# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acknowlegements</td>
<td>1</td>
</tr>
<tr>
<td>Preface</td>
<td>2</td>
</tr>
<tr>
<td>Methodology</td>
<td>3</td>
</tr>
<tr>
<td>NAMI CA Findings</td>
<td>4</td>
</tr>
<tr>
<td>Barriers to Access</td>
<td>4</td>
</tr>
<tr>
<td>Community Needs</td>
<td>6</td>
</tr>
<tr>
<td>Culturally and Linguistically Appropriate Resources and Services</td>
<td>6</td>
</tr>
<tr>
<td>Education and Stigma Reduction</td>
<td>7</td>
</tr>
<tr>
<td>Prevention and Early-Intervention (PEI)</td>
<td>7</td>
</tr>
<tr>
<td>Structural Change</td>
<td>7</td>
</tr>
<tr>
<td>Role of NAMI CA Programming &amp; Advocacy Efforts</td>
<td>8</td>
</tr>
<tr>
<td>Best Practices for Diverse Communities</td>
<td>9</td>
</tr>
<tr>
<td>Community-Informed Recommendations</td>
<td>10</td>
</tr>
<tr>
<td>Education &amp; Stigma Reduction</td>
<td>10</td>
</tr>
<tr>
<td>Prevention and Early Intervention (PEI)</td>
<td>10</td>
</tr>
<tr>
<td>Culturally Appropriate Outreach and Services</td>
<td>10</td>
</tr>
<tr>
<td>Engaging Diverse Communities in Advocacy Efforts for Structural Change</td>
<td>11</td>
</tr>
<tr>
<td>Moving Forward</td>
<td>12</td>
</tr>
</tbody>
</table>
ACKNOWLEDGEMENTS

NAMI California (NAMI CA) extends tremendous appreciation for the support, advocacy, and strength that diverse communities bring to mental health awareness and this report by sharing their experiences. We hope to create better outcomes for all diverse communities and continue to empower these individuals. We would also like to express gratitude to the advisory committee who have helped voice community needs in mental health, and to our local and state partners and affiliates who have engaged in dialogue, education, and advocacy and have given amazing energy and support to NAMI CA and truly impacted the lives of underserved populations. Lastly, we would like to thank the Mental Health Services Act Oversight & Accountability Commission (MHSOAC) for funds to continue to reach individuals from underrepresented communities affected by mental illness.
Figure 1: Infographic highlighting disparities. Percentages expressed as rates among each diverse community total population.
METHODOLOGY

NAMI CA collected qualitative and quantitative data on the needs and experiences of diverse community members (racial and ethnic communities, Transitional Age Youth or TAY, and LGBTQI) navigating the public mental health care system (PMHS) through purposive sampling with the help and support of various cultural brokers and NAMI Affiliate/Community-Based Organization (CBO) leaders from throughout the state. NAMI CA Multicultural Symposiums involved 262 attendees representing 21 different self-identified racial/ethnic backgrounds and 39 different counties and Stakeholder Surveys collected included 202 responses in English, Spanish, and simplified Chinese from throughout 22 counties. MHSOAC-funded deliverables were used to collect data such as communications with the Advisory Committee, Qualitative Interviews, Focus Groups, Community Gathering Sessions, Stakeholder Surveys, Multicultural Symposiums, and Program/Training/Advocacy events.

“We’ve all [BRL participants] gone through something traumatic or life-changing…I didn’t really have an outlet for those things until I got to BRL [Beats, Rhymes, and Life]. So beforehand, I just had it bottled up, pushed to the side as if that would solve anything.”

–Oakland, African American youth, Northern CA Regional Multicultural Symposium
Barriers to Access

Through Stakeholder Survey analysis, common barriers that individuals from diverse communities’ face in mental health services were ranked. Participants ranked cost, stigma, and lack of culturally competence services as the most substantial barriers to care (Figure 2).

Figure 2: Stakeholder Survey question regarding barriers - a higher weighted average indicates the item was chosen as “most substantial”

![Chart showing barriers to access](image)

Figure 3 shows that most participants disagree with a statement about their communities’ acceptance and treatment of someone with mental illness; a larger majority disagree with their communities’ acceptance of someone with a known hospitalization for mental illness. A little over half of the participants disagreed with the third question and most participants agreed that they feel comfortable talking with close friends, family, and community about mental health. A further breakdown of the responses regarding statement four, “I feel comfortable talking with close friends, family, and community members about mine/my loved one’s health,” revealed that 40.67% of those who selected “strongly agree” or “agree” identified as White. Rates of those who strongly agreed or agreed among racial/ethnic minority communities were comparatively lower: 12.5% identified as African American/Black, 12.5% as East Asian, 8.33% as Latino, 4.17% as Southeast Asian, 4.17% as Multiracial, 4.17% as AI/NA/AN, and 4.17% as Middle Eastern. These disparate responses indicate serious differences in current experiences of stigma.
A qualitative theme analysis was conducted using all compiled focus group, gathering session, stakeholder survey, and program/training/advocacy/symposium evaluation responses. Our findings are consistent with the barriers found in Year 1; however, some additional themes emerged:

<table>
<thead>
<tr>
<th>THEME</th>
<th>SUB-THEME</th>
<th>QUOTE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Structural Barriers</td>
<td>HIPAA</td>
<td>“I think it's ridiculous that since my daughter turned 18 that I can't have information about her health unless she signs a waiver and I am the one that makes her appointments, pays for her treatment and researches the providers (therapist, psychologists)” – Los Angeles County, Stakeholder Survey Participant</td>
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<td>Culturally Appropriate Services</td>
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<td>“No Chinese services within the insurance company’s network were found.” – Unknown, Chinese Stakeholder Survey Participant</td>
</tr>
<tr>
<td>Funding</td>
<td></td>
<td>“We have been knocking on county mental health services doors for [9] years. They made promises and never gave it to us. And then they say ‘Well hey, you can bill Medi-Cal.’ They finally came up with a way where they can still make money and use us without paying us.” – Monterey County, African American, Focus Group</td>
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<tr>
<td>Provider Burnout &amp; Sustainability</td>
<td>Patient &amp; Provider Perspectives</td>
<td>“I am the only Spanish-speaker at my work [social work and case management] for all of the Latino communities we serve.” – Los Angeles County, Provider</td>
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<tr>
<td>Stigma</td>
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<td>[為了不讓人看到我去看精神科醫師和治療師，我得開車45分鐘到較遠的門診去看病，我羞於啟齒告訴人家我在服抗憂鬱藥物和抗焦慮藥物] “In order not to be seen [going to] see a psychiatrist and therapist, I had to drive 45 minutes to a distant clinic. I’m ashamed to tell people I’m taking antidepressants and anti-anxiety medications.” – Unknown, Chinese Stakeholder Survey</td>
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<td>PEI within Education System (K-12)</td>
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<td>[El distrito hace mucho para nosotros [padres] de entender y educación porque [una líder de la comunidad] fue y les hablo de salud mental y la necesidad y ellos fueron receptivos a eso, pero que tristeza, yo sé que no todos los distritos son así!] “Our district does a lot for awareness and education for us [parents] because [a community leader] went to the district and talked to them about mental health and the need and they were receptive...what sadness, I know not all districts are like that.” – Riverside County, Latino Community, Community Gathering Session</td>
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</tbody>
</table>
Community Needs

Individuals who reported having experienced discrimination while accessing mental health services and treatment were then prompted to respond to the question in Figure 4; nearly 60% of individuals reported experiencing discrimination based on their racial/ethnic identity and/or cultural heritage. Additionally, nearly 60% of respondents cited experiencing microaggressions sometimes or very often and over 40% cited experiencing lack of cultural awareness/humility and racist language, attitudes or beliefs.

Concurrent to current literature, diverse communities spoke of their needs paralleling the current barriers in mental health. This includes implementation of culturally and linguistically appropriate services and professionals, finding more resources and ways to reduce cultural mental health stigma, enabling ways to streamline resource navigation and access, applying early intervention for youth, needing more care and support from providers, and advocating for and incorporating structural changes to increase utilization of services and ultimately improve the experiences among diverse community members navigating the current system.

Culturally and Linguistically Appropriate Resources and Services

"I appreciate that I both experience a person of color and a white person to diagnose me and gave me their diagnosis, but at the end of the day, someone from my culture will understand me the best. Unfortunately, both professionals cannot relate the struggle I have as an immigrant."

– Sacramento County, Southeast Asian, Stakeholder Survey Participant
Education and Stigma Reduction

“I have attended classes and have benefited from opening up and listening to others to learn alternative ways to deal with issues that I may not have thought about.”

– San Joaquin County, Filipino, Peer and Family Support/Connection Training

Prevention and Early-Intervention (PEI)

“Unfortunately, the focus in our county is reactionary and focused on teen and TAY suicide, which is important, but so is prevention and early intervention.”

– Orange County, Middle Eastern, Stakeholder Survey

Structural Change

“I am a medical provider who just happened to not have insurance at the time. Not having insurance coverage (except county medical) does not mean you’re uneducated or deserve to be tested as such.”

– Los Angeles County, Latino, Stakeholder Survey

“arous, we need the money to prosper. The system needs to be looked at.”

– Monterey County, African American, Focus Group

Additionally, the following interview was conducted with a family member. Harold Turner admits that he, like most people, had no prior knowledge of mental illness until it became personal — it “invaded.” Like many, he tried to specifically figure it out—definition, prognosis, next steps, and who can help. While everyone goes through similar things in the mental health arena, each person must find individual ways of dealing. Turner was able to take a broad view and then take solutions and make them personal.

Turner states the biggest barrier for people experiencing mental illness is connecting with the resources—whether that is housing, treatment, or multiple services. Put simply, the current mental health system is not designed for an illness which is not predictable. Turner wants services available around the clock for individuals and families seeking assistance. There must also be a change of the face of mental health care in California. Providers need to instill trust and confidence that client needs are being met. Turner notes that the mental health field is a tough place for people of color to feel that they are understood. Turner works to put emphasis in education and developing programs to get people, especially from underserved communities, interested in careers in the mental health field. Turner looks to the active components of a community. He looks to the pool of talent available in the area and to people with a history in the community and concern for the community. Putting them on a track on understanding is an opportunity for them to provide services to the community.
NAMI CA has taken steps toward addressing and creating innovative solutions for various of these needs across the state with grassroots organizing, advocacy, and community empowerment at the heart (Figure 6). For more information on this programming please visit namica.org.

**Figure 6: NAMI CA MHSOAC-funded programming attempts to address the needs of diverse communities**

“It means everything to me as a minority! I’m a mental health advocate & speaker who openly speaks about my mental health challenges, recovery, and wellness as a way to raise awareness and promote hope especially in communities of color where there is so much stigma and a lack of knowledge & resources.”

– Los Angeles County, African-American Peer, Mental Health Advocacy

“I work with/volunteer with the Asian-American Resource Center in San Bernardino. This organization is a non-profit organization that has a program dedicated to reducing stigmas within Asian/Asian Pacific and other hard-to-reach cultures and communities associated with mental illness and seeking treatment for mental health conditions. I would love to share this resource [Mental Health 101] to the community at this organization. I also teach at CSUSB where I have students and colleagues of all diverse backgrounds. This would be a great resource to access at the campus.”

– San Bernardino County, Vietnamese, Mental Health 101 – Presenter Training
Throughout our Multicultural Symposiums, we highlighted several current and upcoming best practices from throughout the state. Various CBO representatives discussed their missions, methodologies, and outcomes. Regardless of the diverse community being engaged, one overarching and effective practice is the idea of cultural responsiveness and honoring the historical context and cultural background of the patient. This can be done by using techniques that are already implemented by CBOs like The Village Project, Inc and UAII Seven Generations Counseling Services like tailoring holistic mental health services, treatment, and healing practices to the needs of the patient. Dr. Carrie Johnson and her team developed a Native American Healing Model that considers the cognitive, social, physical, and spiritual intersections that exist in healing among this community (Figure 16). This duality between healing and cultural background was found to be important for each of the diverse communities highlighted in this report.

“Children (K-4th grades) learn & study their true African Ancestry in this 5-year research study that seeks to prove this ‘Community/Culturally Defined Practice,’ designed to strengthen positive racial identity and self-esteem, will prevent these children from developing mental health issues that will become severe and disabling.”

– The Village Project PowerPoint, Southern California Regional Multicultural Symposium

Stakeholder Survey participants shared various practices they are aware of that support diverse communities and address mental health disparities. Support groups, mental health trainings, and services provided by CBOs were most used by the communities for gaining knowledge, reducing stigma, and seeking support by peers and professionals. Best practices for these communities include capacitating the current mental health workforce to understand how various forms of discrimination against patients (from all mental health staff including clerical staff that interacts with the patient first) affects the likelihood of further accessing services, completing treatment, or recommending services to their given communities. Empowering consumers to engage with members of their own communities by becoming certified trainers, teachers, and facilitators establishes trust within diverse communities and gives facilitators tools to better engage with diversity in mental health. Peer support can also reduce social and perceived stigma that many of these individuals still face at alarming rates.

Figure 7: Native American Healing Model (Johnson et al.)
COMMUNITY-INFORMED RECOMMENDATIONS

Education & Stigma Reduction
- Educate society on what mental illnesses are, the signs and symptoms of mental illness, and how to support individuals with mental illnesses.
- Create more opportunities where individuals can speak openly about their experiences with mental illness with the community.
- Continue research into effective stigma reduction campaigns and innovations and partner with schools, K-12 and universities, to embed these into their systems.
- Reduce perceived stigma among diverse communities where mental illness is still not accepted or tolerated through use of culturally responsive models (i.e. Native American Healing Model) and programs (i.e. MH101).

Prevention and Early Intervention (PEI)
- Incorporate PEI programs and models for children and youth into various community services who work directly with families such as faith-based organization, schools, behavioral health organizations, and specialized service centers for unique populations (i.e. individuals experiencing homelessness, women and children, etc.)
- Encourage oversight committees to implement a transparent process for the distribution of MHSA funds in which community input is considered and executed.
- Support a wide array of options for permanent, private, secure, stable, and affordable housing based on an individual's needs and choices.
- Advocate for housing options that include appropriate supportive services, such as case management, tenancy support, clinical services, employment, transportation, and crisis intervention.

Culturally Appropriate Outreach and Services
- Recognize and respect differences in determinants of mental illness and recovery among diverse communities; acknowledge the role of cultural background, historical oppression, intergenerational trauma, immigration status, food insecurity, socioeconomic status, discrimination, cultural norms, and more.
- NAMI Affiliates and partner organizations should empower individuals from diverse communities to facilitate outreach and awareness events.
- Provide culturally and linguistically appropriate services, using community input, and couple with targeted community partnerships (i.e. temples, churches, and community gatherings) to increase the availability of informal mental health services and support outside of the impacted public mental health care system (PMHS).
- Build trust with these communities or individuals through rigorous research-based community engagement processes and the use of cultural brokers (i.e. Principles of Community Engagement, Second Edition).
- Further spread knowledge and resources around what it means to meaningfully and intentionally engage and outreach further to unserved and underserved communities (i.e. Solano County Behavioral Health Interdisciplinary Collaboration and Cultural Transformation Model).
Engaging Diverse Communities in Advocacy Efforts for Structural Change

- Increase participation and engagement of peers, family members, and providers in local and state mental health systems decision making processes.
- Create and sustain financial opportunities like travel scholarships to sponsor individuals who could otherwise not attend large-scale advocacy events.
- Advocate for serious change in the PMHS through increased community participation within decision-making spaces, awareness walks, resource panels, trainings, and meetings with local, state, and national decision makers.
- Ensure that every person with a SMI or SED can easily access mental health and related services without being required to navigate multiple, complex, and overly bureaucratic systems.

- Promote a culturally appropriate client- and family-centered approach that gives the consumer encouragement to participate fully in planning, monitoring, and evaluating treatment; and gives the family the information, skills, and support to make informed decisions as equal partners in treatment (provided the consumer wants their family to be engaged). This could include changes in HIPAA and other administrative processes.

Attendees take a photo with Assemblywoman Blanco Rubio at the Bebe Moore Campbell Advocacy Day, Sacramento County, CA
One of the main goals of NAMI CA is to advocate for the lives of individuals experiencing mental illnesses, especially for underserved diverse communities. Moving into Year 3, we will continue the process of understanding current access and barriers, community needs, and best practices that take into consideration the unique needs of specific diverse communities. The focus will be around actionable, sustainable solutions to addressing some of the issues highlighted in this report and throughout Year 3. Additionally, we plan to bring to the forefront mental health concerns for individuals experiencing homelessness and individuals in the juvenile and criminal justice systems.