds for FSP programs represents a significant opportunity to reduce disparities as it allows counties to use funds to address social determinants of health– the social conditions that affect mental health and wellness. As social determinants are key drivers of disparities in mental health, allocating resources to address these directly within the mental health system holds promise for improving the mental health of racial, ethnic and cultural communities.

Interviews with several cultural brokers, though, reveal that some of the counties' first attempts with the FSPs did not end up enrolling a significant number of consumers and their families from underserved communities into these programs. There was an

underestimation of how long it would take to enroll new clients and that once enrolled, the clients and family members may not have desired the intensive and frequent participation requirements for these new FSP programs.

In sum, the MHSA has created promising and significant opportunities to address disparities by improving the quality of care, improving access to services, and increasing participation in mental health priority setting for racial, ethnic and cultural communities. Further, it has provided mechanisms for addressing social determinants of health, which may be seen as fundamental causes of disparities in mental health. What remains to be seen however is whether the existing system will take the opportunity to actually change practices for outreach, engagement, and providing services to unserved, underserved, and inappropriately served communities so that disparities are actually reduced.

Changing Economic Landscape

The MHSA created the opportunity to transform the mental health system by providing an influx of funds earmarked specifically for mental health care. However, the promise of the MHSA was blighted by the recession which began to affect social services shortly after the implementation of CSS programs. California's fiscal crisis resulted in budget cuts that led to decimation of county mental health programs. As counties struggled to implement new programs developed through the MHSA they contended with major cuts to their existing programs. While counties managed these financial pressures differently, all county mental health programs suffered from cuts. Thus, while the MHSA created unprecedented opportunities to transform and improve mental health services and ultimately the mental health of California communities, subsequent economic downturn severely curtailed the progress of this transformation.

One of most critical pieces of legislation to pass in the 2010-2011 Legislative session to affect the MHSA was Assembly Bill (AB) 100. AB 100 was a budget trailer bill which implemented a major shift in implementation and administration of the MHSA. Statewide oversight of the MHSA was essentially removed, thus providing some rationale for a drastic cut in the state Department of Mental Health budget of $862 million and the loss of over 130 positions. This fit into the Governor's overall plan for realignment of many state services to the local or county level.

The major responsibility for oversight of the MHSA plans (annual reviews, the Innovation component, plan updates, etc.) would be shifted to stakeholders at the local level. If representatives from underserved communities were fully engaged at the local level, this might be a shift with little consequence. However, although many counties made unprecedented outreach efforts to underserved communities for initial MHSA stakeholder meetings, many have not kept representatives from these communities engaged, nor have they increased their participation in the current MHSA stakeholder meetings. Some counties have reduced their MHSA stakeholder meetings to the point where even mainstream consumer and family groups have voiced concern that they no longer feel involved.

The 2011-2012 Legislative Session has brought continued progression of the restructure (some say "dismantling") of the State Department of Mental Health (DMH). All the functions of DMH– except for those pertaining to the State Mental Hospitals – will be transferred to other state departments, primarily the State Department of Health Care Services (DHCS). However, the Office of Multicultural Services (OMS) which oversees the California Reducing Disparities Project, of which the CMMC is a component, may have a different fate. At this point, the functions of OMS may be divided between the Department of Public Health, as well as the DHCS.

The major organizations and coalitions in the area of reducing disparities and cultural competence in mental health all voiced concern about the proposed division of duties and staffing of OMS. While community stakeholders were grateful for the retention of the county cultural competence plan requirements, there were only four staff positions in OMS to begin with. Splitting these staff was seen as inevitably making it more challenging for them to share the duties, and therefore, also diminishing their effectiveness. However, at the writing of this section, the final outcome of OMS has not been determined.

Statewide Penetration Rates

What has been the outcome of state and county-wide efforts to reduce disparities? What improvements have been made in mental health care for racial, ethnic and cultural communities? The California MHSA Multicultural Coalition was charged with the task of answering these questions. The initial intent of the CMMC was to evaluate progress by reviewing county Cultural Competence Plan requirements and examining the counties' strategies for addressing disparities. However, these Plans were not finalized in time for the first State of the State report and thus were not available for analysis.

Given this limitation, the current report will focus on available data sources to provide insight into the current state of disparities in California, focusing specifically on access to mental health services. Two sources of data will be used to evaluate access to care for racial, ethnic and cultural populations:

1) DMH Department of Statistics and Data Analysis and

2) Medi-Cal data reported by the California External Quality Review Organization (CAEQRO).

These two databases provide information on mental health services utilization by ethnicity. While this statewide data is often used to estimate access to care, significant concerns regarding the validity and reliability of this data limit the interpretation of the findings. These concerns will be discussed in the following section.

CSI and Medi-cal Penetration Rates

California DMH Penetration Rates

One way to evaluate progress towards reducing disparities is to examine changes in access to services for racial, ethnic and cultural groups. In other words, has the number of racial, ethnic and cultural individuals obtaining mental health services through the public mental health system improved over the last few years?

State and county penetration rates are often used to estimate ratio of the number of people seen in the public mental health system to the number of people needing services. A penetration ratio of 1, or 100%, would indicate that all people who need services are receiving treatment.

$$\frac{\text{Total Clients Served}}{\text{Number of Clients Needing Services (Holzer Targets)}}$$

The numerator, *Total Clients Served*, is intended to reflect every person that received services through the county. However, reporting practices vary by county. For example, some counties provide data for services provided in the jails and other criminal justice settings while others do not. Additionally, many counties face challenges in tracking contacts with homeless individuals – a key target for MHSA services. Thus, this number of clients served may reflect an underestimate of services provide and may vary widely by county. The DMH collects this data through the County Mental Health Client and Services Information database (CSI) which received input from county information systems.

The denominator, *Number of Clients Needing Services*, is derived by a complex formula developed by Dr.Charles Holzer (Holzer & Nguyen, 2009). This formula makes use of prevalence rates from various nationwide epidemiological studies to provide estimates of the number of individuals needing services by age and by ethnicity. The Holzer prevalence estimates are most likely among the most accurate available, however it is important to note that there is always a degree of error involved in estimation.

The State DMH currently provides penetration rates for the years: 2003-2004, 2005-2006, and 2007-2008 (California Department of Mental Health, 2011). These numbers are depicted in the table below.

Ethnicity	**Penetration Rate 2003-04**	**Penetration Rate 2005-06**	**Penetration Rate 2007-08**
Latino	33.07%	27.27%	26.77%
non-Latino White	104.71%	82.28%	73.71%
African American	145.07%	109.26%	86.51%
Native American	72.46%	55.57%	41.06%
Asian Pacific Islander	67.11%	55.47%	49.48%
Other	302.33%	405.25%	309.68%

The penetration rates presented above indicate a sharp reduction in individuals served across all ethnic groups (with the exception of individuals categorized as "Other") between 2003 and 2008. While this would suggest that the number of individuals receiving services through the public mental health system was drastically reduced from 2003 to 2007, ***the data do not provide an accurate picture of mental health service utilization. Instead, the reductions in penetration rates reflect vagaries in the reporting process.*** Two important factors contribute to the reductions in number of clients reported through DMH penetration rates. These are:

1) In 2005, counties were required to change the manner in which race and ethnicity data were collected to match the US Office of Management and Budget Census categories. This change in reporting requirements resulted in significant confusion and delays in reporting.

Current penetration rate data does not represent an accurate picture of the number of people served in the public mental health system.

2) Drastic reductions in the DMH budget resulted in the curtailing of the capacity of the department of Statistics and Data Analysis. Personnel working in this department decreased from 19 to 3. Without adequate person-power, this department was not able to keep pace with the increasing complexities in data management and changes in data structure. As a result, much of the information reported by counties in recent years has not been processed.

These weaknesses suggest that penetration rate data currently available through DMH does not represent an accurate picture of the number of people served in the public mental health system and instead represents a gross underestimate.

Even if penetration rates were an accurate reflection of county mental health service utilization, there are significant flaws in the data that limit the validity of penetration rate data for racial, ethnic and cultural groups. These flaws will be reviewed following description of CAEQRO data.

CAEQRO Statewide Studies

In 2004, the state initiated a contract with APS healthcare to provide ongoing evaluation of California mental health programs as well as training and technical assistance. CAEQRO analyzes Medi-Cal data to provide estimates of individuals served in county mental health programs and average payment per Medi-Cal beneficiary. The information provided here is drawn from the "CAEQRO Statewide Report Year 5: 2008-2009" as well as from more recent CAEQRO findings presented by the California Mental Health Planning Council in October of 2011 (CAEQRO, 2009; 2011). It is important to note that CAEQRO penetration rates are much lower than the DMH data because utilization (the numerator) is compared to Medi-Cal eligibles (the denominator) - a much larger number than the denominator in DMH penetration rates (estimated number of individuals needing services).

$$\frac{\text{Medi-Cal Mental Health Claims}}{\text{Medi-Cal Eligibles}}$$

CAEQRO reports the following findings related to disparities in mental health:

1) Latinos continue to be underserved in the public mental health system.

2) County information systems lack data integrity – accurate and timely reporting as well as data management and interpretation.

3) The majority of counties are not addressing cultural competence effectively.

These findings are reviewed in detail in the following section.

The year 5 statewide report indicates that disparities in access to services as well as payment to beneficiaries persist, particularly for Latinos. The report primarily addresses disparities for the Latino population, a population with the greatest discrepancy between the number of Medi-Cal beneficiaries and the number of people served. Medi-Cal penetration rates suggest that while access to services is improving for Latinos, there continues to be a substantial difference between the penetration rates of Latinos compared to non-Latino Whites. Specifically, the report states, "the ratios for penetration rates for Hispanic beneficiaries remain below 30 percent statewide — indicating continuing barriers preventing Hispanic beneficiaries from either seeking or entering the mental health system." (EQRO, 2009; p 114).

"Hispanic beneficiaries continue to be underserved by the public mental health system." CAEQRO, 2009

Regarding the amount of money spent on clients (payment per Medi-Cal beneficiary), the report suggests the following trend, "Data on cost per unduplicated beneficiary served suggests a positive trend toward financial parity for Hispanic beneficiaries. However, female and Hispanic beneficiaries continue to be underserved by the public mental health system."

In October of 2011, the California Mental Health Planning Council presented Medi-Cal based penetration rate data derived from CAEQRO studies. This data provides a more comprehensive and up-to-date snapshot of disparities, as it includes other ethnic groups in addition to Latino and non-Latino White including African American, Native American, Asian/Pacific Islander, and Other. CAEQRO Medi-Cal penetration rate data suggests that - regarding Medi-Cal beneficiaries only - disparities in access continue to be most significant for Latinos.

Ethnicity	**Penetration Rate Fiscal Year 04/05**	**Penetration Rate Calendar Year 09**
Latino	3.1%	3.6%
non-Latino White	12.3%	11.4%
African American	10.1%	10.5%
Native American	11.7%	10.1%
Asian Pacific Islander	5.04%	4.40%
Other	5.8%	7.9%

In addition to analyzing the utilization and costs of mental health care in California, CAEQRO also examined counties' information systems, the effectiveness with which they collected and reported data, and the extent to which they used the data to inform programs. Their analysis suggests that even though Medi-Cal data is considered more reliable than data obtained from mental health services funded through other sources, there continue to be substantial problems affecting data integrity. Many counties are not reporting all of their data in a timely and accurate fashion. CAEQRO states, "The ratings suggest that almost a third of all MHPs have not met the most basic of information system requirements." Furthermore, CAEQRO reports that counties do not have the data management and analysis capability to make adequate use of the data to inform programs.

"Almost a third of all MHPs have not met the most basic of information system requirements." CAEQRO

Finally, CAEQRO provided a brief analysis of the extent to which counties addressed cultural competence in their mental health programs. Findings suggest that the majority of counties did not effectively evaluate or address cultural competence and that in general, counties did not provide services in accessible, community based settings.

Limitations to Penetration Rate Data

Information regarding both CSI and Medi-Cal data reviewed above suggests that significant challenges to reporting and processing of data limit the interpretation of findings based on this data. In addition to these concerns regarding the reliability of the data, there are significant concerns regarding the accuracy of this data in reflecting the state of mental health care utilization for racial, ethnic and cultural groups. These concerns are reviewed below.

Limitations to the Validity of Penetration Rate Data for Racial, Ethnic and Cultural Populations:

1. **Overrepresentation of racial, ethnic and cultural populations in coercive and restrictive settings.** Research suggests that racial, ethnic and cultural populations, in particular African Americans, Latinos, and Native Americans, tend to be overrepresented in criminal justice and child welfare systems, as well as in inpatient psychiatric treatment centers. For example, in 2009, Child Welfare System disparities indices for African American and Native American children compared to Whites were 3.4 and 3.17, respectively (Child Welfare Dynamic Report System, 2009). African American and Native American children's representation in the Child Welfare System is significantly disproportionate to their population estimates. Regarding incarceration, the Legislative Analysts Office reported that in 2007, while Hispanic adults constituted only 31% of the population and they made up 39% of the prison population. Disparities for Blacks were even more dramatic: Blacks constituted only 9% of the population and yet made up 29% of the prison population (California Legislative Analyst Office, 2007). (See appendix for specific data on the CWS and Incarceration). Finally, a significant body of research has documented the overrepresentation of Blacks in psychiatric inpatient settings.

This overrepresentation affects penetration rates in two ways:

a) *It results in an underestimate of racial, ethnic and cultural population's need for services* (the denominator): For racial, ethnic and cultural populations, mental health problems may be masked by social conditions. For example, an African American or Latino male with substance abuse problems is more likely to be incarcerated than a non-Latino White male with the same condition. Some researchers have argued for a broader definition of mental illness that would incorporate behavioral manifestations of mental health problems. In a seminal article Alegria and colleagues argue, "Defining disparities in mental health status for ethnic minorities requires a broad definition of psychopathology, one that moves beyond psychiatric disorders to include mental health symptoms (for example, suicidality) and behavioral problems (for example, domestic and sexual violence)" (p.52; Alegria et al., 2003). Some have also suggested that the definition should be expanded to include the psycho-social impact of trauma from racism. Many have suggested that untreated mental illness results in involvement in criminal justice and child welfare systems as well as inpatient psychiatric treatment.

"Defining disparities in mental health status for ethnic minorities requires a broad definition of psychopathology, one that moves beyond psychiatric disorders"

The disproportionate involvement of racial, ethnic and cultural groups in criminal justice and child welfare systems, and in inpatient psychiatric care may be considered a failure of the mental health system to provide adequate and timely services.

b) *Services are more likely to be delivered in coercive and restrictive settings* (the numerator). Some have argued that when racial, ethnic cultural groups receive services, it is typically through the Criminal Justice or Child Welfare Systems or through inpatient psychiatric services. These services are often mandated and at times treatments are administered without patient consent. While these services constitute clinical encounters documented through CSI and Medi-Cal databases, many of these types of interventions are not considered desirable and/or adequate and timely by clients and families. In fact, the disproportionate involvement of racial, ethnic and cultural communities in these types of care may be considered a failure of the mental health system to provide adequate and timely services. Thus, some have argued that while some racial and ethnic groups do appear to have relatively high penetration rates (African Americans and Native Americans), the services received are more likely to be delivered in restrictive and punitive settings and are less likely to represent appropriate mental health care. In other words, penetration rates mask significant disparities in the quality, appropriateness, and timeliness of mental health care for racial, ethnic and cultural communities.

2. **Race and ethnicity categories used by counties to summarize utilization rates are broad and mask significant heterogeneity within ethnic groups.** Currently, statewide penetration rates are calculated for African Americans, Latino, Whites, Asian American/Pacific Islander, Native American, and Other. Within each of these categories there is significant heterogeneity in culture, country or place of origin, exposure to social and economic adversity, language, and mental health needs.

For example, individuals of Armenian, Russian, and Persian descent may be included in the "White" category. Individuals from these groups may differ greatly in their backgrounds, experiences, languages, cultures, and, in particular, their need for mental health services. Los Angeles County has made efforts to disaggregate the "White" category and has found distinctly different levels of need, stigma, and utilization of services.

The Asian/Pacific Islander community is comprised of individuals with widely varying backgrounds and needs[1]. For example, the Hmong population is newly immigrant, has experienced war and trauma, and faces challenges related to refugee status. In contrast Japanese Americans have been in this country for several generations. Among Latinos there is wide variation in acculturation and country of origin. For example, Mixtecos, a growing ethnic group in some parts of California, are considered by many to be Latino. However, many do not speak Spanish or English and often have very different experiences prior to immigrating than other Latino groups. Experiences like exposure to war, immigration, acculturation, discrimination, poverty, and trauma that may differ widely within ethnic groups may contribute to differences in mental health.

The aforementioned are a few examples that illustrate the danger of "ethnic lumping." By disaggregating ethnic categories, and developing more detailed race and ethnicity categories, counties may improve their capacity to identify and address community needs effectively.

3. **Other vulnerable groups that experience significant disparities in mental health may not be represented in racial and ethnic categories currently used in data collection.** Recently, there has been increased awareness of specific vulnerable population groups that face historical inequities in mental health and mental health care such as veterans, refugee populations, foster children and youth, and LGBTQ individuals. Individuals that identify as Lesbian, Gay, Bisexual, Transgender, and Questioning (LGBTQ) often experience significant discrimination, harassment, and rejection within their communities. These experiences may produce or exacerbate existing mental health concerns such as depression, hopelessness, and suicidality. Despite these experiences, LGBTQ individuals often face challenges in accessing culturally responsive mental health care.

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1 "The term Asian Pacific Islander American is composed of over 26 subgroups including Bangladesh, Burmese, Cambodians, Chinese, Filipinos, Hmong, Indians, Indonesians, Japanese, Koreans, Laotians, Malaysians, Pakistanis, Singaporeans, Sri Lankans, Taiwanese, Thai, Vietnamese, and original peoples of Fiji, Hawaii, Guam, Samoa, Tahiti, Melanesia, Micronesia, Polynesia, and other Pacific Islands."

Understanding the needs of LGBTQ and other vulnerable groups and the extent to which the current mental health system meets these needs is challenging given the lack of statewide data. In particular, current data systems do not collect information on sexual orientation. Thus, the CSI and Medi-Cal databases provide no option for assessing the state of mental health care for LGBTQ clients.

Collecting data on the sexual orientation of clients is critical to effectively targeting services, however this data collection must be conducted in a sensitive and thoughtful manner. For example, as our understanding sexual identity development has increased, the categories of sexual orientation have changed. In addition, in some California communities, disclosing sexual orientation may lead to harassment, discrimination, and violence. If sexual orientation information is collected, efforts must be made to ensure the safety of respondents and confidentiality of the information.

4. **Inaccurate or missing information on forms.** There are additional reasons to believe the penetration rate data is not accurate. Many individuals from racial and ethnic communities are reluctant to note their race or ethnicity on forms due to past breaches of confidentiality, immigration status, etc. As a correlating example, data collection for the United States census faces similar challenges as people from different communities of color and ethnic communities hesitate or decline to fill out the question regarding race and ethnicity or even the entire form due to fears that this information will be leaked or shared with other branches of government.

   Another reason was alluded to earlier in this report. Not all counties train the staff who either fill out or receive initial Medi-Cal or other forms, on how to obtain the most accurate information regarding race and ethnicity. CMMC members reported on more than one instance whereby a staff person has made a determination of a client's race or ethnicity by observation (outward appearances) alone. Statisticians and others who work in the area of data collection also have been known to miscategorize or misclassify individuals and groups. A prime example was in Alameda County where a number of people who identify as Native American were not allowed to be counted as such, but were placed into the category "Other".

   In addition, an increasing number of bi-racial and multi-racial individuals are unsure "what box to check" when filling out information about race or ethnicity. To make matters more complicated is that it is unclear whether counties use the same form or same categories for race and ethnicity in collecting their data.

Summary and Next Steps

Together, the findings of the studies cited above suggest that 1) despite countless efforts to improve data collection, state and county information systems lack the resources and capacity to provide accurate, timely, and useful information regarding client access and utilization of services, 2) the data that is available does not suggest significant improvements in mental health for racial, ethnic and cultural communities.

The MHSA has provided an opportunity to develop programs and policies that improve mental health care for racial, ethnic and cultural communities. The CMMC has been charged with the task of examining the extent to which this objective has been met in an annual "State of the State" report. In the current "State of the State" report, the evaluation of statewide progress in reducing disparities has been hampered by the lack of access to county cultural competence plans and inadequate statewide data sources. In the next "State of the State" report, the CMMC will have another opportunity to examine what has been done to reduce disparities and what has been the outcome of these efforts.

To provide an accurate evaluation of these efforts, a comprehensive and multifaceted approach must be taken. While a complete and thorough assessment of these activities is beyond the scope of the CMMC's activities, insight into progress may be obtained in several ways. The following is a description of potential strategies to measure reduction in disparities.

There are three main drivers of disparities in mental health differences in:

1) access to care,

2) quality of care, and

3) exposure to adverse social conditions (social determinants of mental health).

Progress in the reduction of disparities may be measured by reviewing the *activities and programs* or by examining *outcomes* in each of these areas.

1. Review of Programs and Activities

For **access** to care, institutional and programmatic changes may be made to increase access to care for racial, ethnic and cultural communities. The list below provides some examples of activities that may lead to improvements in access to care for these communities:

Institutional	Programmatic
• Improved relationships with community, CBOs, and community leaders • Increased awareness of mental illness • Increase awareness of disparities • Collection of accurate and detailed information on race and ethnicity	• Increased workforce diversity • Services provided in field or in community based agencies • Reduced stigma • Services provided in clients' primary language • Co-location of programs • Welcoming environments • Funding allocated for outreach and engagement

Activities in the following areas may result in improvements in the **quality of care** for racial, ethnic and cultural communities.

Institutional	Programmatic
• Institutional and leadership commitment to cultural competence • Institutional standards, policies and practices supporting cultural competence • Racial, Ethnic and Cultural communities present in decision-making bodies • Establishment of cultural competence advisory committees • Increases in number of programs targeting racial, ethnic and cultural groups • Increases in outreach efforts • Increases in funding allocated for outreach, engagement, and ethnic specific programs	• Ethnic specific programs • Community defined practices • Cultural Competence Trainings • Partnerships with community based organizations • Funding allocated for ethnic specific and/or community defined practices

Addressing **social determinants** of health requires new approaches and strategies. The following are some examples of activities to address social determinants:

Institutional	Programmatic
• Advocacy for improved living conditions • Development or support of policies that improve social determinants of health and mental health • Awareness of the importance of addressing social determinants to improve mental health	• Programs (like FSP) that address social conditions such as housing, employment, and racism • Partnerships with other social service providing agencies • Collaboration with law enforcement, legal services, refugee services, employment agencies.

2. Evaluation of Outcomes

In addition to reviewing programs and policies implemented to reduce disparities, a thorough evaluation of disparities will examine the outcomes of these efforts. The following is a list of potential outcomes:

Potential Outcomes of Efforts to Reduce Disparities

- Improved Penetration Rates for Racial, Ethnic and Cultural Populations
- Greater use of outpatient specialty mental health care
- Improved satisfaction
- Improved mental health outcomes on behavioral measures
- Decreases in self-reported suffering and distress
- Decreases in reported mental health problems
- Higher retention rates
- Lower rates of homelessness
- Lower rates of child removal from home
- Lower rates of incarceration
- Fewer inpatient hospitalizations
- Lower rates of suicidal behavior and suicide

3. Methods

Ideally, the evaluation of activities to reduce disparities would examine changes in each of these three domains using both qualitative and quantitative methods.

To obtain information in the aforementioned areas, the CMMC may choose several methodological approaches.

1. The CMMC may choose to review cultural competence plans or other county documents and analyze the types of activities conducted and the number or portion of activities related to reducing disparities as well as the funding dedicated to reducing disparities.

2. The CMMC may choose to focus on quantitative data and use existing databases such as DMH penetration rates or CAEQRO data used in this report. In addition, other data such as the California Health Interview Survey (CHIS), the Child Welfare Dynamic Report System, or criminal justice statistics may be used. The CHIS provides information regarding level of need as well as service use, retention, and type of service. Examination of these data sources may require collaboration with the creators of these databases (UCLA Center for Health Policy Research, UC Berkeley, Center for Social Services Research, and the California Department of Justice).

3. To provide a more accurate picture of the state of disparities in California, the CMMC should supplement data sources with qualitative data. Many researchers have noted that qualitative data is often more effective for capturing information for racial, ethnic and cultural communities than quantitative data (Sue, 1998). CMMC may choose to refer to existing qualitative reports (e.g. Center for Reducing Health Disparities "Building Partnerships" series). Alternatively, the CMMC may choose to conduct a brief qualitative study consisting of key informant interviews or focus groups to gather further information.

4. Current Policy and Advocacy Efforts

At the state level, there has been an unprecedented amount of activity by underserved communities in areas of policy and advocacy. Representatives of underserved communities have been participating in coalitions and information groups such as the Racial and Ethnic Mental Health Disparities Coalition (REMHDCO), the MHSA Partners Forum, the CMHDA Social Justice Advisory Committee, and the California Stakeholder Process Coalition, in addition of course, to the CMMC. These coalitions are working to see that the voice of underserved consumers, families and communities are at the MHSA state level policy and decision- making tables. The overlapping concerns of mainstream client and family organizations with those of newer advocacy groups - such as those for seniors and older adults, transition age youth, and racial, ethnic and cultural communities - has allowed the issue of cultural competence and reducing disparities to remain a critical focus point.

REMHDCO's greatest success was to influence the development of the California Reducing Disparities Project so that the entire planning project did not go to a single agency, but rather to community-based organizations that specialized in serving particular communities targeted in the project. The CMHDA Social Justice Advisory Committee developed an "Essential Ingredients" document that could be used to develop or evaluate a meaningful and inclusive stakeholder process. The community stakeholders on the MHSA Partners Forum have banded together more than once to influence policy decisions of the Mental Health Services Oversight and Accountability Commission, as well as the California Mental Health Services Authority.

One of the most critical components of MHSA is the stakeholder process at both the state and local levels, which while starting out robust and inclusive, now seems to be in danger of becoming weak and ineffectual. Now that state oversight of the MHSA was changed by AB 100, the stakeholder process at both the state and local level will take on an even more important role in ensuring that government entities work collaboratively and transparently with all the communities and special populations they serve. The newest coalition, the California Stakeholder Process Coalition is building momentum in developing a definition of a "meaningful stakeholder process" that is acceptable to both government and community stakeholders. The Coalition will be continuing its work beyond the 2011-2012 Legislative session and regardless of the specific definition and process that is developed, it is certain that underserved communities will be noted and required in what constitutes a meaningful stakeholder process whether at the state or local level. If knowledgeable and committed representatives of underserved communities are included in meaningful state and local stakeholder processes, then progress in the reduction of mental health disparities is more likely to become a reality.

Conclusion

Of course, obtaining more accurate penetration rate data will only be the first step towards ensuring that services will be culturally competent and mental health disparities will be reduced. After counties identify the communities that are underserved in their jurisdiction, they need to prioritize serving these communities and actually "do business differently". It is obvious that though counties may have the best intentions and seem to be concerned with mental health disparities, they must actually ***change the way they do things*** since it is evident that the way they currently outreach, engage, and provide services to some communities ***is not working***.

This will not be easy as there will be political challenges when it is noticed that a county begins to serve unserved and underserved communities. There are factions in the mental health community that will object to targeting or changing services to better serve "a certain community". Some actually object to outreach to new clients and families because they proclaim, "Why would we bring in new clients when the mental health department does not provide adequate services to clients and families already in the system?"

Increasing the provision of culturally competent services usually means contracting with new and different agencies and organizations, especially ethnic community based organizations (ECBOs). Again, there will be political challenges to this as well as evidenced by one county mental health department that actually had to justify proposing to award an agency for a "Promotoras" program. The County Board of Supervisors balked at approving the award because of the Spanish name of the new program.

The passage and implementation of the MHSA has resulted in increased awareness of disparities in mental health for racial, ethnic and cultural communities and has prioritized cultural competence and the reduction of disparities in mental health services. However, the fiscal crisis that followed the passage of the MHSA substantially marred efforts to reduce disparities that were in their infancy. As counties move forward in these changing economic circumstances, addressing disparities will require creativity and commitment as well as an understanding of the nature and scope of disparities for local communities. This will require accurate data and timely access to this data. Given the results of this, the first "State of the State" report on reducing disparities, it is clear that a primary objective of the CMMC and of mental health advocates across the state should be to advocate for better, more accurate, accessible, reliable, and valid data systems.

References

Alegría, M., Pérez, D., & Williams, S. (2003). The role of public policies in reducing disparities in mental health status for people of color. *Health Affairs, 22(3),* 51-64.

California Department of Mental Health (2011*). Statistics and Data Analysis: Penetration and Retention Rate Data.* http://www.dmh.ca.gov/Statistics_and_Data_Analysis/RetentionPenetrationData.asp Extracted on March 12, 2011.

California External Quality Review Organization (CAEQRO, 2009). *Statewide Report FY2008-09 Year Five*. http://www.caeqro.com/webx/.ee83711/ Extracted on March 12, 2011.

California External Quality Review Organization (CAEQRO, 2011). *California Mental Health Planning Council Cultural Competence Presentation, October 19, 2011*. http://www.caeqro.com/webx/.ee847f6/ Extracted on March 12, 2011.

California Legislative Analyst Office. *California's Criminal Justice System: A Primer*. http://www.lao.ca.gov/2007/cj_primer/cj_primer_013107.aspx (2007). Extracted on March 12, 2011.

Child Welfare Dynamic Reporting System, (2009). *Child Maltreatment Allegation and Substantiation Rates.* http://cssr.berkeley.edu/ucb_childwelfare/ Extracted on March 12, 2011.

Holzer, C., & Nyugen, H., (2009). *Estimation of Need for Mental Health Services*. http://66.140.7.155/estimation/estimation.htm. Extracted on March, 12, 2011.

Sue, S. (1998). In search of cultural competence in psychotherapy and counseling. *American Psychologist*, *53*, 440-448.

Appendix

***Child Welfare System*:** The Center for Social Services Research at UC Berkeley provides information regarding disparities in the Child Welfare System (CWS) through the Child Welfare Dynamic Report System (Child Welfare Dynamic Report System, 2009). The following table illustrates entries into the Child Welfare System by race and ethnicity as well as disparity indices.

CWS Entries by Ethnicity and Disparity Indices 2003, 2009

Ethnicity	Percent of Entries into CWS 2003	Disparity Indices Compared to non-Latino Whites 2003	Percent of Entries into CWS 2009	Disparity Indices Compared to non-Latino White 2009
Latino	44.00%	.96	50.46	1.01
non-Latino White	31.97	1.00	26.80	1.00
African American	19.52	3.03	18.85%	3.4
Native American	1.31	2.71	1.24%	3.17
Asian	3.19	.33	2.65	.25

California Legislative Analyst Office: Incarcerated Population By Ethnicity, 2007 (California Legislative Analyst Office, 2007).

Ethnicity	Prison Population	California Adult Population
Hispanic	39%	31%
White	27%	48%
Black	29%	6%