



Mental Health Association in California

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To the Mental Health Services Accountability and Oversight Commission:

We are a coalition of organizations that provide services to underserved communities in California. We have been meeting under the auspices of the Mental Health Association in California through a grant from the California Endowment. We have reviewed the MHSOAC's paper on Eliminating Stigma and Discrimination against Persons with Mental Health Disabilities presented to the public on June 14th. Regardless of what recommendations are chosen for initial funding, each program or strategy should include language that specifies:

1. **Services should be located in places where consumers and families from underserved communities feel comfortable or already access for other purposes.** These places include: community clinics and community health centers, family resource centers or other family service agencies, non-profit community based organizations serving ethnic or non-English speaking communities, organizations serving refugees and immigrants, community centers, etc.

If programs are set up in schools, colleges, or other government entities, partnership with the above entities in service delivery, training, etc, should be strongly encouraged.

2. Services need to be delivered by individuals (whether consumers, family members, or professionals) who have **knowledge and understanding of the culture, life experience, and community history** of whomever is targeted for receiving the services. If the potential consumer is non-English speaking, preferably, the provider needs to be to be bilingual. If the provider is not linguistically proficient, appropriate use of interpreters and translators should be utilized.
3. As part of stigma and discrimination reduction, **people hired to provide services and work in these programs should have common life experience and common culture with the targeted communities.** Workforce development should encourage hiring and training of people with a common culture and common experience of underserved communities. i.e. Refugees should be hired and trained to provide services to refugees, immigrants should be hired and trained to provide services to immigrants, Hmong individuals should be hired and trained to provide services to the Hmong community, African Americans should be hired

and trained to provide services to the African American community, Native Americans should be hired and trained to provide services to the Native American communities, etc.

4. **Programs need to be designed in ways that are culturally and linguistically appropriate and inviting to specific underserved communities.** California is rich with cultural, ethnic and linguistic diversity. A major component of MHSA is to reach these underserved communities. Therefore, it is critical that services, programs and outreach must be delivered in a culturally and linguistically appropriate and competent manner, using best practices recommendations.

Adjustments to services and alternative delivery systems are to be expected in order to provide “mental health services” to people from underserved communities. Outreach is but a starting point to both obtain information from underserved communities and offer appropriate and available services to them. Counties need to specify a process delineating how feedback information from underserved communities will be considered and integrated into service modifications.

5. On January 26, 2007, the OAC approved the joint Key Policy Direction paper. The first item mentioned under California’s 5 Key Community Mental Health Needs is “**Disparities in Access to Mental Health Services**”. We strongly support this priority which is in line with the fact that, according to the California State Department of Finance, California’s population will reach almost 60 million people by 2050, three-quarters of which will be Hispanic, Asian, African American and American Indian and Pacific Islander descent. *It is critical to develop specific outcome measures so that we can see what kind of progress we are making in providing services to these populations.* We suggest that counties be required to establish goals and related timelines in the area of reducing disparities for specific threshold populations.
6. Programs developed to address mental health stigma and discrimination should also recognize and address adversity due to factors in addition to the mental health diagnoses (such as race, ethnicity, sexual orientation, poverty, class, language barriers, immigration status and pre-immigration experiences such as ethnic cleansing, genocide, and war trauma, etc.) recognizing that mental health other forms of discrimination are inextricably intertwined. It is the hope of this coalition that these programs will ameliorate the despair of people caused by discrimination based on ethnicity or cultural group and despair caused by adverse societal conditions.

On page 11 of the document "Eliminating Stigma and Discrimination against Persons with Mental Health Disabilities" is a powerful quote from the Surgeon General: "Racism and discrimination are clearly stressful events that adversely affect health and mental health and place persons of color at risk for mental disorders". As this statement suggests, social stigma and discrimination can cause or exacerbate distress that results in mental illness and/or

related outcomes such as homelessness, suicide or homicide. It is the hope of this coalition that the programs designed to reduce stigma and discrimination against persons with mental illness include funds for interventions that will also reduce discrimination and stigma based on ethnicity, cultural affiliation, and the despair that can be caused by adverse societal conditions.

With these rapidly changing demographics, state legislative leaders will face new challenges as well as opportunities to ensure that the state's economic, education, and health outcomes benefit all residents and Californians.

The Mental Health Services Act provides us with such an opportunity to invest in the future of the state, and the Oversight and Accountability Commission is to be commended for working with stakeholders to provide language and direction for the proper allocation of these new funds. We must also work with these changing demographics though, as failing to plan for the future of the state could have dire consequences for those suffering from mental illness.

One important indicator of access to mental health services is health insurance coverage. California is currently debating different approaches to covering more of the state's uninsured, but the actual implementation of these reforms could be years away. In the meantime, we are left with millions of Californians suffering from mental illnesses who do not have access to treatment. And these growing populations of communities of color, refugees and immigrants are less likely to have health insurance and less likely to seek or qualify for mental health services. For example, among Latino Americans with a mental health disorder, less than 1 in 11 contact mental health specialists and less than 1 in 20 actually use services from mental health specialists. There is a gap in who is being served, and our coalition hopes that the language adopted by the OAC accurately reflects the needs of California's changing population.

Thank you for your attention to our concerns.

cc: California State Department of Mental Health

Signed,

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