NAMI
National Alliance on Mental Illness
California

The
# ANNUAL STATE
of the
# COMMUNITIES REPORT
with
# DIVERSE COMMUNITIES

*"Nothing about us without us"*

Funded by
MHSOAC
Mental Health Services
Oversight & Accountability Commission

Year
Three
19-20

# TABLE OF CONTENTS

# INTRODUCTION & OVERVIEW

## ACKNOWLEDGMENTS

NAMI California (NAMI CA) expresses gratitude to the individuals who graciously shared their knowledge, experience, and voice as part of this project. This work would not be possible without the dedication and passion of those across the state who participated in all aspects of this project to support the efforts of NAMI CA in the development of this report including the multi-disciplinary coalition that is the Diverse Communities Advisory Committee, our many state and local partners, and the leadership of the local NAMI affiliates across California.

This report is the result of a strong collective state and local effort. Special acknowledgements are given to the NAMI CA Board as well as NAMI CA CEO, Jessica Cruz, for her support and expertise in this field. NAMI CA thanks the many state and local leaders who supported this project, most notably the Mental Health Services Oversight and Accountability Commission as funders for this work. Thank you to the NAMI CA staff, specifically to Sofia Amezcua, Ragini Lal, Tory Martinez, and Brianna Vargas for their significant contributions to this report. This report is dedicated to the many individuals, families, and youth across the state struggling with mental health and mental illness. Through continued advocacy and support, it is the hope that this ongoing work will reduce the stigma of mental illness and bring healing to the many diverse lives, families, and communities of California.

## ABOUT THE NAMI CALIFORNIA

The National Alliance on Mental Illness California is a grassroots organization of families and individuals whose lives have been affected by serious mental illness. Founded in 1977, NAMI CA started as a small group of parents that turned into a national movement to inform and educate the country about mental illness and advocate for the rights and care of mentally ill family members. It is an organization that has changed the way we think about, treat, and care for mental illness as the leading organization of individuals working with mutual respect to provide help, hope, and health for those affected by serious mental illness.

NAMI CA has 56 local affiliates and represents 19,000 people to the California Legislature and Governor on issues of mental health and mental illness. NAMI California educates families, individuals, decision makers, professionals, and the public about the needs of communities to increase access to appropriate services and supports, resources, and education in order to create acceptance, awareness, and eradicate stigma.

In 2017, NAMI CA was awarded a contract through the Mental Health Services Oversight and Accountability Commission (MHSOAC) using funds provided by Proposition 63, or the Mental Health Services Act (MHSA). The Act establishes a one percent (1%) tax on personal income in excess of one million dollars to support and encourage system-wide change in California's public community mental health system that would foster a positive impact on the state's prevention of and response to mental illness. As part of that effort, NAMI CA was selected to enhance the participation, voice, and empowerment of diverse communities through advocacy, education, and outreach efforts at the state and local level by ensuring that all individuals and their families, including those from historically un/underserved communities have a major role in the development and implementation of mental health policies and programs, as well as access to culturally and linguistically appropriate services and supports.

As part of this funding, NAMI CA has compiled this report to outline the significant efforts to engage with individuals across the state to explore and support the needs of the many diverse communities across the state with the goal of improving services and supports for all.

### NAMI California Board of Directors

## NAMI California Leadership

- Jessica Cruz, MPA/HS, Chief Executive Officer
- Steven Kite, Chief Operating Officer
- Kris Amezcua, Vice President of Operations
- Angela Brand, Vice President of Strategic Engagement

## ABOUT NAMI CA'S WORK


*Team NAMI CA #votes4mentalhealth*

### Programs

NAMI CA supports an array of state and local program trainings to individuals and family members in a wide variety of community settings, from churches to schools to NAMI Affiliates. With the unique understanding of people with lived experience, these programs and support groups provide outstanding free education, skills training, and support. Classes and groups are offered and facilitated by trained NAMI leaders and provide invaluable support to families and individuals. Offerings include:

- NAMI Peer to Peer / De Familia a Familia is a class for families, significant others and friends of people with mental health conditions. Designated as an evidence-based program by SAMHSA, it facilitates a better understanding of mental health conditions, increases coping skills and empowers participants to become advocates for their family members.
- NAMI Peer to Peer / De Persona a Persona is a class for adults with mental health conditions. The course is designed to encourage growth, healing and recovery among participants.
- Mental Health 101 (MH101) is a NAMI CA program devoted to giving individuals an opportunity to learn about mental illness through an informative presentation, short video, and personal testimonies that represent a variety of cultures, beliefs, and values. All presenters must have lived experience as peers or family member/caregivers. The goal of this program is to create a multi-generation of culturally diverse individuals that can help address the stigma associated with mental illness through education, support and advocacy.
- NAMI Connections / Conexion is a support group for people with mental health conditions. Groups meet weekly, every other week or monthly, depending on location.
- Family/Peer Support Specialist (FPSS) Webinar Training Program is devoted to providing individuals who have lived experience with a mental health condition (as a peer, family member, or sometimes both) a pathway to employment/volunteer work within the behavioral health field.

### Advocacy

NAMI CA leads a robust effort to support advocacy on behalf of individuals and at the state, local, and national levels to fight stigma, provide support, educate the public, and advocate for better mental care and services for all.

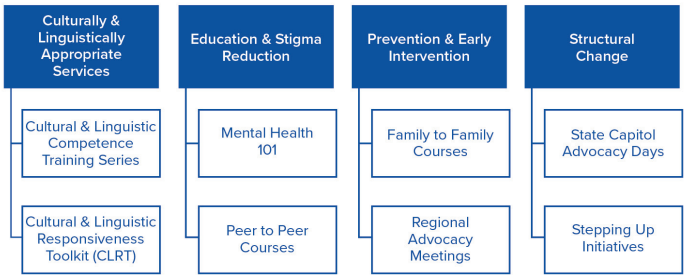



*Figure 1*

NAMI CA works with affiliates to engage with local mental health departments, boards, and commissions to support and ensure family members are included in the development of local program planning. At the state level, NAMI CA works with legislative staff and agencies to address relevant policy issues and educate policymakers about the needs of diverse communities. NAMI CA engages individuals through several activities including:

- NAMI Smarts for Advocacy Training
- MH101 for Policymakers
- Bebe Moore Capitol Advocacy Day
- Regional Advocacy Meetings
- Community Collaboration Meetings

### Community Engagement

NAMI CA works across the state to engage communities, families, and individuals across the state to create awareness of mental health and mental illness. Events and activities bring together community members and other local leaders working to improve mental health care and services in California to reduce stigma among underserved communities and to increase reach into multicultural populations. Through partnerships with local affiliates and community partners, NAMI CA elevates the voice and engagement of communities and provides education and awareness about the issues that impact families and individuals. Activities include:

- Surveys
- Focus Groups and Community Listening Sessions
- Communications and Materials Development
- Town Halls
- Multicultural Symposium
- Youth Symposium

## ABOUT THIS PROJECT

This project funded by the Mental Health Services Oversight and Accountability Commission as part of their work to support and participation of individuals from diverse communities in the mental health system. Through these funds, NAMI CA worked closely with community members to better understand the challenges and barriers faced by individuals and their families when accessing and receiving services as well as how diverse community needs, including cultural and linguistic competence is a factor in the process of treatment, care, and support for individuals living with mental illness.

### Year One Overview: Accessing A Diverse Mental Health Care System

Feedback gathered in Year One indicated that while counties and local behavioral health departments were working with stakeholders from diverse communities, the quality and consistency of those interactions were mixed. Further, NAMI CA found common barriers in access to treatment including lack of available appointment times, cost of services/lack of insurance, access to childcare, lack of culturally competence services, proximity/ transportation, stigma and discrimination. Feedback received highlighted that stigma/ discrimination was the most significant barrier and lack of time was the least significant. Lack of culturally competent services ranked the third most substantial barrier following proximity/ transportation.

Community recommendations included consideration for how to increase mental health awareness in underserved as well as how to engage diverse populations of individuals impacted by serious mental illness need to support their involvement at every step of the planning process to support the develop of meaningful programs and services. Many members shared there simply is not enough services available including culturally and linguistically appropriate services. Using this information, NAMI CA was able to work with local affiliates to increase access to additional local classes and support groups as well as offering local programs in multiple languages. Additionally, NAMI CA was able to identify opportunities for more focused advocacy training in communities and counties to better support individuals in navigating the system and advocate for a key role in the planning of programs through the MH101 Program.

### Year Two Overview: Addressing Mental Health Stigma

Through ongoing community engagement efforts, NAMI CA was able to explore the impact of stigma on members of diverse communities. Building on the information gathered in Year One about the barriers in seeking and receiving culturally competent care, discussion was focused on community response to issues of mental health and mental illness. Often, community members shared that they did not feel accepted by friends and family and that their relationships within the community were impacted by their mental illness.

Notably, when comparing survey results across communities, responses to the question, "I feel comfortable talking with close friends, family, and community members about mine/my loved one's health," revealed that 40.67% of White/Caucasian respondents agreed. Comparatively, only 12.5% African American/Black, 12.5% East Asian, 8.33% Latino, 4.17% Southeast Asian, and 4.17% Middle Eastern respondents agreed with this statement further indicating disproportionate experiences of stigma within multiple communities.

Further, 60% of individuals reported experiencing discrimination based on their racial/ethnic identity and/or cultural heritage and nearly 60% of respondents cited experiencing microaggressions. 40% cited experiencing lack of cultural awareness/humility and racist language, attitudes or beliefs. In addition, further themes emerged including structural barriers (HIPAA, culturally appropriate services, funding), provider burnout and sustainability (patient and provider perspectives), stigma, and lack of PEI programs within the education system (K-12).

Considering these issues, NAMI CA worked to engage with members of communities to offer opportunities for becoming certified trainers, teachers, and facilitators as a strategy to establish trust within diverse communities and gives facilitators tools to better engage with diversity in mental health. NAMI CA also provided support by creating communications and materials for communities to share about mental health and mental illness to create conversation geared toward stigma reduction. Additionally, the Cultural and Linguistic Competence series and Cultural and Linguistic Responsiveness Toolkit were implemented to help consumers, professionals, and key stakeholders learn about the need for culturally and linguistic appropriate services.

### Year Three Overview: Factors Impacting Access to Appropriate Services and Supports

NAMI CA focused final efforts on engaging communities across the state about issues related to the availability and efficacy of services and supports and what is needed to ensure quality access to care for all individuals and their families. Information and feedback gathered highlighted challenges faced by communities when engaging with the criminal justice system as well as issues related to housing/homelessness.

### IMPACT OF COVID-19

In February 2020, California leadership issued rigorous recommendations, requirements, and state mandates in response to the worldwide pandemic outbreak of the SARS-CoV-2 (COVID-19) virus. As part of these recommendations, counties across the state closed businesses, transitioned schools to a virtual learning model, and participated in statewide lockdown to help prevent the spread of the virus. As restrictions have been lifted and modified, much of California remains in various stages of lockdown and quarantine. Emerging research by leading health experts have demonstrated the severe impact that the pandemic has had on physical health, mental health, and overall well-being. Some of these findings have concluded serious increases in call-volume for various mental health hotlines, increases in stress and symptoms of depression and anxiety disorders among the general population, and increases in symptoms of those who were already living with mental illnesses or co-occurring disorders.

The COVID-19 pandemic has negatively impacted many diverse community members including peers, family members, caregivers, parents, children, and especially the most vulnerable populations including incarcerated individuals, unlawfully detained immigrants, and individuals experiencing homelessness all experiencing mental illness. COVID-19 has also disproportionately affected diverse racial and ethnic populations including Black/African American and Latino populations as compared to their white counterparts.

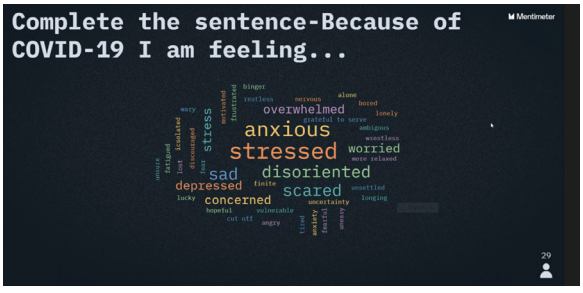
"Covid-19, stay at home order, and the low hours of limited work hours. Finances is difficult in these horrible times."

*- Mental Health Survey Respondent*

"Right now during the pandemic, it is harder for most of us to get hired for any number of jobs but now the safest jobs for us, (remote positions), are being taken by a larger amount of able bodied "well minded" people. Those with disabilities and mental illnesses should have a reduced premium and copays for the amount of time we go to many different doctor and therapy appointments. All resources and information have to be available in the most common used languages that can address as many people as possible as well as online and Braille materials. Online courses for those with mental illnesses/disabilities on how to search for employment, write resumes and cover letters because most of us have large gaps in our employment, interview tips with mental health conditions in mind, common obstacles in the workplace and how to leave a position."

*- Mental Health Survey Respondent*

Throughout the pandemic, NAMI CA has worked diligently to provide support, resources, and guidance to those most impacted by COVID-19. NAMI CA is grateful to NAMI national for creating a guide in Spanish – we were able to share this with many Spanish-speaking communities across the state (https://nami.org/Support-Education/NAMI-HelpLine/COVID-19-Information-and-Resources/Covid-19-Guia). Through community engagement efforts, NAMI CA has heard firsthand about the significant losses experienced by individuals including economic (job loss, business closures, employment cuts) as well as the loss of friends, loved ones, and family members. Further, the closures of county and community agencies left many without access to needed supports and services increasing isolation, despair and exacerbation of mental health challenges. COVID-19 has become a reality for communities, both personally and professionally.




*World cloud responses during town hall event*

While NAMI CA was also impacted by the COVID-19 pandemic, the agency was able to shift quickly, providing supports and services through the state office as well as through many local affiliates in a virtual space. Although, NAMI CA has experienced on-going challenges, NAMI CA has pivoted as a statewide agency and are able to reimagine many of the services, programs, and events outlined in this report.

## IMPACT OF RACIAL TRAUMA ON DIVERSE COMMUNITIES

Further impacting the lives of individuals and families is the current state of race and social justice issues, including Black Lives Matter and impacts of the long-standing legacy of systemic racism in response to recent and more frequent incidents of repeated deaths. The violence and racial trauma experienced by Black, Indigenous, and People of Color (BIPOC) furthered by systemic racism has had a considerable impact on individuals, communities, and populations both physically and mentally. Racism permeates through many systems: law, criminal justice, health, education, mental healthcare, and more; public health experts and mental health leadership, including NAMI CA, support efforts to classify racism as a public health crisis and must be recognized and addressed as such.

The impacts of trauma can be detrimental and can put individuals and entire communities at a higher risk for mental illnesses and co-occurring disorders. Previous Annual State of the Communities Reports issued by NAMI CA have demonstrated a higher rate of discrimination among BIPOC responses in surveys, focus groups, and interviews.

"We understand that we must take steps to right wrongs and demand equality and justice. We must work together to protect our loved ones and fellow Californians impacted by racial discrimination and violence. We must continue to advocate at the local and state level for systematic change and take on long-rooted racial disparities and structural inequities."

*- Jessica Cruz, NAMI CA CEO, Statement on Systematic Racism and the Quest for Justice*

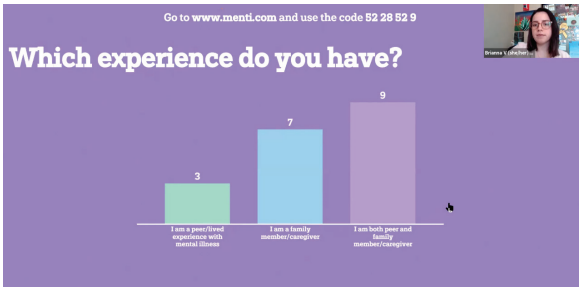
We need to do more to address issues of racial discrimination and injustice. Too often, African Americans are criminalized for living with mental illnesses, which we know are medical conditions.

*– Gigi Crowder, NAMI Contra Costa Executive Director, Fighting Racial Injustices in Our Communities*

# YEAR THREE AT A GLANCE

## EXPANSION OF NAMI CA MENTAL HEALTH 101

Mental Health 101 (MH101) is a NAMI CA program devoted to giving individuals an opportunity to learn about mental illness through an informative presentation, short video, and personal testimonies that represent a variety of cultures, beliefs, and values. The goal of this program is to create a multi-generation of culturally diverse individuals that can help address the stigma associated with mental illness through education, support and advocacy. As a response to the COVID-19 pandemic, NAMI CA revised the MH101 Presenter Training to be delivered in an online format, enhancing opportunities to continue local capacity building through online learning opportunities for community members. Revision Through this project, more than 30 MH101 presentations were delivered across the state for decision makers, education staff, providers, and other CBOs to increase awareness about the needs of diverse communities.




*Mental Health 101 online training*

## EXPANDED NAMI CA PROGRAMS & TRAININGS

Throughout this project, NAMI CA has offered resources for program training at both the state and local level. Notably, state trainings prepare individuals to become local program leaders and facilitators, training for trainers that can thereby increasing the capacity of local affiliates to offer more classes and support groups. NAMI CA has provided support to more than 30 local affiliates, training local community members to become certified teachers, mentors, and facilitators to provide culturally responsive and supports in their community to ensure local program leaders are representative members of diverse communities, with lived experience as an individual in recovery. NAMI CA has trained individuals across numerous local affiliates to become Mental Health 101 Presenters, Peer to Peer/De Persona a Persona Teachers, Family to Family/Familia a Familia, and Connection/ Conexion leaders.

As a result of COVID-19, NAMI CA and local NAMI affiliates have made the remarkable transition to the virtual space, shifting classes and support group to online platforms, regional implementations of their NAMI Programs and moved them to an online platform. With the support of NAMI National, state and local affiliates were provided with the support and guidance to ensure that during the pandemic, families and individuals still had access to the supports and services offered by their local affiliates.

"When I discovered Nami I took their peer-to-peer classes which helped me learn more about self-care, and through them I also learned of ways to get more involved in my community to spread mental health awareness"-

*Diverse Communities Mental Health Survey Participant*

"I have learned to tell others when I am in trouble. I let my family, friends and peers know (when I know) I am in trouble. Currently, I had to have a family member tell me I was seemingly too manic, which got my attention that I needed to check myself quickly before I went into overload and burnout."

*- Diverse Communities Mental Health Survey Participant*

## CULTURAL COMPETENCE TRAININGS

Across various community forums, participants expressed that more culturally and linguistically appropriate education for all involved in the mental health care system could reduce the underutilization of care and decreased engagement. In order to address this key factor and aim to improve the experiences of diverse community members with mental illness, NAMI CA conducted several trainings for cultural and linguistic responsiveness through a series and toolkit. The Cultural and Linguistic Competence Three-Part Training Series created by and facilitated in partnership with the University of CA, Davis (UCD) Center for Reducing Health Disparities begins this conversation

around what it means to be culturally responsive and meaningfully engage all communities. These webinar-based and in-person trainings were created to enhance NAMI affiliate and community partners' capacity to better serve diverse racial/ethnic and underserved communities. The curriculum includes characteristics of culturally diverse audiences relevant to learning, strategies to characterize learning needs, pitfalls and strategies to engaging culturally diverse audiences, key terminology in cultural


*Principles of Community Engagement Training*

competence, mental health disparities, unconscious bias and its impact on diverse communities, strategies for reducing mental health disparities and unconscious bias, managing common challenges when discussing race relations/diversity issues, key features that define community, and key principles and the spectrum of community engagement. Through this effort, NAMI CA trained 108 individuals across 21 counties.

"The strongest part of this presentation were the case examples. The case examples really challenged my critical thinking and helped me apply the information from the presentation in a practical way."

*- Cultural Competence Part 1 Attendee*

## THE CULTURAL AND LINGUISTIC RESPONSIVENESS TOOLKIT (CLRT)

In alignment with the Cultural Competence Training series, NAMI CA developed The Cultural and Linguistic Responsiveness Toolkit (CLRT) in partnership with the Union of Pan Asian Communities (UPAC) and Pacific Clinics to cover key principles and the spectrum of community engagement, key features that define community, and use case scenarios to engage in a deeper discussion about real-world strategies and pitfalls for engaging diverse communities. Content from these trainings have also been incorporated into NAMI CA programming including the Peer and Family Support Certification Program. As there has been an increase in more in-depth conversations about racism as a public health crisis across disciplines and industries, the intersectionality between race and other identities and severe mental illness proved to be extremely critical. Based on findings, these trainings have helped individuals and families gain a better understandings of complex issues diverse communities face and how to better reach and serve these populations.

"I would highly recommend the community survey section and common challenges to review and help get your foot on the door."

*- CLRT Training Attendee*

## MULTICULTURAL SYMPOSIUM

*San Joaquin Danza Azteca Group Regional Symposium Blessing Ceremony*

One of NAMI CA's signature events is the Annual Multicultural Symposium. This event brings together individuals, family members, peer, community leaders, providers, professionals, and other stakeholders from diverse backgrounds to explore the challenges and barriers faced by diverse communities in accessing services and supports, identify potential solutions, and to highlight best and emerging practices developed to support the needs of diverse communities, and to share information with the goal of reducing disparities in access to mental health care for unserved and underserved populations.

Annual themes are developed to focus presentations on specific topics related to the needs of communities to ensure and support access to care and culturally and linguistically appropriate services. Event activities included a robust slate of speakers, presenters, and panelists as

well as interactive workshops and breakouts designed to create conversation and action plans to address the local needs of diverse communities. Of note, the 2020 Multicultural Symposium included a breakout session where participants were prompted to work together to create their own action plan modeled after the Solano County Innovations Project: Interdisciplinary Collaboration and Cultural Transformation Model.

## REGIONAL MULTICULTURAL SYMPOSIUMS

*MHACC tabling at the San Joaquin Regional Symposium*

*Inner G at the San Joaquin Regional Symposium*

Regional Multicultural Symposiums have been a critical component to bringing diverse multi-stakeholder community members to discussions around mental health needs and advocacy opportunities. Through these events, families, peers, mental healthcare professionals, community-based organization (CBO) leadership, policymakers, educators, law enforcement trainers, and county staff are provided with an opportunity to strategize how to best engage with and serve diverse communities. Before the COVID-19 pandemic, NAMI CA hosted the Northern CA Regional Multicultural Symposium in San Joaquin County. 66 participants from 17 Northern California counties included family members, peers, NAMI affiliates, community-based organizations, licensed mental health providers/MSW/MFT, county representatives, students and clinicians. The in-person event featured a robust slate of keynotes, panelists, and presenters.

"Community is much more than belonging; it's about doing something together that makes belonging matters."

*- Raksmey Roeum-Castleman, 2019 Northern CA Multicultural Symposium Panelist*

As a result of COVID-19, NAMI CA launched a virtual Multicultural Symposium series where individuals from across in the state attended a multi-day event including interactive polling software, keynote speakers, Q & A sessions, breakout sessions, and interactive workshops and panels. NAMI CA had 151 attendees join us across the three days from representing 20 counties from throughout the state. On average, 82% of the 27 individuals that completed the evaluation reported feeling more confident in their understanding of the ideas and topics discussed.


*Regional Symposium Keynote Speaker, Dr Jei. Africa*

"Dr. Africa was very well prepared. He is a fountain of "conocimiento/knowledge". The presentation de" la Hermana Curandera/Curandera Sister" was innovative and beautiful in terms of "validarle a nuestra gente otros recursos tradicionales de nuestra medicina/validating to our people other traditional resources of our medicine."

*- 2020 Virtual Multicultural Symposium Attendee*

This year, NAMI CA created Multicultural Symposium Toolkit with the goal of supporting communities to continuously improve the ability to serve individuals living with serious mental illness and their families across the state, and to find solutions to cultural, linguistic, and other barriers which prevent individuals and families

from accessing or remaining active in services. This toolkit cumulatively highlights the innovative solutions and strategies that CBO's, agencies, and service providers have discovered and put into practice to increase resources, ensure access, and ensure culturally appropriate programs and services for diverse communities. It also contains weblinks for readers to easily access each of the agencies and organizations programs and work. Appendix C synthesizes the wide range of topics – from the use of culture to heal intergenerational trauma to the impacts of the repeal of the Affordable Care Act – that were addressed by leadership working toward advancing the mental health care needs of diverse communities across the state.

## ONLINE COMMUNITY ENGAGEMENT AND COMMUNICATIONS

Early in 2020, NAMI CA launched a redesigned website to provide a more user-friendly experience and expand NAMI CA's reach to additional communities. Online content includes resources, crisis support, blog posts, statements from the NAMI CA team, announcements, upcoming events, "community voices" and shared stories, links to available program trainings. The website provides access in 17 languages support to ensure valuable engagement and input from diverse community members whose preferred language is not English. Links are provided to locate local NAMI affiliate offices to ensure and support for individuals seeking local classes and support groups as well COVID-19 information and resources.

Included in the redesign is the inclusion of community voices sharing their stories about their experiences in the community with regard to issues of race and social justice. While We're At It: Let's Fix the Systemic Racism in the Mental Health System; Fighting Racial Injustices in Communities; Reflections on Pride Month and Fighting for a Better World. NAMI CA released a Statement on Systematic Racism and the Quest for Justice.

NAMI CA launched a series of community engagement questions during this year, asking individuals about their experiences and challenges, including: What would you say is the biggest challenge faced by diverse communities when it comes to mental health? (Find more community responses here: Community Voices: Members Share Challenges about Diversity and Mental Health)


*Community Voices respondent*

Streamlined efforts include the development of online tools shared through the website and on social media encouraging community members to share their insights and stories with online forms including: What You Can Do to Support the Mental Health of LGBTQ+ Loved Ones; Mental Health Challenges and Support: African American Communities; Mental Health Challenges and Support: Latinx Communities.

## POLICY PRIORITIES AND LEGISLATIVE FOCUS

To ensure a comprehensive statewide advocacy strategy, NAMI CA partnered with members and local affiliates to collect feedback and information on the issues and experiences impacting families and individuals impacted by serious mental illness. Information was gathered through ongoing community engagement, including surveys, focus groups, listening sessions, and advocacy meetings to support an advocacy platform guided by and aligned with the local and state level needs of families and individuals across the state. Community engagement efforts ensure that policy and legislative focus is designed and informed by individuals and families. Table 1 below outlines the legislative focus as prioritized for 2020.

In 2019-2020, NAMI CA worked closely with members and advocates to explore issues related to housing, criminal justice, crisis care, peer certification, telehealth, LPS conservatorship, IMD waivers, and proposed revisions to the MHSA. Additionally, NAMI CA engaged in conversation about issues of race and social justice as well as the impact of COVID-19 on families, individuals, and youth.

| NAMI CA Legislative Focus 2020 |
|---|
| Access to culturally appropriate treatment and services for all ages |
| Housing |
| Crisis services |
| Family involvement in treatment |
| Criminal justice and forensic issues |
| Telehealth |
| Peer and family support |

*Table 1*

The priority sponsor bill for NAMI CA in 2020 was Assembly Bill 3242 introduced by Assembly Member Irwin. Signed into law, this bill authorizes the use of telehealth to conduct and complete needed examinations, assessments, or evaluations as it relates to the involuntary commitment and treatment of individuals under the Lanterman-Petris-Short (LPS) Act. As counties continue to manage the COVID-19 pandemic, telehealth has become critical component to providing safe, timely, and reliable evaluations for individuals across the state resulting in less egregious wait times for evaluation and less overcrowding in hospital emergency departments.

Another legislative victory celebrated by NAMI CA included the passage of Senate Bill 803, introduced by Senator Beall, enabling California to expand the behavioral health workforce by allowing certification of Peer Support Specialists. With the passage of SB 803, California will now be in line with the 48 other states that already recognize peers' value as a critical part of the behavioral health workforce. As the state continues to face the challenges brought on by the COVID-19 pandemic, California will now be ready to utilize the unique role that peers and families play in the state's behavioral health recovery through the development of a statewide scope of practice, standardized curriculum, training and supervision standards, and certification protocol for peer support services.

## REGIONAL ADVOCACY MEETINGS

During the first two years of this project, NAMI CA was able to engage directly with communities through local, Regional Advocacy Meetings. At the start of the project year, NAMI CA partnered with NAMI Yolo County, UC Davis Student Health & Counseling Services and the UC Davis Campus Police to discuss the current mental health system in their region and collaborate on solutions to share with their local policymakers.

As a result of the COVID-19 pandemic, all local, in-person regional meetings were postponed, and activities transitioned to virtual vents.

## TOWN HALLS

As a result of COVID-19, the remaining slate of regional advocacy meetings were reimagined as virtual events planned to reach a broader statewide audience. The resulting Town Halls provided a unique opportunity for NAMI CA to connect local individuals and communities to state level agencies and entities tasked with oversight and support of California's complex mental health system to foster a better understanding of how the system works together and which agency is responsible for which component of the system.

NAMI CA hosted five virtual Town Halls featuring leadership from the California Pan-Ethnic Health Network, Department of Managed Health Care, Mental Health Services Oversight and Accountability Commission, Council on Criminal Justice and Behavioral Health, and California Behavioral Health Directors Association. The leadership from each of these organizations focused their presentations on the various needs of communities across the state, discussed the impact of COVID-19, and shared what their organizations are working on to advance mental health needs of families and individuals at the state and local levels and engaged in a Q&A session with participants. This online platform allowed a wider attendance from across the state; something not available before the COVID-19 pandemic and allowed NAMI CA to host a public forum with no limit on number of attendees. Over 400 individuals participated in the Town Hall events with favorable feedback shared with NAMI CA.

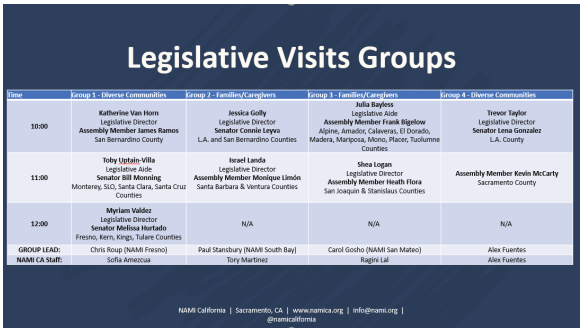

*CPEHN Town Hall, Kiran Savage-Sangwan*

"After this event, I feel more confident in my understanding of the ideas and topics that were presented or discussed. I agree to urge Governor Newsom to make racism a public health crisis."

*- California Pan-Ethnic Health Network Town Hall Attendee*

## BEBE MOORE CAMPBELL CAPITOL ADVOCACY DAY

Held annually, Bebe Moore Campbell Advocacy Day provides a platform for passionate advocates to engage with lawmakers on important policies aimed at improving the quality of life for people with mental illness. As a result of COVID-19, NAMI CA united the voices of individuals, family members, and those from diverse communities in a robust online conversation engaging with state policy makers with the goal of contributing to the elimination of mental health stigma and providing better mental health outcomes for diverse communities. Assembly Member Susan Talamantes-Eggman provided an inspiring keynote outlining the importance of advocacy in advancing the mental health needs of diverse communities across the state. Breakouts were conducted where participants met with state legislators and their teams to discuss their personal experiences and advocate for peer support, suicide awareness, and culturally appropriate services and programs.




*Virtual Advocacy Day Legislative Visits*

This event provided an opportunity for direct engagement with individuals and family to build capacity to engage with legislators and their staff and provide supports for those interested in local advocacy. Overall, participants reported satisfaction with the online platform and the opportunity to meet with advocates from across the state; for some the online platform made it possible to attend this annual event for the first time. NAMI CA will continue outreach in the community and to organizations who might support individuals and families impacted by mental illness to ensure that every individual and family has the tools available to them at the local and state level to advocate for a better coordinated public mental health system.

"Thank you for this opportunity to connect with and share our insight and input with decision and policymakers…It helped me feel empowered to actually be proactive in making changes to our system."

*- 2020 Virtual Advocacy Day Attendee*

"It was so empowering!!!"

*– 2020 Virtual Advocacy Day Attendee*

*Virtual Advocacy Day participants*

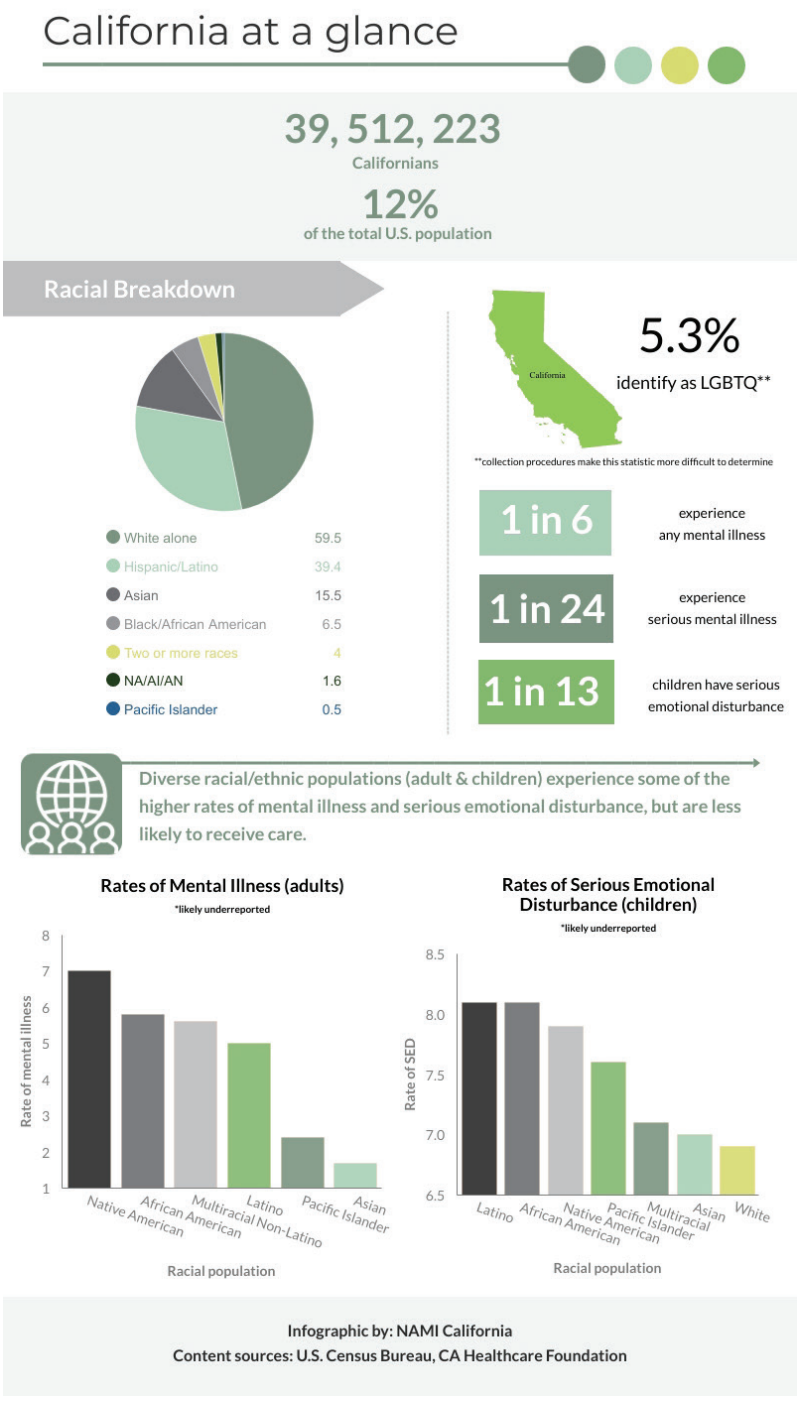

California at a glance
39, 512, 223
Californians
12%
of the total U.S. population
Racial Breakdown
White alone 59.5
Hispanic/Latino 39.4
Asian 15.5
Black/African American 6.5
Two or more races 4
NA/AI/AN 1.6
Pacific Islander 0.5
California
5.3%
identify as LGBTQ**
**collection procedures make this statistic more difficult to determine
1 in 6
experience any mental illness
1 in 24
experience serious mental illness
1 in 13
children have serious emotional disturbance
Diverse racial/ethnic populations (adult & children) experience some of the higher rates of mental illness and serious emotional disturbance, but are less likely to receive care.
Rates of Mental Illness (adults)
*likely underreported
Rate of mental illness
Native American
African American
Multiracial Non-Latino
Latino
Pacific Islander
Asian
Racial population
Rates of Serious Emotional Disturbance (children)
*likely underreported
Rate of SED
Latino
African American
Native American
Pacific Islander
Multiracial
Asian
White
Racial population
Infographic by: NAMI California
Content sources: U.S. Census Bureau, CA Healthcare Foundation

*Figure 1*

# METHODOLOGY

## ADVISORY COMMITTEE

The NAMI CA Diverse Communities Advisory Committee is comprised of individuals with mental health conditions representing the voice of those from Asian Pacific Islander, African American, Middle Eastern, Native American, and Latinx communities. In addition to their racial and ethnic identities, committee members serve as providers, advocates, educators, family members, administrators, and community leaders to ensure a broad range of voice and experience. The primary goal of the Advisory Committee is to ensure that the information and data collected through this project reflects and aligns with the local and statewide perspective of individuals, providers, county, and community-based organizations (CBOs) serving the unique issues of diverse communities.

## FOCUS GROUPS

Throughout this project, NAMI CA hosted a series of community forums including focus groups and gathering/listening sessions designed to gather information to better understand the complex mental health and mental healthcare needs of diverse communities. These events and activities provided an opportunity to engage in meaningful dialogue about the experiences of individuals and families with regard to barriers in access to care, challenges and opportunities in engaging with programs and services, best practices for successful recovery, the mental health system at large, and key issues surrounding housing, criminal justice, employment and prevention and early intervention. Additionally, participants were invited to share information about issues and experiences to help identify new and emerging needs of the community as part of NAMI CA's ongoing effort to better understand topical and relevant needs of multiple communities. All questions were developed using input and information gathered from surveys and advisory committee engagement and revised on an annual basis, taking in consideration trends, topics, and issues emerging throughout the year/project.

## MENTAL HEALTH SURVEY

Similar to the focus groups, annual surveys provided an opportunity to gather information and feedback about the experience and issues impacting communities while also helping to create an overall assessment of the unique challenges facing specific communities and populations. Questions were developed and finalized with guidance from the advisory committee, staff, and NAMI CA leadership.

Surveys were translated in English, Spanish, Simplified Chinese, & Arabic and provided both online and in hard copy formats, disseminated widely through online and in-person networks. NAMI CA partnered with local affiliates, CBO's and other community partners to support a robust effort to engage various communities understand the experiences of diverse communities navigating the public mental health system. Questions utilized a variety of designs from Likert-style scale questions, rank order, and open-ended formats. Figure 2 below summarizes the participant demographics among individuals who completed the survey.

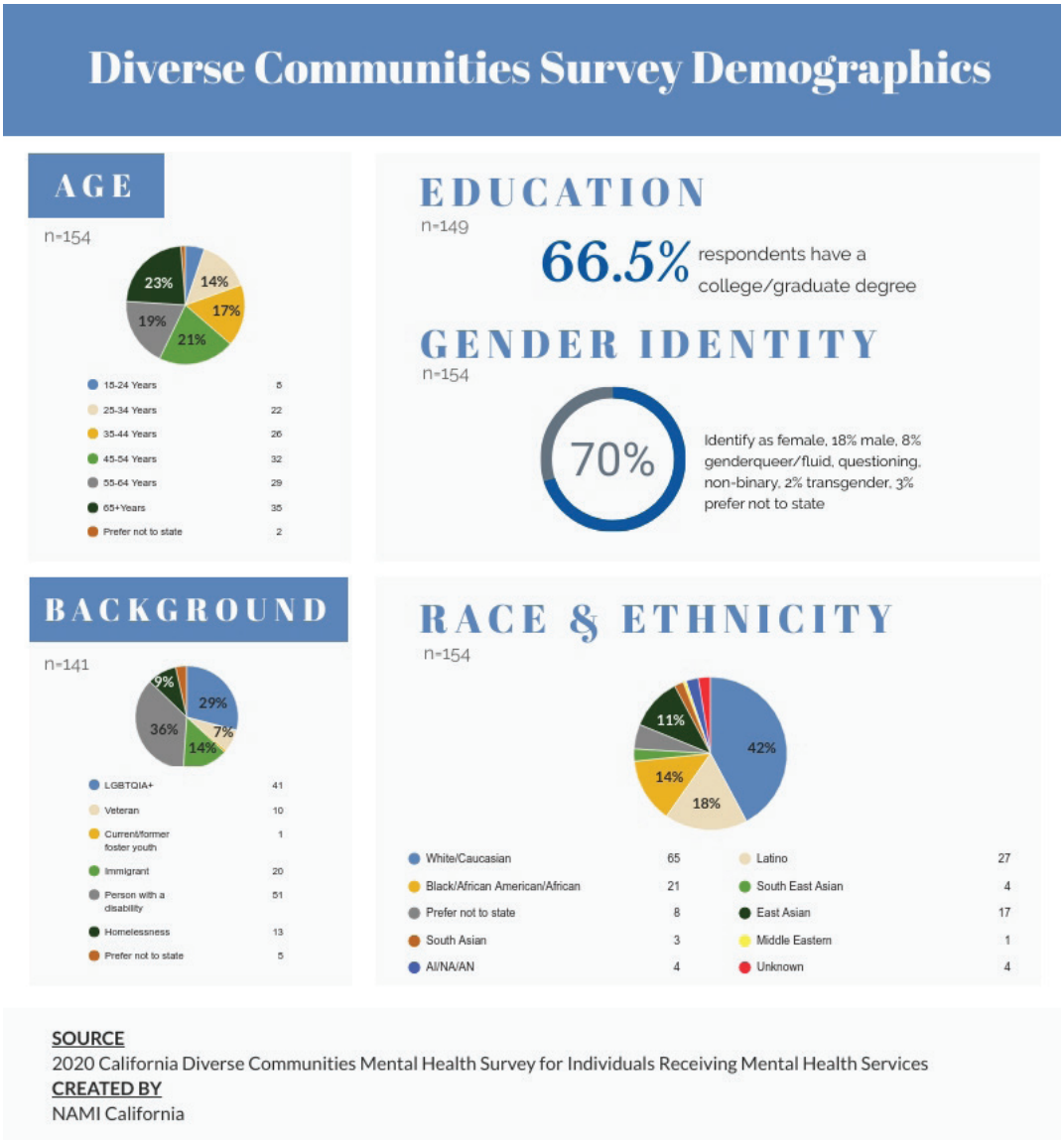

Diverse Communities Survey Demographics
AGE
n=154
23%
14%
17%
19%
21%
15-24 Years 5
25-34 Years 22
35-44 Years 26
45-54 Years 32
55-64 Years 29
65+Years 35
Prefer not to state 2
EDUCATION
n=149
66.5% respondents have a college/graduate degree
GENDER IDENTITY
n=154
70%
Identify as female, 18% male, 8% genderqueer/fluid, questioning, non-binary, 2% transgender, 3% prefer not to state
BACKGROUND
n=141
9%
29%
36%
7%
14%
LGBTQIA+ 41
Veteran 10
Current/former foster youth 1
Immigrant 20
Person with a disability 51
Homelessness 13
Prefer not to state 5
RACE & ETHNICITY
n=154
11%
42%
14%
18%
White/Caucasian 65
Black/African American/African 21
Prefer not to state 8
South Asian 3
AI/NA/AN 4
Latino 27
South East Asian 4
East Asian 17
Middle Eastern 1
Unknown 4
SOURCE
2020 California Diverse Communities Mental Health Survey for Individuals Receiving Mental Health Services
CREATED BY
NAMI California

*Figure 2*

# FINDINGS

## POPULATION OVERVIEW

### Hispanic/Latino

- The largest racial/ethnic minority group in CA are Hispanic/Latino identifying individuals (Cuban, Mexican, Puerto Rican, South and Central American, or other Spanish origin regardless of race) who make up 39.3% of the State's total population. [1]
- Latinos commonly face generalized anxiety disorder, major depression, posttraumatic stress disorder (PTSD), and alcoholism and are 3 times less likely to access mental health care services.[1]
- Primary barriers Latino communities face when accessing mental health services is the lack of culturally and linguistically appropriate services (CLAS), lack of information of mental health, and perceived stigma. [1]
- To best serve the needs of the Latino peer, best practices include tending to the family's health, learning the cultural and family framework, bilingual services, and a cultural awareness of familism or "simpatia."[2]

### Asian/Asian American/Asian Pacific Islander (API)

- API individuals represent roughly 15.3% of the state's total population; they are the fourth largest racial group in CA. Amongst this group, the largest ethnicities are: Chinese, Filipino, Asian Indian, Other Asian, Vietnamese, Korean, and Japanese (3.8%, 3.3%, 1.8%, 1.7%, 1.6%, 1.2%, 0.7%). It is important to note that within each ethnicity, there are various cultural communities and subcultures compromising different languages or dialects, cultures, health beliefs, religions, and histories. [1]
- Although Asian-Americans report fewer mental health conditions than Caucasians, they are more likely to consider and attempt suicide. [2]
- One study found that despite having a lifetime prevalence rate of 9.2% of the population experiencing a psychiatric disorder lasting at least 12 months, only 3.1% of Asian Americans utilized specialty mental health services. [1]
- When discussing barriers to services, API communities face historical and immigrational trauma, cultural barriers, perceived stigma, language barriers, and lack of awareness of resources for services. [1]
- Largely, research suggests that the API community needs family-oriented care, more personalized care which caters to their preferred alternative healing strategies, and language-appropriate services. [1]

### Black/African American

- Based on recent US Census data, individuals who identified as Black/African American comprise 6.5% of CA's population. It is important to note that Blacks/African Americans have varied ethnical backgrounds based on location and African history. [1]
- The main barriers this community faces are current structural systems, historical trauma, discrimination, racism, and racial microaggression which has been reported to increase likelihood of depression, anxiety and other negative effects such as perceived and cultural double stigma. It is imperative to combine more communal centered treatment models that consider the complex needs of this community. [1]
- Most African Americans rely on community, family and faith for sources of strength and support rather than health care providers or services, even in cases where medical treatment may be necessary. Thus, the most critical need is to sustainably fund and institutionalize community and faith-based organization programs that provide meaningful engagement and service delivery. [1]

### American Indians/Native Americans/ Alaskan Natives (AI/NA/AN)

- AI/NA/AN represent approximately 1.6% of CA's population. AI/NA/AN individuals are often identified as "one race" and comprise 0.7% of the population; however, when data is further examined based on "race alone or in combination with another race," the percentage of CA's population of AI/NA/AN individual's rises to 1.9%. Within this population, there are 566 federally recognized Native American tribes with over 200 indigenous languages. [1]

- AI/NA/AN have a higher prevalence of lifetime diagnoses of substance use, alcohol dependence, PTSD, and major depressive episodes, and have an alcohol-related death rate six times greater than the rate for all races. Similarly, to other minority groups in the state, it was found that NA/AN Californians use emergency psychiatric services inconsistently and use less recurring treatment services like emergency situations rather than preventive treatment. [1]
- Some key barriers to care among this community include lack of culturally appropriate mental health care by provides, racism and discrimination, perceptions of misdiagnoses, deficient available funding to secure services, stigma, intergenerational historical trauma, and high poverty prevalence. Understanding and incorporating cultural identity and historical trauma would greatly help improve practices and create appropriate care for the community. AI/NA/AN also want to see providers and staff who look like themselves; this could greatly reduce stigma and increase utilization.[1,2]

### LGBTQI+

- Reports from 2018 show that about 5.3% of CA's population identified as LGBT. It is important to note that the term LGBTQI+ is encompassing of both sexual orientation and gender identity; these populations have unique characteristics and face different challenges and barriers in physical and mental healthcare. [1]
- These statistics are highly underreported due to the stigma and discrimination that comes with revealing such identities and more so across different cultural backgrounds. Research would suggest that this 17.9% of this population accesses services more often than 1.9% of their heterosexual and cisgender counterparts and faces increased rates of discrimination from mental health service providers, poor mental health, and suicide and suicidal ideation.
- Several barriers LGBTQI+ individuals face is lack of culturally appropriate services by providers, systemic-level barriers such as defining LGBTQI+ as a disorder in previous psychological disorder manuals, victimization, prejudice, and discrimination, being denied care, being blamed for their sexual orientation and sexual or physical assault. [1]
- Training programs for "peer advocates" or allies where community health care workers are trained to "enhance social support and access to professional services for LGBTQI+ residents" are necessary for the advancement of mental health care among this population. These programs for community members and professionals would emphasize inclusive language, non-binary ideals, and intersectionality. [1]

### Transitional Age Youth (TAY)

- Although TAY represents youth aged 16-20, for the purposes of compiling needs for youth, the ages for TAY in this report is 0 to 20 years old. In 2013, it was recorded that there are over 10 million youth aged from 0-20 in CA. [1]
- TAY most commonly experience depression. Between 2005 and 2014, the number of adolescents who experienced depressive episodes increased threefold. More alarmingly, suicide is the second leading cause of death for 15 to 24-year-olds. Furthermore, the prevalence rate for TAY racial minorities and LGBTQI+ increase significantly along with cultural and systematic barriers to care. Year 2 MHSOAC survey results also include cost and/or coverage and lack of knowing where to go for help as a barrier. A recent increase in disparities among diverse TAY is due to the separation of families, primarily of Latino descent, occurring at the US-Mexico border. [1]
- Longitudinal studies suggested that it is best to target and reduce mental health disparities among youth as early as possible as 50% of individuals with mental illness express symptoms by age 14. Educating schools and medical primary care providers on symptoms, treatments, resources, support groups, and youth interventions is necessary to improve access to care for youth of color and low-income youth. [1]

## LITERATURE REVIEW

### Mental Health in Criminal/Juvenile Justice System

Due to a lack of data, it is difficult to obtain accurate data on the impacts and challenges faced by diverse communities regarding their encounters with law enforcement. In 2015, CA's legislature passed the Racial and Identity Profiling Act (AB 953) requiring law enforcement agencies to collect and record data on all initial police interactions with the public, including reason, location, race/ethnicity, gender, and age. However, this data will not be available for statewide analysis until 2023. There has been a noticeable racial disparity in arrests and placement in the system in CA. [1]

In 2016, 41% of all arrests in CA were identified as Latino which are most overrepresented and have most commonly been arrested in the past decade. 16.3% of arrests were identified as African American, 16.9% as others, and 39% were identified as LGBTQI+. African Americans are 3.6 times more likely than whites/Caucasians to be arrested, convicted; and experience more lengthy prison sentences. Additional data concluded that LGBTQI+ individuals are disproportionately impacted within the system; nearly 30% of LGB prisoners were placed in restrictive housing compared to 18% of non-LGB inmates. [1]

Despite the limited data, criminal justice systems face significant disparities in addressing the mental health needs of underserved communities who have been incarcerated. A study revealed that currently 15% of state and federal prisoners and 26% of jail inmates reported experiencing serious psychological distress (SPD). Treatment for SMIs such as bipolar disorder or schizophrenia in incarcerated settings is costly and challenging; however, without treatment mental health conditions can linger or worsen, increasing the likelihood of further involvement in the criminal justice system for individuals without care. Moreover, upon release from incarceration, individuals with behavioral health issues such as addiction or SMI face many barriers to successful reentry into the community, such as lack of health care, job skills, education, stable housing, and poor connection with community behavioral health providers, which may jeopardize their recovery and increase probability of relapse and re-arrest. [1]

Regarding the juvenile justice system, although the rate of incarceration (5.3%) for youth in CA has been declining, the disparities that youth faces from imprisonment are more severe. Youth with severe mental/ emotional distress are disproportionately placed in solitary confinement which can negatively influence development and increase risk of suicide. Youth in custody have a four times greater risk of suicide than their youth who have mental illness but not incarcerated. Out of all youth who faced incarceration, 65%-70% have a mental health condition. Those typically ended up imprisoned due to lack of mental health resources and shelter. [1] Furthermore, at least 75% of TAY in the system experienced traumatic victimization, plus 93% reported exposure to hostile childhood experiences including child abuse, family, community violence, and serious illness.[3–5]

Providing ample, culturally appropriate resources such as training to law enforcement to properly respond to individuals with mental illnesses, links and warm hand-offs from provider to each individual post-incarceration, using evidence-based assessments to ensure correct treatment and support would prevent the increasing rate of imprisonment of individuals with mental illness. [1] Furthermore, placing individuals and youth with SMI in a culturally appropriate community based mental health care would help reduce and prevent unnecessary involvement in the juvenile and criminal justice system.[6]

### Housing/Homelessness

Recent point-in-time data show that CA has approximately 151,278 individuals experiencing homelessness on any given day.[7] California also has the highest number of homelessness by population at 33 per 10,000 individuals.[8] Out of the total estimate, 7,044 were family households, 10,980 were veterans, 11,993 were unaccompanied TAY, and 41,557 were individuals experiencing chronic homelessness.[9,10]

According to the National Institute of Mental Health (NIMH), 30-35% of the total US homeless population have a mental illness, 25% have a SMI, and about 25% suffer most commonly from concurrent disorders such as depression and bipolar disorder, schizophrenia, anxiety disorders and substance abuse disorders. [1] In CA 76% of individuals experience homelessness were reported and observed to be affected by mental illness or substance abuse contrary to agencies reporting only 29%. This provides insight on the lack of accurate data on the access for mental health care needed for individuals experiencing homelessness with SMI.[11] Homelessness and mental illnesses are connected as a bi-directional relationship.

An individual may experience severe mental illnesses without proper treatment or misdiagnosis which makes it difficult for them to maintain daily activities and loss of a home. Experiencing homeless with mental illnesses can influence higher levels of psychiatric distress, higher levels of alcohol use, and decreased chance or perceived recovery. Studies also show that extended time of experiencing homelessness leads to poorer quality of health and increased likeliness of experiencing assault. [1] Rates of mood disorders, suicide attempts, alcohol abuse, physical or sexual abuse, conduct disorders, and post-traumatic disorders are 3 times higher for youth experiencing chronic homelessness.[11,12]

Further, those struggling with homelessness are at a higher risk of engaging with the criminal justice system. Homeless adults with mental illness are more likely to encounter police, courts and/or hospital staff without proper support or treatment. Research indicates that 60% of homeless individuals and families were more likely to improve their mental well-being and overcome other disparities such as poverty with access to stable housing. [1] Research data also affirms than around 10% of individuals who were incarcerated with homeless before arrest; moreover, 51% of homelessness have been incarcerated in their lifetime. These individuals showing significant symptoms of drug and alcohol abuse, had been physically abused or have been through traumatic life-threatening experience.[13]

Providing stable housing with additional supports can help improve mental health disparities for diverse community members experiencing homelessness as well as reduce the number of inpatients of psychiatric hospital and reduce criminalization and stigma. Contrary to popular belief, many people experiencing homelessness and severe mental illnesses are willing to accept treatment and services and many organizations are more successful when workers establish direct relationships. [1]

### Immigration and Mental Health

26.9% of all California residents are immigrants, more than double the percentage of the rest of the US.[14] Major counties in CA report more than one third of their residents are foreign-born. Nearly three in four Californians believe immigrants are a benefit to the state and more than half believe that the state should protect the legal rights of undocumented immigrants separate from the federal policies.

Of the total foreign-born population, about 52% are US citizens, 25% note another legal status, including refugee and asylum-seeker statuses. Data regarding immigrants who are undocumented are not accurate due limited knowledge and self-reported research. According to Center of Migration Studies, only around 23% have reported as undocumented immigrants. 50% of immigrants in CA are from Latin America, 40% are from Asia. Recent data suggests that more than 56% of immigrants have been arriving between the years 2017-2020.[15]

Although immigrants have varied levels of education and occupations levels, they tend to be both overrepresented and underrepresented in prevalence rates of mental illnesses. Immigrants also have high levels of resilience and adaptability when facing acculturation.[14] Many immigrants who have recently arrived already have faced vast stressors such as poverty, discrimination, social isolation, unsafe war grounds, physical harm and more. However, it has been shown that regardless of the stressors, immigrants tend to have higher indicators of resilience in the US and CA.

Despite the resilience, immigrants face a series of gaps and challenges in their new region of area they have traveled to such as acculturation, discrimination, language barriers, lower access to healthcare, isolation, structural barriers, and current political climate policies. In coping with these factors, immigrants have a significantly higher prevalence rate of mental illnesses than their citizen counterparts. The process of acculturation leads to acculturative stress and SMI. Acculturation also plays a significant role in intergenerational differences where the parents and children live in different cultural worlds which can lead to misunderstanding between the generations and cause stressors throughout the immigrant children's lives.[15] In many immigrant communities, mental health education was lacking due to stigma which led to them being reluctant to seek out for help. If the community did reach out for mental health treatment, they faced language barriers, mistrust between professionals and clients, discrimination due to stereotyping, and lack of culturally appropriate services.[16]

Research indicates that mental illness in immigrant communities is complex in subpopulations, so each community is likely to have different needs according to their race, age of when they migrated, social and community support, education, occupation, faith, etc. Many immigrant communities rely on faith-based leaders,

holistic healing organizations such as churches and temples, and their own community to help guide them during their process of acculturation and mental illness. Thus, nurturing relationships and providing mental health education to faith leaders, collaborating with holistic health organizations, and reducing stigma within the community can help reduce mental health disparities for immigrant populations.[17]

Across communities, research indicates nuanced challenges that impact access to care. Data shows that Asian populations do tend to rely and trust a leadership role such as doctors but still won't access treatment due to lack of culturally appropriate professionals they feel familiar with or due to discrimination. Other populations, such as African Americans and Latinx will rely less on doctors and more on faith-based organizations to access help.

Reducing language barriers, training cultural diversity mental health professionals and medical professionals, providing social support, providing intervention and alternative services, developing collaborative care models in treatment, reducing political fear and social stigma are all ways to meet mental health needs for immigrant populations.[14]

## NEEDS OF DIVERSE COMMUNITIES

In the final year of this project, NAMI CA identified that in addition to the need for effectively accessing appropriate services and supports, individuals often experience challenges within the system as it relates to engagement with criminal justice system, housing needs, available crisis care. Through additional engagement on these issues, community members shared their experiences as well as strategies and practices outlining various points of potential intervention for mental health services and supports. However, many of the diverse community engagement efforts were severely impacted as a result of the COVID-19 pandemic. While re-imagined and revised activities have been possible through numerous online and virtual platforms, there is still a lack of engagement with those impacted by the "digital divide" – those without access to the digital tools and supports, computers, smartphones, etc. that often disproportionately impact diverse community members. NAMI CA would like to recognize the efforts of many local NAMI affiliates to continue to reach these individuals and provide support through these trying times.

### Prevention and Early Intervention

There is a serious need for prevention and early intervention among diverse communities. The statewide survey presented respondents with two questions pertaining to their ages at time of first symptoms and at time of correct diagnosis.

- Although, 64% of individuals first experienced symptoms of mental illness before the age of 21, only 21% of individuals received a correct diagnosis before the age of 21.

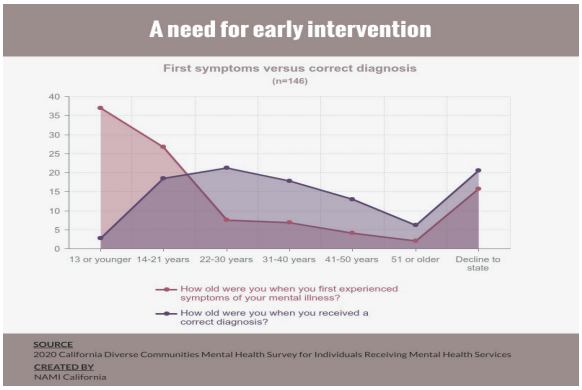



*Figure 3*

Phase one is the earliest intervention exists at the level of prevention through community-based partnerships (schools, etc.). This may include emotional well-being courses in elementary school and early resilience and empowerment programs youth.

Phase two, or early intervention before the on-set of symptoms, requires that individuals be aware of warning signs. It also involves mental health education for all so that individuals know when someone is at higher risk for mental illness (considering family history, adverse childhood experiences, etc.).

Phase three, early intervention at the immediate on-set of symptoms, requires that individuals be aware of early symptoms of mental illnesses and know immediate next steps and readily available resources. According to the WHO, mental health conditions start by age 14 in 50% of those afflicted.

During Phase four symptoms may go untreated for a variety of reasons. In diverse communities, this could be due to cultural stigma, fear of discrimination, lack of understanding, lack of culturally appropriate care, etc. At this point, symptoms may begin to interfere with someone's daily life activities or routine (e.g., work, school).

If individuals do not receive care by this point, it sometimes escalates to moments of crisis.

Phase five includes the need for crisis care. Crises vary from person to person, but may involve encounters with law enforcement, the juvenile or criminal justice system, self-harm, or psychiatric holds. After crisis, a clear issue comes to light, maybe even a first-time diagnosis where someone may or may not be linked to care or treatment. At this time, family, primary care providers, mental health providers, lawyers, and more may become involved. There is also opportunity for continued engagement and intervention during treatment when an individual is receiving care and following a treatment plan that consists of unique components. The treatment team may or may not be incorporating whole-person care.

Finally, through recovery, individuals need continued mental health support and services. Here individuals are balancing the pillars of recovery - health, home, purpose, or community (Figure 3).

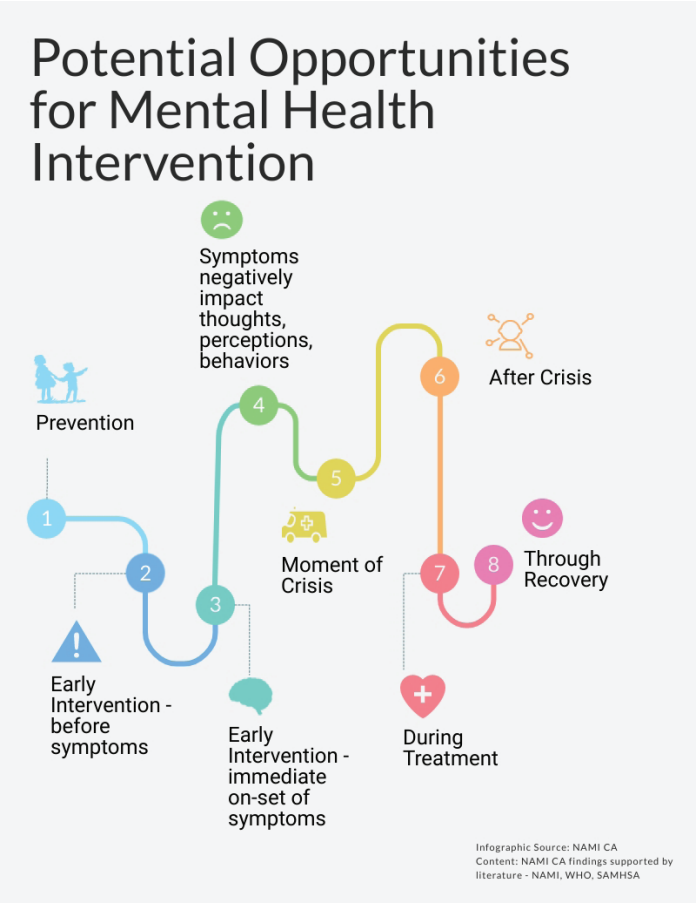
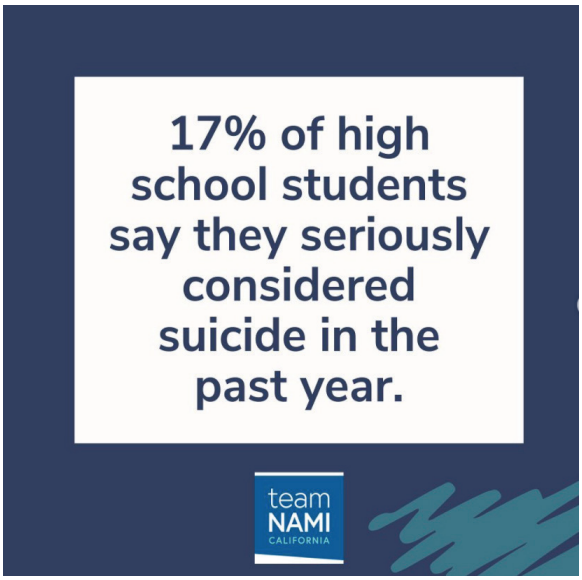
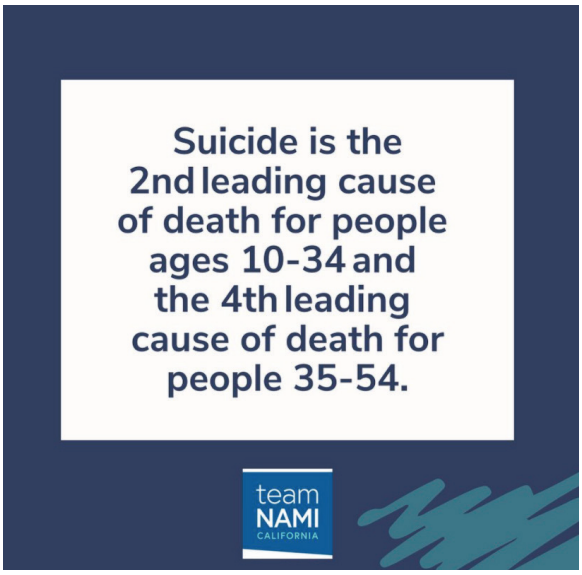



*Figure 4*

*Suicide Prevention*




*Youth Suicidality*




*Rates of suicide*

At a community forum, one participant shared that her seven-year-old child had attempted suicide. This is unacceptable and further supports the idea that it is never too early to begin conversations around prevention and the realities of mental illness and SMI. According to the University of California, Davis Center for Reducing Health Disparities, mental illness is the number one cause of lost wages and missed workdays, it is the number one most costly biomedical problem and most underfunded biomedical area. Many of the participants across gatherings and surveys reported wanting more supportive services for the youth in their families.

"Better quality inpatient for teens, and also those with serious mental health issues. More community support for groups. NAMI groups are for serious issues and there is a need for parent support for teens with depression."

*- Diverse Communities Mental Health Survey Respondent*

Additionally, CRHD reports that mental illness is the number one cause of injury deaths (suicide). In the survey, when asked to rate the types of mental health care services available, very few individuals under the age of 25 responded to the question indicating a lack of accessing health services. From the current literature and previous findings, this is due, in large part, to public and self-stigma, cost or lack of access/insurance. However, respondents under 25 rated peer or family support and campus organizations/CBO's such as NAMI or NAMI On-Campus as "excellent."

"These are programs that helped me get through and receive the proper care that I needed."

*- Diverse Communities Mental Health Survey Respondent*

"Peer support and nonprofits are the most useful services for me."

*– Diverse Communities Mental Health Survey Respondent*

Given these recent findings and the troubling increase in suicides among diverse communities in the state and in younger populations, many public health leaders are springing into action to mitigate this growing crisis. The pandemic has only exacerbated feelings of depression and anxiety and thoughts of suicide. NAMI CA must continue the momentum that has been accumulating across disciplines and combine early intervention, stigma reduction, and decreasing barriers to mental health care access for suicide prevention.

"We have a suicide prevention crisis team that has a high degree of professionalism in documenting outcomes and recruiting and training volunteers."

*– Diverse Communities Mental Health Survey Respondent*

"Suicide Hot Line has been a huge resource."

*– Diverse Communities Mental Health Survey Respondent*

"Having an understanding community for support is extremely helpful, as many people ignore the signs and don't know how to help."

*– Suicide Prevention Community Voices Respondent*

### *The Criminal Justice System and Mental Health*

One of the previous findings echoed throughout the first two years of this project was the persistent criminalization of mental illness and encounters with law enforcement and the juvenile and criminal justice system for all individuals with mental illness and SMI. Moreover, it is important to highlight that diverse racial and ethnic populations also reported experiencing negative encounters with law enforcement and this system at higher rates through focus groups and open-ended survey questions. Thus, it is of critical importance to designate additional efforts and resources into the first four potential points for interventions for diverse communities in order to reach individuals before a crisis occurs (Figure 3).

"I was told by my son's PD while going to court that if he had been White, he would have been going home."

*- Diverse Communities Mental Health Survey Respondent*

"Police were trained to approach individuals as human beings. Not all people are criminals. But they treat Black people less than, they always have as long as I have been here on this earth. WE ARE NOT TREATED THE SAME!!!"

*- Diverse Communities Mental Health Survey Respondent*

In the statewide survey, NAMI CA posed questions on this topic and found that less than half of all respondents chose to answer this set of questions regarding police encounters. However, over half of the respondents disclosed that they have encountered police interaction during a crisis.

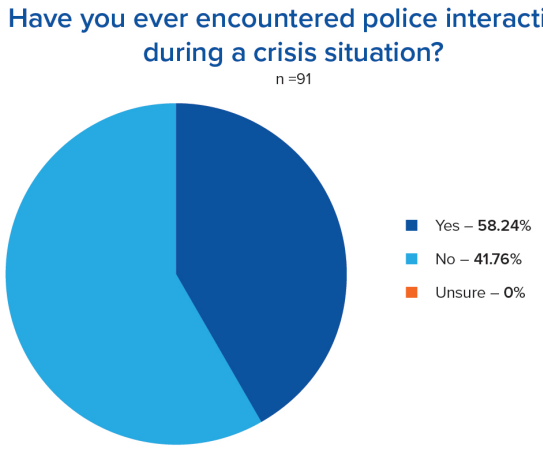



*Figure 5*

Survey results indicate that of the 58% who have encountered police interaction:

- 29% reported that the police team had mental health training or trained crisis responders.
- 38% said the police team did not have mental health training or trained crisis responders.
- 33% said they were unsure.

Within those encounters,

- 64% of respondents shared that they did not feel supported or were unsure whether they felt supported.

"Being spoken to in a calm voice instead of yelling and pointing, it makes things to be very stressful and confusing."

*- Diverse Communities Mental Health Survey Respondent*

- 37% reported feeling supported through the experience.

**When encountering police interaction during a Mental Health crisis, did you feel supported through the experience?**

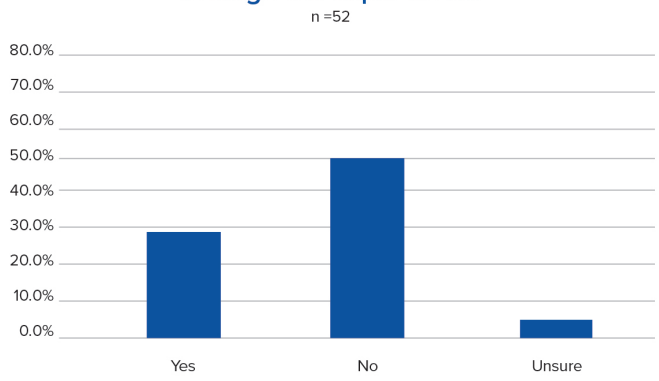



*Figure 6*

Many respondents shared their recommendations for how crisis experiences could be improved and mitigated for those with mental illness and SMI. Ultimately, the overall feeling from peers and family members is that there are opportunities for crisis situations to not be escalated at all to the point of the juvenile and criminal justice systems. Instead, these individuals should be immediately linked to mental health care and treatment that is culturally appropriate and works for them.

"But I do believe that crisis response, emergency crisis response services should not be in the hands of law enforcement because it begins to immediately criminalize a person who may be in a psychiatric crisis and then it turns into something criminal because they are law enforcement. They are not clinicians. They are not peer or family specialists who are, who have additional training to de-escalate certain situations."

*- Online Diverse Communities Focus Group Participant*

"Emergency crisis responsiveness should not be under law enforcement because it criminalizes the situation and mental health."

*-Diverse Communities Mental Health Survey Respondent*

"Law enforcement kept making determination, not the clinician- on the phone can't make decision to admit someone into the hospital."

*- Diverse Communities Mental Health Survey Respondent*

Additionally, respondents shared some of their experiences after initial encounters with law enforcement that led to an arrest or incarceration. Issues persisted throughout the entire process and ultimately, once it had escalated, they were not given autonomy of their treatments or recovery journey's.

"I didn't get any help until after a conviction that I tried to withdraw and it was late in the process it seemed condescending when I was transferred to mental health clinic which then subjected me to mandatory treatment with only local providers and refused to allow me to seek treatment in a facility outside of the state for a short intensive program, I was then told I wasn't doing enough even though all requirements were met and had gone above the stipulations in seeking better treatment options was sentenced for contempt of court for a 30 day mandatory sentence."

*- Diverse Communities Mental Health Survey Respondent*

"They broke my glasses, dislocated my shoulder when they handcuffed me, took me to a hospital that didn't want me and then said I " made them" take me there. Then I was transported by more cops to another hospital. I was handcuffed the whole time. I can't walk without crutches, but no one believed me, so I fell, and they yelled at me."

*- Diverse Communities Mental Health Survey Respondent*

### *Housing*

Throughout all of the qualitative and quantitative findings across populations, housing is a critical issue. Secure housing is recognized as such by many leading mental health organizations and agencies and research professionals as a key component of supporting recovery. 7% of survey respondents said they experienced

homelessness (n=141). Additionally, many diverse community members shared a concern that their loved one with SMI does not have secure housing or cannot find any type of residential care as they are experiencing less availability. Many participants shared the known importance based on their own lived experiences as a peer or family member or as those who work with individuals with SMI. They also discussed how the current pandemic is exacerbating the issue.

"We need housing. Assisted or Independent-we need housing."

*- Diverse Communities Mental Health Survey Respondent*

"Needs of the homeless. We are going to face critical issues with COVID-19."

*- Mental Health Survey Respondent*

CA is experiencing a housing crisis that is creating severe challenges for state residents and puts diverse communities and those with SMI at much higher risk. NAMI CA engaged in many conversations with state and local leaders including legislators. Senator Scott Wiener shared that in a state of 40 million residents, there is only construction underway to build 100,000 housing units; creating a profound deficit of 2.5 to 3.5 million houses. There are deep structural barriers that get in the way of providing those with SMI with supportive housing. In San Diego, where CBO's are seeing many immigrant communities – refugee, asylum-seekers, and undocumented individuals in need of mental health services – struggling to find the shelter they need for themselves and their families because the demand is too great.

"Shelters available are full; there is a 3-4-week waitlist to get folks into shelter. [They] lose health insurance that they had when they lose employment, and it is very hard for this community to get another job."

*- Immigrant Communities Focus Group Participant*

Furthermore, information was shared about how CBO's, faith-based organizations, and private organizations throughout the state have been working to fill these gaps and the critical needs in many communities. Many voiced frustration that tax dollars never seem to make it all the way to families experiencing homelessness.

"I am a case worker in Orange County. A single parent with small children are expected to be on the street BEFORE they qualify for housing resource support and section 8 housing has a 5-year waitlist. Churches and private organizations are the only places I've found support."

*- Housing Forum Participant*

"If I could just come back to COVID for a minute just to point out the heroism, a quiet heroism, that is happening in all the residential programs around the state: Mental Health Association, the halfway houses, the social rehab's that still have to come to work every day."

*- Ian Adamson, Executive Administrator, Mateo Lodge*

### *Immigrant Experiences*


*Q Le & JR Kuo Multicultural Symposium Presentation*

Many of the events held throughout the year highlighted immigrant experiences. Q Le and JR Kuo received many questions during their discussion session at regional symposium asking about the current barriers these communities face and tangible action steps for overcoming those barriers. In the NAMI CA 2020 mental health survey for diverse communities, 14% of survey respondents identified as immigrants (regardless of documentation status). Additionally, in the 2020 mental health survey for family members/caregivers supporting someone with a mental health condition, 6% identified as immigrants (n=694). These experiences are impacted by many factors, including immigration status, access to health care coverage, and place of work during the current pandemic.

"I'm an un/documented immigrant seeking asylum, and I ran away from my country having a lot of stress & bad experiences there, so I need counseling that is culturally understanding, and free." -Diverse Communities Mental Health Survey Respondent

Engagement with immigrant/refugee communities was conducted largely through partnering agencies. NAMI CA conducted one focus group, a "Community Gathering Session" in San Diego demonstrated the difficulties in

engaging with such a vulnerable population. Outreach was intentionally limited to ensure a safe space for this specific population and handled by partner organizations, so individuals received the invitation from agencies they trusted. Partnering organizations for this focus group were Jewish Family Services, Survivors of Torture, Nile Sisters, & Immigration Justice Project. Unfortunately, there were only six attendees, all of which were leadership from the partnering organizations; none of the attendees were community members. This was an important note for us to discuss as it demonstrated the real difficulty faced by unknown organizations in accessing this population. Even when the outreach came from known organizations, there were still undeniable barriers to engagement: fear, immigration status, lack of childcare, travel to site, etc. These agencies and CBO's that work directly with these populations have success because they have developed trust within the community, have staff and volunteers with similar backgrounds, and they incorporate faith, spirituality, and overall, culturally and linguistically appropriate services and resources. It is critical that the MHSOAC and other funding entities look to these CBO leaders and continue to support them fiscally because these are the types of services and best practices reaching this largely underserved populations (See Appendix C).

"We provide direct services and we come from other countries like them and we know them and their struggle, so they feel more comfortable to disclose these issues."

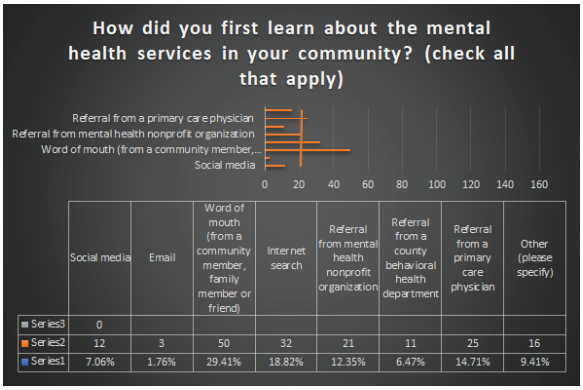
***-Elizabeth Lou, Nile Sisters Founder & CEO, San Diego Immigrant Population Focus Group***

"There is a big issue right now with over 4,000 deported US veterans who served this country – because of DUI or other minor issues/misdemeanors get sent to Tijuana and Ensenada even though they are not from there – many are from Peru and Central America. They rely on state hospitals and private therapists who are willing to take on the long patient histories. They feel very abandoned."

***- Yuliana Gallegos-Rodriguez, PhD, NAMI San Diego Board Member, San Diego Immigrant Population Focus Group***

### *Intersectionality, Stigma, and Discrimination*

Through ongoing engagement efforts, participants shared that finding a unique and trusted community that understood their mental health needs was a critical component to seeking and receiving services. Some described that while they had some community that understood (including their own families, friends, faith groups, and NAMI groups), others shared that they did not have a supportive community. Survey results reported 29% of respondents shared that they first learned about local mental health services available through word of mouth (community member, family, friend). Further, 26% of respondents that shared that they first learned about these services on their own through an internet search or social media.




| | Social media | Email | Word of mouth (from a community member, family member or friend) | Internet search | Referral from mental health nonprofit organization | Referral from a county behavioral health department | Referral from a primary care physician | Other (please specify) |
|---|---|---|---|---|---|---|---|---|
| Series3 | 0 | | | | | | | |
| Series2 | 12 | 3 | 50 | 32 | 21 | 11 | 25 | 16 |
| Series1 | 7.06% | 1.76% | 29.41% | 18.82% | 12.35% | 6.47% | 14.71% | 9.41% |

*Figure 7*

Many diverse community members also shared about the impact of the role of intersectionality on their mental health experiences. Individuals revealed the deep layers of stigma and discrimination that built up based on their various identities - including cultural background, sexual orientation, gender identity, and more. This builds up in addition to the public and self-stigma experienced as a result of their own mental illness or illnesses.

Survey questions designed to help identify and better understand these specific experiences showed:

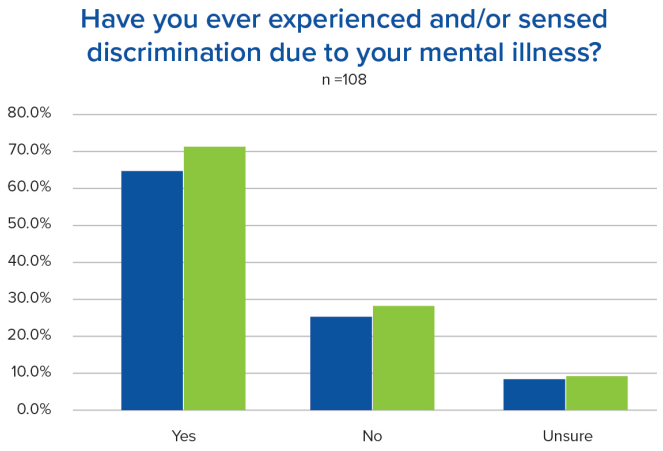



*Figure 8*

- 66% of respondents shared that they have experienced or sensed discrimination due to their mental illness.
  - 21% said they experienced this discrimination from society in general
  - 19% from community
  - 17% from family
  - 17% from employer
  - 10% from school/district staff
- Notably, 15% of respondents experienced this discrimination from a mental health care provider as well.
- Only 31% of respondents reported never having experienced discrimination during interactions with mental health care workers, including clinic receptionists, social workers, case managers, therapists, psychiatrists, and other staff members.
- When asked to rank topics from highest concern to lowest concern when accessing care, "stigma and discrimination" was ranked 3rd highest concern after "cost of services with insurance" and "wait time for appointments with providers" (n=106).

Furthermore, while accessing mental health care treatment and services, most individuals also reported experiencing discrimination regarding their socioeconomic status, physical appearance, cultural background, sexual orientation, and racial/ethnic identity. Less also reported experiencing discrimination based on their linguistic needs and gender identity.

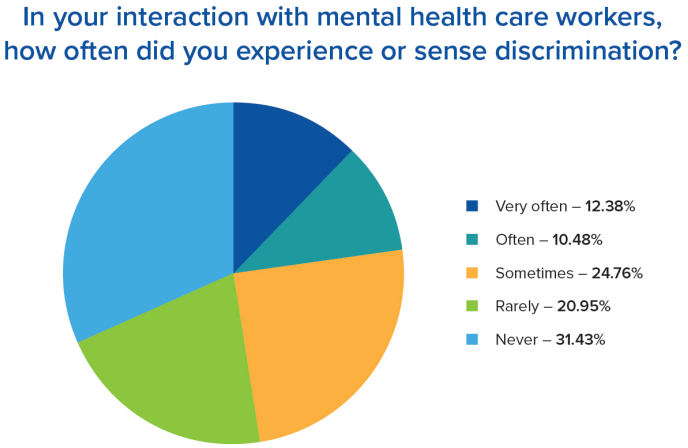



*Figure 9*

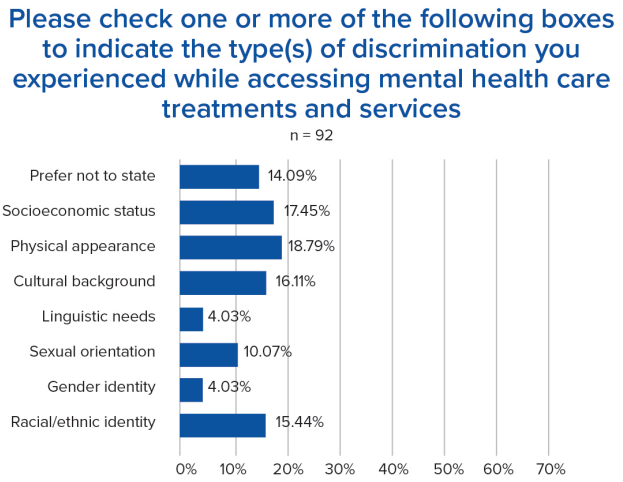



*Figure 10*

NAMI CA's mental health survey also asked open-ended questions to give individuals an opportunity to give more details, if they felt comfortable, regarding their responses to the two survey questions above and the discrimination they experienced.

| | |
|---|---|
| "I was discriminated against by counselors because of my cultural background, as I was expelled from university and confidentiality was broken." | "In society in general; not sure about the reason, mental health or other. I am tired of being called by a slur, having to do with sexual orientation." |
| "I was not included in therapy groups when I complained about appointments been cancelled without notice. (Meanwhile, I was receiving medication). Anyway, I kept waiting, and waiting and finally one year went through and when I requested explanations, I was informed I had been cancelled all services due to time gone by even though I was receiving meds and I kept asking for group therapy." | "Doctors, nurses and therapists lack the ability to give information about illness, treat patients with patience and compassion, and give relevant or helpful discharge plans. I was identified in my psych hospital medical records (I requested them) as "homeless" even though I had private insurance through my employers." |

*Table 2*

Respondents also discussed the impacts of public stigma and discrimination and how those experiences have influenced other parts of their lives including self-stigma and their future health-seeking behaviors. It is a huge steppingstone when someone with any mental illness and especially with SMI decides to take the next step and seek the help and support they deserve. Yet, often these diverse communities are met with this type of discrimination. One participant shared that it becomes exhausting to try and find a provider that understands and respects them and that will not discriminate while they are seeking necessary services.

"It is very difficult to seek help (therapy) when not enough providers look like me and/or can understand my experiences. When people have a better understanding, everyone feels better. Unfortunately, this takes time when sharing with complete strangers and TIME is what we don't have enough of including lack of providers. It becomes exhausting when seeking services and going through the many hurdles in CA healthcare system."

*- Diverse Communities Mental Health Survey Respondent*

## COMMUNITY-INFORMED RECOMMENDATIONS

Prior community engagement efforts were focused on community needs, challenges and barriers faced in the public mental health system, and issues that prevented individuals from accessing services. Previous recommendations included accessibility, holistic care, cultural responsiveness, quality of care, care for providers, affordability, and language assistance. This year, efforts were focused on better understanding what is currently working for individuals and their families across the state, identifying best practices and successes that contribute to positive health outcomes for historically underserved communities. Overall, these recommendations come directly from the community and highlight the importance of cultural responsiveness across the following:

### Recovery – increased and appropriate family education/ involvement

Peers across the state shared their own unique definitions of recovery. The four key pillars to recovery are home, health, community, and purpose. Within community exists the role of support from family and loved ones. Many of the survey respondents shared that they wanted family involvement to be on their terms. A large majority also shared that their families lack understanding and awareness and stressed that families should be more educated around their mental illnesses before trying to be involved. NAMI programs equip family members and loved ones with knowledge and tools for how to best work with their loved ones and positively support recovery.

"Needs to be more education for families (NAMI/family integration) to better support loved ones. [Example] Whole person care in Riverside County – hospitals & treatment centers that integrated family and conducted meetings with the whole treatment team."

*- Diverse Communities Mental Health Survey Respondent*

"I don't want them involved in anything that has to do with my mental health, but if they were, I would want them to be more understanding."

*- Diverse Communities Mental Health Survey Respondent*

### Peer Support/Peer Certification


*FPSS NAMI CA & NAMI San Diego Trainers*

Navigating the mental health care system can be challenging and sometimes disheartening for individuals living with mental illness and more so for diverse communities who worry about providers not understanding or respecting parts of their identities. Often, peers will turn to someone who has a similar lived experience. Peer Support Specialists are individuals that have been through the mental health system, know how to identify resources, and how to navigate crisis and recovery and can offer the type of support that is needed for families and individuals.

NAMI CA and local affiliates provide year-round opportunities for Family and Peer Support Specialist (FPSS) Trainings Program, funded by the Office of Statewide Health Planning and Development. This program offers individuals career counseling and support with job placement.

"It would be great to have Peer Specialists who are really a great support for those with a mental health diagnosis. We could talk with someone without feeling judged, someone who is not analyzing everything we say."

*- Diverse Communities Mental Health Survey Respondent*

Further, NAMI CA has been a long-standing advocate for Peer Certification, a nearly 10-year journey in California. Finally signed into law in 2020, the passage of SB 803 will create a Peer Support Certification program in California. NAMI CA is thrilled to support the implementation of SB 803 and will work with counties and affiliates to ensure implementation includes individuals and family members as a part of all programming.

### Stigma Reduction

Overall stigma reduction is vastly critical to the advancement of mental health for all diverse communities. Successful stigma reduction campaigns have been shown to increase health-seeking behaviors. Stigma reduction also has the potential to mitigate increasing suicide rates, low rates of accessing care, and self-stigma that impacts various aspects of life (i.e. job, housing, etc.). Reducing community and public stigma could also increase the amount of youth that go into the public mental health system to serve as providers. NAMI CA is currently studying the effectiveness of a mental health education and stigma reduction program, Mental Health 101, and its impact on Catholic Latinos through a project funded by the RAND Corporation.

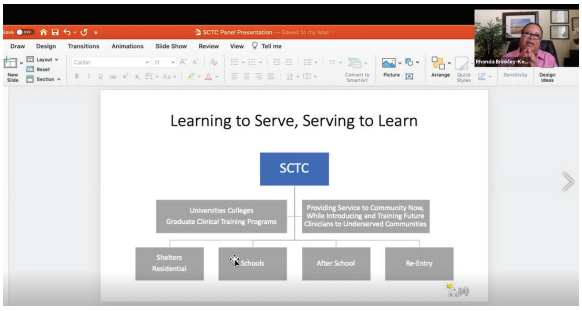
"[A challenge faced by diverse communities when it comes to mental health is] stigma, lack of knowledge about services and culturally inviting programs."

*- Challenges Community Voices Respondent*

"Our communities don't even have a word for stigma, but it is really just shame."

*- Focus Group Participant*

### Workforce Expansion (including culturally & linguistically diverse providers)




*Rhonda Brinkley-Kennedy Multicultural Symposium Presentation*

Addressing workforce expansion is addressing a key systemic barrier that many diverse communities face. Individuals who identified as one or more of the following diverse identities, youth, LGBTQI+, or diverse racial/ethnic populations – expressed a desire to access services that were culturally and linguistically appropriate. They expressed a desire for peer support and traditional

services outside of the mental health care system because of a clear lack of representation in mental healthcare providers. First, acknowledgement of historical oppression and structural violence within the system must be addressed (e.g. history of sexual orientation and gender identity in psychiatry diagnosis, forms of oppression of indigenous communities).

NAMI CA's FPSS program strives to recruit individuals of diverse backgrounds and NAMI CA's cultural competence training strives to educate current providers to fill the gap while more meaningful strides are made for increasing diverse communities within the workforce. At this year's virtual Multicultural Symposium, Dr. Rhonda Brinkley-Kennedy discussed how the South Central Training Consortium provides meaningful opportunities and accessible trainings programs to all individuals seeking to provide direct clinical services to underserved communities.

"What is important thing to me in regard to elements of health care needs, I would say having providers that looked like me, African Americans or Black. Or at least having providers that understand our plight and understand, you know, all the ways which, you know, I have to navigate day-to-day life ensembles, you know, systemic issues."

*- Diverse Communities Online Focus Group Participant*

### Traditional/Cultural Methods of Health Care

Throughout this project, NAMI CA has engaged with leadership across the state who are moving the needle forward by offering culturally appropriate services that take into consideration culture, language, religion, and other backgrounds that are key to an individual's identity (See Appendix C). Many participants shared that these components must be included to make healing and recovery possible for many of them and their loved ones. This includes the use of trained community "Promotoras" or lay community health workers among many Latinx and Indigenous populations. It is vital that programs and services "meet" communities where they are, including community food pantries, faith-based organizations, Child Protective Services, social media, etc.

NAMI CA strongly believes that diversity is the biggest strength of programs, services, and supports. Many NAMI CA programs have been adapted to meet those cultural needs, including the creation of Mental Health 101 for Diverse Communities and the Cultural and Linguistic Responsiveness Toolkit which shared community voices and aimed to give tools for better understanding cultural context and implementation.

"Traditional methods of healing like limpias (cleanings) or use of herbs in treatment plans especially for Latinx community."

*- Diverse Communities Online Focus Group Participant*

"Emphasize the importance of using like local healers and like a spiritual leader and just because you need to use the faith-based community."

*- Diverse Communities Online Focus Group Participant*

### Innovative programs – including Prevention and Early Intervention (PEI)

*Conversation with Surgeon General, Dr. Nadine Burke Harris*

Feedback and information gathered from diverse communities indivates that PEI is of critical importance and sets the foundation for the services needed to thrive and recover. Dr. Nadine Burke Harris, CA Surgeon General has also indicated the true importance of early intervention especially in regard to adverse childhood experiences (ACES) and early serious emotional disturbances and has centered many of her projects around addressing these issues. Furthermore, NAMI CA would be remiss not to acknowledge the harm that has come to many diverse communities while seeking services and during crisis intervention. LGBTQI+, diverse racial/ethnic populations, and youth already face stereotypes and discrimination associated with their identity and those with mental illness suffer twofold, or more at the hands of systems that historically and currently oppress them. These communities share their needs loud and clear, in order to keep themselves safe, mental illness must be addressed as early as possible before they experience increased encounters with law enforcement and the juvenile/criminal justice system which puts folks at higher risk for experiencing homelessness.

NAMI CA offers an array of PEI programming and will continue to partner with mental health agencies that have innovative programs like early school-based resilience and cultural history programs. NAMI CA recognizes the importance of crisis care, while also pushing for the advancement of PEI as it relates to early serious emotional disturbances and ACES.

"Mandatory Mental Health courses in schools featuring: emotions (what are they/how do they effect people), self-care (not just self-pampering but true self-care), how to journal (making sure to keep track of emotions/medications/activities/goals/etc.), appropriate aged materials on mental illnesses/disabilities (most common), how people can coping/coping skills/breathing exercises, socializing, anger management, importance of creative works - can be combined with other courses as well such as English, art/paint, music/band, dance, creative writing, journalism, etc., basic medication overviews, how to find help w/all of the hotlines"

*- Diverse Communities Mental Health Survey Respondent*

"I would love to see expanded access to crisis mental health services and prevention/intervention services in schools as these programs were cut/reduced in my county."

*- Diverse Communities Mental Health Survey Respondent*

## BEST PRACTICES IN THE MENTAL HEALTH CARE SYSTEM AS DEFINED BY DIVERSE COMMUNITIES

While this project focused on better understanding of the needs and challenges of communities, increasing access and building capacity of systems, it is important to recognize the success and positive feedback that was gathered from participants throughout community engagement efforts.

| PEER SUPPORT | |
|---|---|
|  | "I think one of the things that I found very beneficial was having people with lived experience. So, people who have mental illness being involved in my treatment team. To have not only your psychiatrist in your therapist and a caseworker, but someone who's been trained and behavioral health care services that also can advocate with you who has experienced things that you've experienced, and maybe help you to filter them or comfortable, or an almost kinda like, relate to a therapist a little bit better."<br>*- Diverse Communities Mental Health Survey Respondent* |
| | "Peer support has contributed greatly to my recovery, as have crisis services and the support of organizations such as my local NAMI affiliate."<br>*- Diverse Communities Mental Health Survey Respondent* |
| **TELEHEATLH (ESPECIALLY DURING COVID-19)** | |
|  | "Telecare, because some of us have challenges with getting to appointments, travel, childcare, work, etc. It would be most cost effective and beneficial to access care through phone or video in order to overcome those obstacles."<br>*- Diverse Communities Mental Health Survey Respondent* |
| | "We have had to switch all of our services to telehealth. [During COVID] some places just stopped answering their phones so I am very grateful to the ones that offer telehealth."<br>*-Community Listening Session Participant* |
| **COMMUNITY-BASED PROGRAMS AND SERVICES** | |
|  | "Berkeley has a place called creative wellness center where people can do art, go to yoga, buy lunch. It's people with diagnosis, and regular people, not just people who can't live on their own. All kinds of people. Why can't everywhere have a place like that with classes and art for mentally I'll people to be with friends of all kinds of abilities. People with jobs to people in group homes."<br>*-Diverse Communities Mental Health Survey Respondent* |
| | "When I discovered NAMI, I took their Peer to Peer classes which helped me learn more about self-care, and through them I also learned of ways to get more involved in my community to spread mental health awareness."<br>*- Diverse Communities Mental Health Survey Respondent* |
| **RECOVERY AND POSITIVE FAMILY SUPPORT** | |
|  | "I am so thankful that my partner is willing and able to be included in as much or little of my treatment as I want him to be."<br>*- Diverse Communities Mental Health Survey Respondent* |
| | "And the biggest, the biggest thing that really helps me. It's just, you know, surrounding myself with people who love and care about me, and it kind of helps, you know, that transition of always growing and always trying to better yourself and not, you know, letting your mental illness own you."<br>*- Diverse Communities Online Focus Group Participant* |
| **TRADITIONAL METHODS OF HEALING** | |
|  | "I practice meditation. I do yoga. So, all kinds of things that I'm incorporating into, what's happening at the clinical setting, sadly, I don't have a lot of expectations that I'm going to receive the help that I need. If I stick to the traditional Western clinical setting, I mean, I just had to realize that. I had to incorporate other elements."<br>*- Diverse Communities Online Focus Group Participant* |
| | "Whole Health Care is also being done with VA psychosis clinic. Recovery plan is often person-centered, but they are moving toward an option to include family, church, nonprofit, or community of choice to involve them further into the patient's treatment and plan. This works especially well with high-risk for suicide."<br>*-San Diego Focus Group Attendee* |

*Table 2*

# CONCLUSION

Through this project, NAMI CA worked with individuals and communities across the state to increase understanding of the needs and importance of individuals involvement in the overall design and implementation of mental health programs, supports, and services. While NAMI CA has been working with communities for more than 40 years, the landscape of the system has changed greatly over time. It is critical that agencies and entities take the time to hear from families and individuals to ensure the relevant and timely issues that impact families are identified early and often.

NAMI CA remains committed to the improvement of the mental health system in California to ensure increased access to appropriate services and supports for all individuals and families impacted by mental health and mental illness. However, it is important to acknowledge the unique risks and strengths of each community especially those from vulnerable, un/underserved diverse communities.

The feedback and information shared by individuals across the state provided a better understanding and a deeper dive into exploring the challenges and barriers in accessing and receiving care as well the best/emerging community-defined practices that work for diverse populations. It is the inclusion and support for grassroots, community-based organizations that practice trauma-informed and culturally appropriate services and program that are extremely beneficial for communities, especially for youth. Additionally, many communities are feeling the overwhelming impact of COVID-19 and continued racial trauma on communities of color, veteran, LGBTQI+, older adults, and TAY. As NAMI CA moves forward, the focus will be around actionable, sustainable solutions to addressing some of the issues highlighted in this report.

In order to address the needs of communities and populations in need, strategies and solutions must be informed by difficult conversations about how race, ethnicity, and vulnerable populations are impacted by the intersection of economics, employment, housing, the criminal justice system, and issues of mental health and mental illness. Individuals, families, children, and youth of all backgrounds deserve equal access to the proper supports and supports to ensure safe, healthy, and equitable communities.

These findings will have important implications for further mental health research and the development of effective and innovative interventions to addressing the complex needs of individuals living with mental illness. These findings also provide a roadmap for continued advocacy on behalf of communities as priorities and policies can be developed in response to the needs of those across the state. NAMI CA will continue to share these findings to create positive change, advocate for expansion of and increased access to available services and supports, as well as identify strategies to improve the lives of individuals and families across the state.

# APPENDIX A

## DEFINITIONS

**Acculturation:** lifestyle changes of groups of individuals from different cultures and backgrounds whom either combine or completely transfer their culture with the new culture they are getting accustomed to. [1]

**Acculturative Stress:** consists of psychological and social stress experienced due to an incongruence of beliefs, values, and other cultural norms between a person's country of origin and country of reception. This form of stress also may be triggered by perceived feelings of inferiority, "otherness," discrimination, language barriers, undocumented immigration status, or poverty.[18]

**Any Mental Illness (AMI):** a mental, behavioral, or emotional disorder. AMI can vary in impact, ranging from no impairment to mild, moderate, and even severe impairment. [1]

**Black, Indigenous, and People of Color (BIPOC):** emphasizes, more specifically than the term "people of color,". The term represents people of color face varying types of discrimination and prejudice. It raises awareness to systemic racism where it continues to oppress, invalidate, and deeply affect the lives of Black and Indigenous people in ways other people of color may not necessarily experience. It recognizes that Black and Indigenous individuals and communities still bear the impact of slavery and genocide. The term aims to bring to center stage the specific violence, cultural erasure, and discrimination experienced by Black and Indigenous people. It reinforces the fact that not all people of color have the same experience, particularly when it comes to legislation and systemic oppression.[19]

**Communal Health Models:** include interpersonal learning, developing new socializing techniques and universality.

**Consumer:** an individual of any age who is receiving or has received mental health services; also referred to as 'peers.' Some agencies use the term 'client', 'survivor patients', or 'ex-patients' synonymously. [1]

**Criminal Justice System:** a set of legal and social institutions (police enforcement, trial and appellee courts, prosecution and public defender offices, probations, private and public attorneys, custodial institutions, etc.) for enforcing the criminal law in accordance with a defined set of procedural rules and limitations. In the United States, there are separate federal, state, and military criminal justice systems, and each state has separate systems for adults and juveniles.[20]

**Cultural Broker:** a person who acts as a bridge/ mediator between two cultures for the two or more cultures to come to a better understanding, resolve conflict, or make changes in the community. [1]

**Cultural Responsiveness:** Cultural responsiveness is the ability to learn from and relate respectfully with people of your own culture as well as those from other cultures. [1]

**Culturally & Linguistically Appropriate Services (CLAS):** a way to improve the quality of services provided to all individuals to ultimately help achieve health equity. CLAS is about respect and responsiveness. National CLAS standards are 15 action steps. [1]

**Double Stigma:** occurs when a person with mental illness simultaneously experiences more than one type of stigma such as a mental health diagnosis and a physical disability. [1]

**Emotional Emancipation Circles (EEC):** model that promotes inclusivity in all processes highlighting historical, all diversity, environment, and social influences developed by the Association of Black Psychologists in collaboration with the Community Healing Network. [1]

**Family Member:** any individual who is now or ever was in the past the primary caregiver for a child or youth with a serious mental health condition who accessed services, particularly public services, for that condition. Families can include biological, adoptive, grand- or foster parents, siblings, or other kinship caregivers, friends, and others. [1]

**Juvenile Justice System:** including the definition of criminal justice system (above), Juvenile justice is the area of criminal law applicable to persons not old enough to be held responsible for criminal acts. In most states, the age for criminal culpability is set at 18 years. Juvenile law is mainly governed by state law and most states have enacted a juvenile code.[21]

**Homelessness:** People who are living in a place not meant for human habitation, in emergency shelter, in transitional housing, or are exiting an institution where they temporarily resided. People who are losing their primary nighttime residence, which may include a motel or hotel or a doubled up situation, within 14 days and lack resources or support networks to remain in housing. Families with children or unaccompanied youth who are unstably housed and likely to continue in that state. People who are fleeing or attempting to flee domestic violence, have no other residence, and lack the resources or support networks to obtain other permanent housing.[22]

**Immigration:** the act of leaving one's countries and moving to another country of which they are not natives, nor citizens, to settle or reside there. A person who migrates to another country, usually for permanent residence. Immigrants are motivated to leave their countries of citizenship, or habitual residence, for a variety of reasons. Such reasons may include a desire for economic prosperity, to change one's quality of life, better job opportunities, family reunification, retirement, climate or environmentally induced migration, exile, escape from prejudice, conflict or natural disaster.[23]

**Latinx:** a person of Latin American origin or descent (used as a gender-neutral or nonbinary alternative to Latino or Latina). [1]

**Lived Experience:** a person who is employed in a role that requires them to identify as being or having been a mental health consumer or caregiver. [1]

**LGBTQI+:** Abbreviation for Lesbian, Gay, Bisexual, Transgender, Queer/Questioning, Intersex. Term consistent with recent CA policy typically used to refer to the non-heterosexual community as a whole. There are many individuals whose gender or sexual orientation identities fall outside of this acronym. [1]

**Minimally Adequate Treatment (MAT):** involves four or more visits with a health professional in the past 12 months and at least two months of prescribed medication, or at least eight visits of psychotherapy lasting at least 30 minutes in the past 12 months, for the treatment of a serious mental illness. [1]

**Mental Health Services Act (MHSA)**: also known as Proposition 63, is a law that was approved by California voters and took effect on January 1, 2005. MHSA establishes a 1% tax on personal income over $1 million to expand mental health care in California.[24]

**Mental Health Services Oversight and Accountability Commission (MHOAC)**: the role of the MHSOAC is to oversee the implementation of the Mental Health Services Act (MHSA). The MHSOAC is also responsible for developing strategies to overcome stigma. At any time, the MHSOAC may advise the Governor or the Legislature on mental health policy. [1]

**Minority:** racial, religious, ethnic, or social group of individuals who have limited political power and social resources, as well as unequal access to opportunities, benefits, social rewards and status. [1]

**Multiple Marginalization:** when a person experiences the interaction of multiple marginalized identities and thus multiple levels of discrimination; this increases the odds of developing mental health challenges.[25]class, gender, and other marginalizing characteristics that contribute to social identity and affect health. Adverse health effects are thought to occur via social processes including discrimination and structural inequalities (i.e., reduced opportunities for education and income

**Peer Support:** A recovery-oriented treatment model in which individuals provide mental health services in a clinical setting who have received formal peer support provider training and/or certification; as well as having their own lived experience and recovery of a mental health condition. [1]

**Perceived Stigma:** the internalizing by the mental health sufferer of their perceptions of discrimination which involves significant feelings of shame and lead to poorer treatment outcomes. [1]

**Public Mental Health System (PMHS)**: Publicly funded mental health programs/services and entities that are administered by the California Department of Health Care Services, or a California county. PMHS does not include programs and/or services administered by federal, state, county or private correctional entities or programs or services provided in correctional facilities (9 CCR § 3200.253). [1]

**Prevention and Early Intervention (PEI):** program applied in order to engage individuals to avoid occurrences of serious mental illness or serious emotional disturbance and to ease the need for additional mental health treatment by facilitating access to services and supports at the earliest signs of mental health struggles. [1]

**Racial and Ethnic Minorities:** People who identify as African Americans, American Indians and Alaska Natives, Asian Americans and Pacific Islands, and Hispanic/Latino Americans; non-white. [1]

**Recovery**: A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential. [1]

**SAMHSA (Substance Abuse and Mental Health Services Administration)**: the agency within the U.S. Department of Health and Human Services that leads public health efforts to advance the behavioral health of the nation. SAMHSA's mission is to reduce the impact of substance abuse and mental illness on America's communities. [1]

**Serious Mental Illness (SMI):** a mental, behavioral, or emotional disorder resulting in serious functional impairment, which significantly interferes with or limits one or more major life activities. [1]

**Social Stigma:** prejudicial attitudes and discriminating behavior directed towards individuals with mental health problems based on the psychiatric diagnosis they have been given. [1]

**Stakeholder**: an individual or group which has an interest in or is affected by a nonprofit organization and its services. Examples of stakeholders include:

- **Beneficiaries**: People who use the services provided by the nonprofit organization.
- **Donors and Funding Sources**: Those who help fund the operations of the nonprofit organization.
- **Community**: The surrounding community has a stake in how well a nonprofit organization completes its mission and objectives.
- **Employees and Volunteers**: Provides vital services to keep the nonprofit running.
- **Federal, State, and County Administrations**: Government entities require nonprofit organizations to provide various reports in exchange for funding, tax exemption, and tax deductions. [1]

**Stigma:** when someone, or even you yourself, views a person in as a mark of disgrace associated with a circumstance, quality, or person just because they have a mental health condition. [1]

**Transitional Age Youth (TAY):** Term used for individuals or youth between the ages of 16 to 20 years old. *For the purposes of compiling needs for youth, complete youth age statistics in this report include 0 to 20 years old. [1]

# APPENDIX B

## 2020 FOCUS GROUP QUESTIONS FOR DIVERSE COMMUNITIES

1. **Recovery** - Different underserved communities may have different understandings of recovery.
    a. What does recovery mean to you?
    b. What is the most important thing to you in regard to your own mental health care needs and unique treatment plan? (i.e. services, providers, etc.)
2. **Mental Health Care Vision** - There are various community-based organizations, clinics, nonprofits, and community centers who cater services and allocate resources to serve diverse communities.
    a. How would you describe a best practice that understands the needs of your specific community or communities? Have you ever accessed a best practice service?
    b. If yes, describe the impact of these services on you or your community? (How do these services make you or others feel?)
    c. What kind of support do you need to cope and thrive with your mental health condition?
3. **Early Intervention** - Early intervention for teens and young adults can reduce the impacts of mental health conditions on individuals and their loved ones.
    a. Please describe the types of early intervention services that are available in your community. Have you or other community members utilized these services?
    b. What are some of the outcomes of these services?
    c. In your personal experiences, what are the outcomes when early intervention is not available to your community?
4. **Public Mental Health** – Incarceration of persons with mental health conditions has been an intervention for serious mental health conditions for many years due to the lack of in-patient services and the inability of law enforcement to effectively manage mental health crisis situations.
    a. Do you or other community members have experience in the criminal and/or juvenile justice system?
        i. Have you or a community member even been arrested during a crisis situation? If yes, describe the process. (i.e. legal assistance, outcome of court case, etc.)
        ii. What did the person's mental health treatment look like throughout the process?

# APPENDIX C

## MULTICULTURAL SYMPOSIUM TOOLKIT PRESENTERS & TOPICS TABLE

| Event | Presenter | Position/Organization *(at time of presentation)* | Topic of Presentation |
|---|---|---|---|
| 2017 Annual Multi-cultural Symposium | Rachel Guerrero, LCSW | Retired, Chief of the Office of Multicultural Services at the California Department of Mental Health | Keynote - Committing to serving diverse populations in a culturally competent manner. |
| 2017 Annual Multi-cultural Symposium | Kimberly Knifong<br>Tracey Lacey, LMFT<br>Hendry Ton MD, MS<br>Arcenio López | Associate Governmental Program Analyst, Office of Health Equity<br>Senior Mental Health Services Manager, Solano County Behavioral Health<br>Associate Professor of the Department of Behavioral Health and Sciences, University of California Davis<br>Executive Director of Mixteco/Indigena Organizing Project, Ventura County | Panel – Discussed unique challenges that each community represents as well as the implementation of programs and services that work for these communities |
| 2017 Annual Multi-cultural Symposium | Sergio Aguilar-Gaxiola, MD, PhD<br>Betzabel Estudillo<br>Mayra E. Alvarez | NAMI CA Board Member<br>Health Policy Manager, California Immigration Policy Center<br>President, The Children's Partnership | Immigration Policy and the impact on the mental wellness of immigrant communities and children |
| 2017 Annual Multi-cultural Symposium | Elaine Peng | Founder, NAMI Chinese | Multicultural Outreach Excellence Award for Outstanding Engagement and Cultural Inclusion |
| 2017 Annual Multi-cultural Symposium | Mary R. Hale, MS, CHC | Behavioral Health Director, Orange County Health Agency | Innovation Project: OC ACCEPT (Orange County Acceptance through Compassionate Care, Empowerment, and Positive Transformation) – OK to Be Me |
| 2017 Annual Multi-cultural Symposium | Juan Garcia | NAMI CA Board Member | Repeal of the Affordable Care Act (ACA) Breakout Session |
| 2018 Northern CA | Melissa Jones, MPA | Executive Director, Bay Area Regional Health Inequities Initiative (BARHII) | Keynote – BARHII, advocacy, and the housing crisis |
| 2018 Northern CA | Marcel Rodriguez-Harris | Community Engagement Manager, NAMI CA | Using Culture to Heal Historical/ Intergenerational Trauma Breakout Session |
| 2018 Northern CA | Beats, Rhymes, & Life | Beats, Rhymes, & Life | Original hip-hop music – creative art therapy |
| 2018 Northern CA | ThuHien Nguyen, PhD<br>Eramelisse de Castro, MPA<br>Adelina Trujillo<br>Mohamed Ali | Program Manager, ECCAC Family Outreach and Engagement Program<br>Mental Health Peer Support Worker, Filipino Team Lead<br>Mental Health Peer Support Worker, Native American Team<br>Mental Health Peer Support Worker, African Immigrant Team | Community Based Innovations Panel: Ethnic & Cultural Communities Advisory Committee (ECCAC) |
| 2018 Northern CA | Jenna J. Rapues, MPH<br>Amber Gray<br>Carolyn Henry | Director, Gender Health SF, San Francisco Department of Public Health<br>Health Worker II, City and county of San Francisco, Case Manager, Treatment Access Program (TAP)<br>Support-Group Volunteer, Transgender Pilot Project | Collaborative Innovations Project: Transgender Pilot Project (TPP) |

| Event | Presenter | Position/Organization *(at time of presentation)* | Topic of Presentation |
|---|---|---|---|
| 2019 Southern CA | Melvin Mason, MSW, LCSW | Co-founder & Executive Director, The Village Project, Inc. | Keynote - Power and effectiveness of culturally appropriate services in the lives of diverse community members. |
| 2019 Southern CA | Jonathan DuFresne | Community Engagement Manager, NAMI CA | Empowering Peers & Family Members Navigating the Mental Health Care System Breakout Session |
| 2019 Southern CA | Ping Ho, MA, MPH | Founder and Director, UCLArts & Healing | Beat the Odds Program - Drumming for Mind, Body, & Spirit |
| 2019 Southern CA | Sonya Young Aadam<br>Paris Adkins-Jackson | Chief Executive Officer, CABWHP<br>Community Panelist | State Innovation Project Panel: California Black Women's Health Project (CABWHP): Sisters Mentally Mobilized, California Department of Public Health Reducing Disparities Project |
| 2019 Southern CA | Samin Yoak<br>Phaly Sam<br>Carrie Johnson, PhD | PACS - INC Peer Specialist<br>PACS - INC Peer Advocate<br>Director, Seven Generations | Culturally- Focused Innovations Panel: Pacific Asian Counseling Services (PACS) & United American Indian Involvement (UAII) Seven Generations Child & Family Counseling Services |
| 2019 Northern CA | Kalpulli Ketzalkoatl Ehecatl | Kalpulli Ketzalkoatl Ehecatl | Welcome Blessing Ceremony – Danza Azteca |
| 2019 Northern CA | Edna Ealey | President, NAMI San Joaquin | Introductions |
| 2019 Northern CA | Kimberly Warmsley, LCSW | CEO & Therapist, Kimberly Warmsley Therapeutic & Trauma Services | Barriers that communities face systematically and socially. "Change the Narrator and the Narrative" |
| 2019 Northern CA | Ragini Lal<br>Kimberly Knifong, MBA | Community Engagement Coordinator, NAMI CA<br>Chief, Business Operations Unit, California Department of Public Health (CDPH) | Call to Action: Building Initiatives to Reduce Mental Health Disparities Among Diverse Communities in the Criminal Justice System Breakout Session |
| 2019 Northern CA | Melen Vue<br>Brianna Vargas, MS | Vice President, NAMI CA<br>Community Engagement Manager, NAMI CA | Call to Action: Creating Innovative Strategies to Mitigate the Mental Health Crisis Among Immigrant Populations (incl. Refugee, Asylum Seekers) Breakout Session |
| 2019 Northern CA | With Our Words | With Our Words | Spoken Word – creative art therapy |
| 2019 Northern CA | Jazmarie La Tour<br>Jasmire Harlee Gibson<br>Chezzere Day<br>Rajah<br>Mirna Xiuhyolotl Juarez | CEO and Founder, Inner G<br>CEO and Founder, Inner G<br>Founder of Hella Deadass Entertainment<br>CEO and Founder, Inner G<br>Student, San Joaquin Delta College | Community-Based Innovations Panel: Inner G – Alternative Healing and Collaboration |
| 2019 Northern CA | Raksmey Roeum-Castleman, PhD<br>Angelo Balmaceda | Public Health Educator, Program Administrator at Telecare Corp., Professor at San Joaquin Delta College<br>Mental Health Services Act (MHSA) Coordinator, San Joaquin County Behavioral Health Service | Collaborative Innovation Project Panel: Telecare Corporation & San Joaquin Behavioral Health Services |
| 2019 Northern CA | Maggie Fry | Program Director, NAMI Yolo | Closing Remarks – Further Opportunities to Stay Involved in Mental Health Advocacy |
| 2020 Virtual Symposium | Jei Africa, PsyD, MSCP, CATC-V | Practicing Clinician, Director at Behavioral Health and Recovery Services, County of Marin - Department of Health and Human Services | Keynote – Why We Should Bring Conversations about Race and Racism to the Table |

| Event | Presenter | Position/Organization *(at time of presentation)* | Topic of Presentation |
|---|---|---|---|
| 2020 Virtual Symposium | Mirna Xiuhyolotl Juarez | Founder, Fireheart Botanicals | Smudging for Healing |
| 2020 Virtual Symposium | Tiffany Ross, LCSW | Behavioral Health Services Supervisor, Community Behavioral Health Assessment Team and Crisis Intervention Training Program Coordinator, Riverside University Health System - Behavioral Health | Keynote – Behavioral Health and Law Enforcement: Developing an Understanding |
| 2020 Virtual Symposium | Ania Townsell PsyD<br>Ragini Lal | Psychology Postdoctoral Resident, Kaiser Permanente<br>Community Engagement Manager, NAMI CA | Call to Action: Building Initiatives to Reduce Mental Health Disparities Among Diverse Communities in the Criminal Justice System Breakout Session |
| 2020 Virtual Symposium | Mara Alaniz, MPH<br>Brianna Vargas, MS | Project Manager, UCD Center for Reducing Health Disparities<br>Director of Community Engagement, NAMI CA | Call to Action: Creating Innovative Strategies to Mitigate the Mental Health Crisis Among Immigrant Populations (incl. Refugee, Asylum Seekers) Breakout Session |
| 2020 Virtual Symposium | Luther Richert<br>NamQuyên (Q) Lê<br>JR Kuo<br>Rhonda Brinkley-Kennedy, PsyD<br>Tory Martinez | Chief Services Officer, L.A.'s South County for Mental Health America of Los Angeles<br>National Asian American Pacific Islander Mental Health Association (NAAPIMHA)<br>National Asian American Pacific Islander Mental Health Association (NAAPIMHA)<br>CEO & Founder, South Central Training Consortium, Inc.<br>Community Engagement Manager, NAMI CA | Collaborative Community-Based Innovations Panel |
| 2020 Virtual Symposium | JR Kuo | CEO, CoffeeWithJR and Director at NAAPIMHA | Self-Care - Building Daily Habits |

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