Narrative

Lead Agency: UC Davis Center for Reducing Health Disparities

The University of California at Davis, Center for Reducing Health Disparities (CRHD) proposes to undertake the scope of work described in RFP 09-79055-00, Strategic Planning Workgroups for Reducing Disparities Project, California Department of Mental Health. The CRHD will complete the described workplan and deliverables for the **Latino** population.

Section 4: Proposer Qualifications

The Center for Reducing Health Disparities (CRHD) is uniquely qualified to address the issues relating to reaching out and engaging the Latino community in California on identifying community-defined, strength-based strategies and recommendations to reducing health disparities experienced by the Latino population in California. CRHD conducts studies of mental health issues among California Latinos, reviews other studies' findings, and monitors current available public data, and describes the issues as follows:

A. Characteristics of the population: California's large Latino population is estimated at 13,305,913[1] or over 36% of the state's population. Latinos are heavily concentrated in the southern part of the state, Central Valley, and Salinas[2]. Two-thirds of the state's Latinos live in Los Angeles, Orange, San Bernardino, Riverside, San Diego, and Imperial counties; however, even very rural California counties like Modoc and Mono experienced high Latino growth rates (between 85% and 99% from 1990 to 2000)[3]. In some counties, including Los Angeles, Latinos are approaching majority status. In many public schools and school districts throughout the state, majority status has been already achieved, forecasting a future mental health workforce that is increasingly Latino. In the Los Angeles Unified School District, 73% of all students are Latino, and at many schools the majority of students speak Spanish at home.[4] The overwhelming majority of California Latinos are of Mexican descent (about 85%), with significant numbers from Central America, South America, and the Caribbean. Twenty nine percent of Latino residents are non-citizens.[5]

Latino residents of California have lower rates of educational attainment, lower annual personal earnings, and higher birthrates than California non-Latinos.[6]

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[1] U.S. Census Bureau, Claritas estimate, 2008.
[2] Gey, F., Jiang, C., Stiles, J. & Einowski, I. (2004). California Latino demographic databook, 3rd edition: 2004. Retrieved 8/7/2009 from http://ucdata.berkeley.edu/pubs/Databook2004.pdf
[3] ibid.
[4] www.ed-data.k12.ca.us/
[5] Pew Hispanic Center tabulations of the 2006 ACS (1% IPUMS sample). More information on the source data and sampling error is available at http://usa.ipums.org/usa/design.shtml and http://www.census.gov/acs/www/Downloads/ACS/accuracy2006.pdf.
[6] Ibid.

More than one in four Latinos (28%) under the age of 65 living in California do not have health insurance compared to 9% of non-Hispanic whites. Many Latinos living in California do not have health insurance because their employers do not provide health insurance. Only 43% of employers with Latino staff provide health insurance compared to 76% of employers with white employees.[7]

Prevalence of mental health conditions: Mental health concerns for Latinos living in the U.S. vary based on demographic characteristics including age, nativity, length of U.S. residence, and sex. Age is an important determinant. For example, Latino youth experience anxiety, delinquent behaviors, drug use, depression, suicidal ideation and attempts at higher levels than their white counterparts. Among adult Latinos, immigrants have consistently lower rates of mental disorders and substance abuse than their U.S.-born counterparts. Among Latinos/as, sex is an important predictor. Specifically, Latinas suffer from depression at higher rates than their male counterparts. Latinas also have lower rates of substance abuse than their male counterparts. However, U.S.-born Latinas have higher rates of substance abuse than their immigrant counterparts.[8]

Children and Adolescents. Cultural and language barriers influence the mental health treatment of Latino children. One of the risks of health care providers' inability to communicate with Latino patients is the under-detection of psychological conditions.[9] A 2006 study of mostly low-income Latino children and adolescents between the ages of 2 and 16 years residing in East Palo Alto, CA found that pediatric primary care providers did not diagnose **any** children with anxiety or depression, although 30 children's parents reported high anxiety/depression scores on the Child Behavior Checklist.[10] This is worrisome because Latino children and youth are less likely to visit mental health specialists than their non-Hispanic white peers. A study of adolescents between the ages of 6 and 18 in San Diego County who were diagnosed with at least one mental health condition found that non-Hispanic whites participants on average began mental health treatment at a younger age than their Latino counterparts. Non-Hispanic whites participants were also 2.2 times more likely to receive specialty outpatient mental health services than their Latino counterparts. It is important to note that in this study non-English speaking Latino participants were excluded because instruments were not available in Spanish. Researchers predicted that if non-English speaking Latinos had been included in the sample, the gap between mental health service use of non-Hispanic whites and Latinos would have been even wider. These results show that English-speaking Latino adolescents begin mental health treatment at a later age and

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[7] Aguayo, J., Brown, E. R., Rodriguez, M. A. & Margolis, L. (2003). Important health care issues for California Latinos: Health insurance and health status. Retrieved 8/3/2009 from http://www.lchc.org/documents/HealthPolicyFactSheet01-24-03.pdf

[8] U.S. Department of Health and Human Services [U.S. DHHS] (1999) Surgeon General's report. Retrieved 8/3/2009 from http://mentalhealth.samhsa.gov/cre/fact3.asp

[9] Marin, H., Escobar, J. I. & Vega, W. A. (2006). Mental illness in Hispanics: A review of the literature. *Focus: The Journal of Lifelong Learning in Psychiatry, 4(1),* 23-37.

[10] Tarshis, T. P., Jutte, D. P. & Huffman, L. C. (2006). Provider recognition of psychosocial problems in low-income Latino children. *Journal of Health Care for the Poor and Underserved, 17,* 342-357.

visit mental health specialists less frequently than their non-Hispanic white counterparts.[11]

Migrant agricultural workers. The majority (96%) of California farm workers are Latino, of which more than 30% are undocumented and speak primarily Spanish. More than half of migrant families live in poverty and approximately 70% do not have health insurance. More than 16% of farm workers reported that their employer offers health insurance, however, a third of these workers did not participate due to high premiums or inability to afford the co-payment.[12]

Mexican migrant agricultural workers are the poorest, least educated, and most uninsured population subgroup in California. The Mexican migrant agricultural workers come to the United States to work and a good proportion of them are disabled by mental health illness and substance use problems after their migration to the U.S. These mental health problems lead to loss in worker productivity and ironically take away from the very purpose of their migration to the United States. Mexican migrant agricultural workers perform about 85% of all the labor in California's crops and livestock.[13] Their contribution to the economy is enormous, yet they are deprived of the most basic mental health services. Considering that agriculture ranks amongst the state's most important industries, this population cannot be ignored any longer for economic, political, as well as social reasons. This is especially true for the Central Valley, since half of California's agricultural workers are employed in this region.

Mexican migrant agricultural workers have the highest disparities between their mental health needs and the actual services received. Out of all the Latino groups in California, this subgroup has the lowest documented accessibility to and availability of mental health treatment. Mexican migrant agricultural workers not only have limited access to services, but they also have extremely limited knowledge about where to receive services. Their lack of knowledge of the mental health system, coupled with their frequent migration, decreases their chances of accessing available mental health services. Social isolation and cultural stigma related to mental illness further reduces the limited utilization of mental health services.

Older Adults. Older Latinos are often vulnerable because they have a history of working for employers that do not provide health insurance or retirement benefits, and they do not apply for government services because they are unfamiliar with these programs and do not usually speak English. A qualitative study of Latino older adults residing in San Diego identified some key needs, which included linguistic and cultural barriers. Participants reported a lack of translation services and limited information about

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[11] Hough, R.L., Hazen, A.L., Soriano, F.I.,Wood, P., McCabe, K., & Yeh, M. (2002). Mental health services for Latino adolescents with psychiatric disorders. *Psychiatric Services, 53*(12), 1556-1562.
[12] Latino Coalition for a Healthy California (2005). Latino Health in California, Retrieved 8/3/2009 from http://www.lchc.org/documents/QuickFactsonLatinoHealth.pdf
[13] California Institute for Rural Studies (2000). Suffering in silence: A report of California's agricultural workers. Retrieved 8/7/2000 from http://www.calendow.org/uploadedFiles/suffering_in_silence.pdf

available services, lack of transportation to services, and social isolation. Social isolation, partly due to a language barrier, was tied to depressive symptoms.[14]

Barriers to care associated with disparities: The primary barriers to care have been identified as **lack of insurance** and the lack of **cultural** and **linguistic competence**. Thirty seven percent of Latinos living in the U.S. are **uninsured** compared to other U.S. residents (16%). Since Latinos do not have medical insurance, they are less likely to use mental health services than non-Latinos. In fact, among immigrant Latinos with a mental disorder, less than 1 in 20 use mental health services. Among non-immigrant Latinos, less than 1 in 11 seek mental health services.[15]

Researchers have observed that the lack of **cultural** and **linguistic competence** are primary barriers to providing mental health services for Latinos.[16] This, in large part, can be explained by the low numbers of Latino health care providers; there is one Latino physician for ever 3000 Latinos.[17] The current low educational attainment of young Latinos limits the pool of eligible Latinos and, more specifically, bilingual health care workers.[18] Even for Latinos who speak English, communication about mental health issues is more effective in their home language, particularly while talking about culturally-connected conditions such as depression, psychosis, or post-traumatic stress. As a consequence, cultural and linguistic competence training in mental health professions is essential to the ability of professionals to assist Latino clients.

Community strengths and assets: Latinos are generally poorer, less educated, and medically underserved relative to non-Hispanic whites. Despite what these socioeconomic indicators would predict, Latinos tend to paradoxically have substantially better health than the average US population.[19] Cultural assets are often cited as an important contributor to this "epidemiological paradox." For example, immigrant Latinos may retain traditional values or attitudes that are associated with protective behaviors and favorable health outcomes such as healthier diet and lower rates of risk-taking behavior, including smoking and drinking. These behaviors are associated with lower rates of lung cancer, heart disease, and chronic respiratory disease compared to non-Hispanic whites[20] and seem to contribute to good health outcomes. In addition, Latino immigrants also have very durable, transnational, family and social networks, and use these for meeting instrumental and emotional needs very effectively. Cultural values

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[14] Barrio, C., Palinkas, L. A., Yamada, A. M., Fuentes, D., Criado, V., Garcia, P. & Jeste, D. V. (2008). Unmet needs for mental health services for Latino older adults: Perspectives from consumers, family members, advocates, and service providers. *Community Mental Health Journal, 44*, 57-74.

[15] U.S. Department of Health and Human Services, Surgeon General's Report, supra.

[16] Barrios, et.al., supra.

[17] Latino Coalition for a Healthy California, supra.

[18] Vega, W. A. & Lopez, S. R. (2001). Priority issues in Latino mental health services research. *Mental Health Services Research, 3(4)*, 189-200.

[19] Franzini, L., Ribble, J.C., Keddie, A.M. (2001) Understanding the Hispanic Paradox. *Ethnicity & Disease*, 11(3), 496–518.

[20] Scriber, R. (1996). Editorial: Paradox as paradigm—The health outcomes of Mexican Americans. *American Journal of Public Health, 86(3),* 303-304.

that diminish the risk of chronic illnesses can help diminish stress and rumination which can lead to feelings of hopelessness and ultimately depression.

Asset-based community analysis is useful in the design of strategies to overcome disparities between specific populations when the strategies must improve the accessibility, acceptability, quality, availability, and effectiveness of services.[21] Community strengths can form the foundation of actions that will have the desired effect in the reduction of disparities in access to services, quality of care, and health outcomes. The following community assets have been documented in California's Latino population:[22]

- **Commitment to family:** Individuals in the Latino community tend to put family first. Children are a priority for families, and deep bonds continue through adolescence and adulthood. This asset supports family engagement in the diagnosis and treatment of mental health issues, particularly willingness to engage the family in therapy for the good of the whole.
- **Resiliency:** Latinos who experience social exclusion are characterized as having the ability to keep going during very hard times, and the capacity to adapt to challenging situations.
- **Willingness to work hard**: The characteristic asset of hard work in the Latino community reflects on the dedication of health professionals, who will make home visits, engage in multiple diagnostic and treatment sessions, and seek out the best treatment for their patients. This community strength will be of particular significance in the process to be undertaken by the California Reducing Disparities Project (CRDP). We expect Latino mental health professionals and community advocates to actively participate in identifying strategies to reduce disparities in mental health care for Latinos.
- **Dedication to learning what is necessary to thrive in their new community**: Recent immigrants have a characteristic openness to engagement in unfamiliar processes, which in this case will include both the planning process and the implementation of new strategies for diagnosis, treatment, and prevention of mental illness.
- **Nurturance and support of the extended family**: Ties to family are long-term and extended among members of California's Latino population. An aunt, uncle, cousin, grandparent, or even a neighbor may be a critical part of an individual's support system. The availability of a broad and deep family-based support system is an important asset to recovery from mental illness in any population, and is of particular significance in a population of predominantly recent immigrants who experience language barriers.

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[21] Kretzmann, JP and McKnight, JL, Northwestern University, Building communities from the inside out: a path toward finding and mobilizing a community's assets, Chicago, IL, 2006.
[22] Aguilar-Gaxiola, SA, et.al., Center for Reducing Health Disparities, UC Davis, Engaging the underserved: personal accounts of communities on mental health needs for prevention and early intervention strategies, Sacramento, CA, 2008.

- **Religious leaders**: For members of California's Latino population who are religious believers and are actively involved in a religious community, churches and their pastors are an important source of support in times of emotional crisis.
- **Healthier diet and lower rates of risk-taking behavior:** As previously mentioned, Latinos' healthier diet and lower rates of risk-taking behavior including smoking and drinking are associated with lower rates of lung cancer, heart disease, and chronic respiratory disease than non-Hispanic whites. Cultural values and behaviors that diminish the risk of chronic illnesses are seen as protective factors that are worth reinforcing in Latinos.[23]
- **Community-based organizations and programs**: Community-based programs and organizations such as health centers, advisory committees, promotoras, support groups and parenting classes are trusted sources of support in safe spaces for Latinos.

B. Qualifications: The project will be implemented through a partnership between the UC Davis Center for Reducing Health Disparities and the Latino Behavioral Health Institute, a non-profit training and technical assistance agency headquartered in Los Angeles. Both agencies have extensive experience in identifying community assets and mental health needs in the Latina/o population in California and the U.S., and are well-connected with the Latino mental health stakeholder community throughout the state and the nation.

UC Davis Center for Reducing Health Disparities (CRHD), lead agency: The UC Davis CRHD has become a leading local and state voice for underserved communities dedicated to finding innovative and forward-thinking solutions to California's health disparities. The Center's mission is to promote the health and well-being of ethnically diverse communities by pursuing research, policy and service development, continuing education and training, technical assistance, and information dissemination within a bio-psycho-social framework that recognizes the unique cultural and linguistic contexts of these special populations. The Center takes a multidisciplinary, collaborative approach to the inequities in health access and quality of care. It seeks to build and foster partnerships with local and regional community-based organizations and racially and ethnically diverse communities in which (1) new, scientific and practical understandings of health disparities can be achieved; (2) the knowledge generated can be translated, shared and disseminated; and (3) new approaches to reducing these disparities can be developed for implementation throughout California and beyond. The Center builds on UC Davis' long history of reaching out to the most vulnerable, underserved populations in the region. For 30 years, its student-run clinics have provided free medical care to Sacramento's underserved communities. A comprehensive medical interpretive services program helps overcome limitations in access for those who don't speak English. Its nationally recognized regional telehealth network provides a high tech link between UC Davis health providers and smaller clinics around the state that cannot afford to maintain health specialists on staff.

[23] Scriber, R. supra.

The CRHD represents a major commitment to addressing community needs that goes well beyond the traditional service role of an academic medical center. It is a program designed not only to raise awareness and conduct critical research, but also intended to actually assist those communities whose needs have never been addressed and met by the traditional health-care system. The CRHD's wide-ranging focus on health disparities includes an emphasis on improving access, detection and treatment of mental health problems within the primary care setting. It also focuses efforts on achieving better understanding of the co-morbidity of chronic illnesses such as diabetes, cancer or HIV/AIDS with mental disorders such as depression.

Under contract to the California Department of Mental Health, the CRHD has recently completed a two-year project and authored a series of reports that are related to the proposed scope of work. The *"Building Partnerships"* series reports on personal accounts and data on community assets and mental health needs among Latina/o parents, migrant workers, and community members, and Latino parent advocates through focus groups, one-on-one interviews, and analysis of collected data. The series includes:

- ***Building partnerships: Conversations with communities about mental health needs and community strengths***, June, 2009.

- ***Building partnerships: conversations with Latina/o migrant workers about mental health needs and community strengths***, June, 2009.

- ***Building partnerships: Conversations with Latina/o and Asian American parent advocates about mental health needs and community strengths***, June, 2009

Information collected by CRHD was used in the development of the DMH Proposed Guidelines for the Prevention and Early Intervention Component of the Three-Year Program and Expenditure Plan for MHSA funds.

CRHD is currently disseminating the findings from this community outreach and engagement process to the participating underserved communities, and has just finished providing technical assistance on the engagement of hard-to-reach populations to Riverside and Sacramento Counties.

Latino Behavioral Health Institute (LBHI), subcontractor: LBHI is a leading non-profit training and education agency with 14 years of experience in the provision of workshops, conferences, experiential opportunities, technical assistance, and facilitation of community participation in issues affecting human services received by the Latino community. LBHI has organized and presented the nation's leading Latino Behavioral Health conference since 1995, which now attracts over 1000 consumers, family members, and behavioral health professionals, and the agency provides trainings and other learning activities on Latino behavioral health to a wide range of stakeholders and

service providers. LBHI's *Promo-Vida Project* and *Bajo El Mismo Techo* have trained 25 promotoras in community mental health over the past two years.

The agency's expertise in community participation is utilized by a variety of policy makers, health services planners, and researchers. LBHI is currently providing technical assistance to Ventura County's Department of Behavioral Health in the identification of strategies to address disparities in services to the Latino population. Other recent projects include the coordination of the Latino Roundtable for the Los Angeles County Department of Mental Health in its planning process for the use of Mental Health Services Act funds to reduce disparities in services to the Latino population of Los Angeles County (*PoDER-LA*). LBHI conducted an extensive analysis of the migrant population in the San Joaquin Valley and King County to determine service utilization for the Latino migrant population. In 1998, LBHI assisted the federal Substance Abuse and Mental Health Services Agency (SAMHSA) in organizing the *Hispanic Congreso*. The agency has a high profile at the local, state, and national level in identifying and building support for strategies to improve the mental health of Latina/os.

The CRHD and its partner the LBHI will utilize these experiences to help guide the California Reducing Disparities Project Strategic Workplan to meet the collective goal of reducing mental health disparities by bringing forward community-defined and strength-based strategies and recommendations developed by the Latino/a and other workgroups with the ultimate goal of eliminating mental health disparities in California.

Sergio Aguilar-Gaxiola, M.D., Ph.D., Principal Investigator: Dr. Aguilar-Gaxiola is the founding director of the Center for Reducing Health Disparities at the University of California at Davis School of Medicine, and is Professor of Internal Medicine at the UC Davis School of Medicine. In addition, Dr. Aguilar-Gaxiola is a licensed clinical psychologist. Dr. Aguilar-Gaxiola is the on-site Principal Investigator of the Mexican American Prevalence and Services Survey (MAPSS), the largest mental health study conducted in the U.S. on Mexican Americans.

Dr. Aguilar-Gaxiola has nearly 30 years of experience working in the mental health field as a researcher, clinician, professor, and advocate. He has served on numerous international, federal government, and national advisory committees, including Chair of the Board of Directors of Mental Health America (2006-2008), member of the National Advisory Mental Health Council of the National Institute of Mental Health, and on several advisory committees of the World Health Organization. He has served as principal investigator to a National Institute of Mental Health (NIMH) research program aimed at advancing research to reduce disparities in minority mental health and a program aimed at increasing the number of minority undergraduate students into doctoral programs and pursue careers in mental health related research.

For nearly two decades, Dr. Aguilar-Gaxiola has been conducting community-based studies to determine unmet mental health needs and associated risk and protective

factors to better understand and meet population needs. A primary focus of these studies has been on understanding and reducing mental health disparities in racial and ethnic minority populations, with an emphasis on the Latino population. In addition, he has been also very active in California mental health public policy, participating in the Prevention and Early Intervention component of the MHSA since its inception, and currently serving on the Services, Evaluation, and Cultural and Linguistic Competence Committees of the Mental Health Services Oversight and Accountability Commission (MHSOAC).

Dr. Aguilar-Gaxiola is recognized as one of the top 20 Latinos in Health and Medicine in the U.S. (Latino Leaders Magazine) and has received many honors and awards for his work in reducing disparities in health services including the U.S. DHHS' Office of Minority Health's National Minority Health Community Leader Award (Hispanic Community). He is one of the leading academic researchers in the area of mental health among Mexican-Americans and other Latina/os, with over 80 peer-reviewed publications, and major research support from the National Institutes of Health, the California Department of Mental Health, the Robert Wood Johnson Foundation, and the California Department of Health Services. Dr. Aguilar-Gaxiola will have overall responsibility for all elements of the project, will direct the stakeholder process in Superior California and the Central Valley regions, and will represent and participate in the DMH Reducing Disparities Project at the statewide level.

Ambrose Rodriguez, Director of Partnership: Ambrose Rodriguez is the founder and CEO of the Latino Behavioral Health Institute (LBHI). He has over 40 years of experience in the field of mental health, as a mental health professional and as an executive in the non-profit and government sectors. From 1987 to 2006, Mr. Rodriguez served as the Assistant Director of the Los Angeles County Department of Mental Health. In 1995, Mr. Rodriguez formed LBHI and initiated the Latino Behavioral Health Conference. He has served as Principal Investigator on a series of SAMHSA projects, and has received numerous honors and awards for his work in addressing the mental health needs of underserved populations. He will direct the stakeholder process in Southern California and the Bay Area, and will participate in the DMH Reducing Disparities Project on the statewide level.

Marbella Sala, Management Services Officer: Ms. Sala has served as the Management Services Officer of the Center for Reducing Health Disparities, School of Medicine, UC Davis since 2006. Prior to joining the Center, Ms. Sala spent 10 years as the Director of Medical Interpreting Services at UC Davis Medical Center. She also spent 10 years in the Office of Affirmative Action and Diversity at UC Davis. For this project, Ms. Sala will be responsible for meeting all administrative requirements, including invoicing, reports, record-keeping and communication between the Department of Mental Health and the project. In addition, she will coordinate meeting logistics, including Spanish/English interpretation and teleconferences, and will be responsible for production of all project deliverables, including quarterly and final

program reports and the Population Report, which will be submitted for integration with reports from the other population workgroups.

Alignment with RFP requirements for proposer qualifications

The qualifications detailed above reflect the expertise of CRHD as fully qualified to conduct the proposed strategic planning for the CRDP using a stakeholder workgroup structure.

Knowledge of unique characteristics of the Latina/o population is demonstrated in the description of the population, its mental health characteristics, and its assets and resources.

Experience with working with the Latina/o population is demonstrated in the extensive experience of both CRHD and LBHI described in the qualifications section, along with the extensive experience of the principals of each partnering organization, Dr. Aguilar-Gaxiola and Mr. Ambrose Rodriguez.

Knowledge of services and programs targeted to the Latina/o population is demonstrated through the direct experience of both principals in the service delivery system, and as key advisers in the design and evaluation of mental health services.

Knowledge of the MHSA stakeholder processes involving the selected population is demonstrated by the role of each organization in the MHSA stakeholder processes at the statewide and county levels. Both organizations have organized, advised and facilitated multiple MHSA stakeholder processes at the county level, and have also participated in the statewide process. CRHD has recently conducted key outreach and community assessments of the Latina/o population for the statewide Prevention and Early Intervention Plan for use of MHSA funds.

Section 5: Project Narrative

The University of California at Davis, Center for Reducing Health Disparities (CRHD) proposes to undertake the scope of work described in RFP # 09-79055-00, Strategic Planning Workgroups for Reducing Disparities Project, California Department of Mental Health. CRHD will complete the described workplan and deliverables for the **Latino** population.

The project design is based on a Community Stakeholder Planning Process used by CRHD in its previous work on MHSA and other mental health planning collaborations. The seven-step process is adapted from a model based on *Community-Based*

Participatory Action Research developed by Giachello and colleagues [24] in which stakeholders are involved and empowered throughout the planning process. A brief description of each of the seven steps follows.

Step 1 involves a community dialogue among key stakeholders, who will define the work to be addressed, develop a vision and mission statement, and outline project goals, objectives, tasks, and who will be responsible for the tasks. CRHD will establish a statewide body called "Concilio" to undertake this role (the project structure will be described below).

Step 2 is formation of the regional workgroups, comprised of stakeholders who are identified and recruited by the statewide "Concilio". Members of the workgroups will engage in an orientation and visioning process designed to clarify values, build group cohesiveness, develop roles and responsibilities, and reach agreement on principles of community engagement and collaboration.

Step 3 is stakeholder training. The regional workgroups will review available information and data applicable to their task, and will create a framework for a community inventory and needs assessment.

Step 4 requires each regional workgroup to develop and implement assessment protocols that will define the process and procedures for the self-assessment process. In addition to collecting and analyzing existing quantitative and qualitative data, each regional workgroup will establish opportunities for broader community input and comment on disparities in mental health among Latina/os.

Step 5 will involve the development of possible approaches to reducing these disparities, and analysis of the acceptability, accessibility, quality, availability and effectiveness of proposed strategies. At this stage, it is expected that the regional workgroups will coordinate more closely with each other and with the Concilio to identify strategies that can be applied statewide or with specific subpopulations.

Step 6 is the development and implementation of an action plan. In addition to selecting and prioritizing methods for quality care improvement and integration of services, the workgroups together with the Concilio will create a plan for community outreach, awareness and education designed to facilitate the effective implementation of the approaches that emerge as priorities for reducing disparities.

Step 7 will consist of an evaluation of the process, outcomes, and impact of the reducing disparities project, with recognition of "lessons learned" and best practices in stakeholder planning processes.

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[24] Aida L. Giachello, et al.,*Reducing Diabetes Health Disparities through Community-Based Participatory Action Research: The Chicago Southeast Diabetes Community Action Coalition*, Public Health Rep. 2003 Jul–Aug; 118(4): 309–323.

Project Structure

For all project tasks, the CRHD will utilize an advisory committee called the *California Latino Mental Health Concilio (Concilio)* to advise the project team on the content of proposed activities and the recommendations we make based on the strategic planning process. Thus, the project structure proposed by CRHD will be overseen by the Concilio, which will be led by CRHD and its partner, the Latino Behavioral Health Institute (LBHI). CRHD is located in Northern California, and LBHI is located in Southern California. The Concilio will be comprised of approximately 15 key Latino community leaders from across the state who are subject matter experts. The Concilio will include representatives from the following stakeholder groups among others:

- Consumers of mental health services, both adult and youth
- Families of consumers
- Mental health providers (from both community-based organizations and the public system)
- Members of the California Mental Health Directors Association
- Promotoras
- Representatives of migrant workers
- Representatives of the juvenile justice system

Other stakeholder groups will be added based on gaps in expertise observed during the process of recruiting members of the Concilio. Membership in the Concilio will include stakeholders who have a long history advocating for mental health services in the Latino community.

The strategic planning process will be informed by four geographic workgroups in the Superior California region, the Southern California region, the San Francisco Bay Area region, and the Central Valley region. CRHD will facilitate the planning process in Northern California and the Central Valley. LBHI will facilitate the planning process in Southern California (includes the larger LA metropolitan area) and the San Francisco Bay Area (see Figure 1 that depicts the proposed project's governance structure).

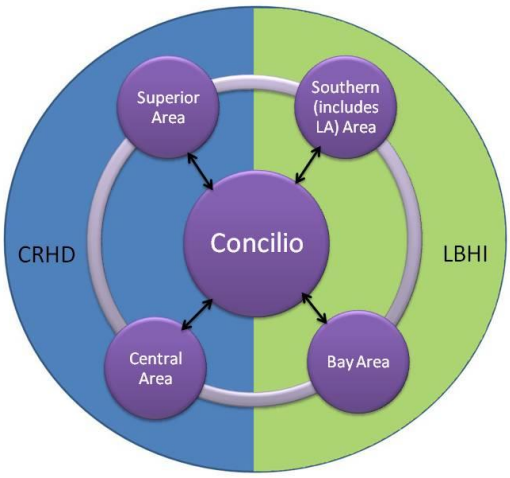

Figure 1. Project structure depicting the project governance and the relationship and interconnectedness among the various partners and workgroups.

The role of the Concilio will be to plan and oversee the project, with the ultimate goal of attaining consensus on the recommendations that will result from the strategic planning process. The Concilio will establish an agenda for the regional workgroups, and will recruit participants for the workgroups. The role of the regional workgroups will be to propose specific community-defined, strength-based strategies for reducing disparities in mental health services for Latinos in the region. The strategies will be assembled into a final report by the project team, which will be reviewed and approved by the Concilio. The final report will be presented to the California CRDP, Strategic Planning Group for incorporation into the aggregate strategic plan for reducing disparities in mental health services among target populations.

The work of the Concilio will begin with a full-day retreat. The group will meet monthly for the first project quarter, and will meet quarterly thereafter, by teleconference.

Upon awarding of the contract, CRHD will execute a subcontract with the Latino Behavioral Health Institute (LBHI).

CRHD and LBHI will represent the Latino population in the four other Strategic Planning Population Workgroups and the CRDP Multicultural Collaborative, and will work closely with DMH and the CRDP Facilitator/Writer once this is in place.

CRHD and LBHI are fully aware that, at this time in the history of California, the goal of reducing disparities in access to and quality of mental health services can only be achieved through improvements in health systems efficiency and the rational allocation and distribution of scarce mental health resources. This task will require commitment, creativity, flexibility, and compromise. There must be a clear buy-in to the strategic

planning process, with trust that the outcome will be transparent, fair, and will improve access to mental health services for California's Latino population.

The strategic planning process will be based on principles of community engagement, recognizing that this is an iterative process in which all parties communicate fluidly and negotiate continuously. We recognize that true partnerships and coalitions that help mobilize resources and influence systems, policies, programs and practices should be guided by real principles and strategies of community engagement. It involves "building authentic partnerships, including mutual respect and active, inclusive participation; power sharing and equity; mutual benefit or finding the 'win-win' possibility" [25] in the collaborative project. The emphasis on community engagement promotes a focus on common ground and recognizes that communities have important knowledge and valuable experience to add to public stakeholder discussions.

Both the CRHD and LBHI have ample experience reaching out to and effectively engaging underserved communities including diverse Latino populations. For example, the CRHD recently released a report titled *"Building Partnerships: Key Considerations When Engaging Underserved Communities under the MHSA"* written under a contract with DMH that (1) introduces guiding principles of community engagement with underserved communities; (2) outlines some guiding questions to assist counties in their MHSA community outreach and stakeholder processes; and (3) suggests specific strategies for County Mental Health Departments to nurture sustained and equitable partnerships with underserved communities.

Project Implementation

The project team has developed a list of specific tasks in response to the program components described in the RFP Scope of Work, and has identified responsible staff and a timeline for completion of activities comprising the project deliverables. The project implementation is described in the attached ***Workplan/Cost Sheet*** which summarizes the project's proposed approach to program components.

Program Component #1: Establish Strategic Planning Work Group

As previously described, CRHD and LBHI will establish a strategic planning workgroup called Concilio that will be broadly representative of stakeholders in the Latino community, including consumers and families, advocates, and providers of mental health care. The project will establish an advisory group at the statewide level, and workgroups in each of four regions. All these elements will be in place by July, 2010.

[25] Zakus JD, Lysack CL (1998) Revisiting community participation. *Health Policy Plan* 13: 1–12.

Objective #1: Establishment of a California Latino Mental Health Concilio (Latino Mental Health Advisory Committee)

During November and December, 2009, project leaders at CRHD and LBHI will contact approximately 15 key Latino community leaders and invite them to become members of the Latino Mental Health Concilio. The group will be representative of stakeholders in the Latino community, including mental health providers (from both community-based organizations and the public health system); the California Mental Health Directors Association; consumers of mental health services, both adult and youth and family members; promotoras; representatives of migrant workers; and representatives of the juvenile justice system. Other stakeholder groups will be added based on gaps in expertise observed during the process of recruiting members of the Concilio, and input from the DMH team. The group will represent a diversity of mental health issues, and will also reflect economic, age, gender, and geographic diversity. Each member of the Concilio will be asked to commit to attendance at quarterly meetings and participation in a collaborative process to produce a community-defined, strength-based culturally and linguistically appropriate report on reducing disparities in mental health services for Latinos.

Objective #2: Concilio Retreat

The project leaders at CRHD and LBHI will organize and conduct a retreat of the Concilio during January or February, 2010. The retreat will develop the following products:

- Description of roles and expectations
- Membership criteria for regional workgroups (roughly based on existing membership criteria for various MHSA Committees)
- Assessment tools, including stakeholder inventories, available public data sources, and public input that will help identify the types and distribution of mental disorders and patterns of mental health services utilization in Latinos and suggest interventions that could help reduce the disparities in services and outcomes.
- Recruitment plan
- Membership agreement statement
- An inventory of the issues affecting the Latino community including individuals who are knowledgeable about different mental health issues including depressive, anxiety, and substance use disorders, issues of trauma and violence, juvenile justice and foster care involvement, etc. and with a diversity of experience.

Even though more details could have been provided for each of the above products, it was recognized that it is critically important to involve the Concilio members in identifying and formulating the questions and come up with their potential interventions without preconceived or a priori notions. Forging relationships without a predetermined product or agenda in mind both builds trust and enables true partnerships.

Objective #3: Workgroup member roster and community affiliation

During the months of March through July, 2010, the Concilio will work to identify stakeholders who will form the workgroups at the regional level (i.e., Superior, Southern (including the LA area), Central and Bay area regions). Each member of the Concilio will develop a list of community leaders with contact information, and will forward the information to the project leaders, who will coordinate contact and recruitment of representative workgroups within each region. Concilio members will make initial contacts to recruit regional workgroup members. During this period, the Concilio will hold monthly conference calls or teleconferences during which the Concilio members will work on the structure and organization of the regional workgroups.

Program Component #2: Convene four regional strategic planning workgroups

Objective #5: Convene two Concilio teleconferences to organize and plan regional strategic meetings.

During July and August, 2010, the Concilio will hold two participatory teleconferences at which they will organize and plan the regional workgroup meetings. During these teleconferences, the Concilio will review, discuss and approve meeting structure, leadership structure, strategies for inclusive participation, procedures for decision making and priority setting, and procedures for identifying barriers to community engagement and addressing concerns and conflict resolution.

The project leaders have discussed their general approach to each of these elements, as follows:

Meeting structure: The meetings of the workgroups will be designed to facilitate achieving consensus among workgroup members, which will then be reflected in each regional workgroup's report.

In order to achieve recommendations that have the support of all group members, it is important that the meeting design facilitates preparation, attendance, the full presentation of all points of view, an open and honest discussion of the issues and solutions presented and inferred from the presentations, a consensus-building process, agreement on the consensus position, and acknowledgement of the consensus position by participants.

Preparation: Prior to the first meeting, each group member will receive orientation materials, and an assignment to prepare a short presentation on a specific topic to share with the other group members. For example, participants might be asked to describe something that happened in the past week that will inform their work during this meeting. A similar format will be arranged for subsequent meetings, with topics suggested by the group at the close of the previous meeting.

At the first meeting of the regional workgroups, members will be asked to participate in a values clarification exercise to raise awareness about the influence of diverse life experiences in the development of cultural and linguistic competence and issue expertise.

Ground rules: a) one person speaks at a time; b) no side conversations; c) no personal attacks (focus on issue and ideas); d) listen to each member as an ally ("we are in this together"); e) abide by time agreements; and f) any other ground rules adopted by the group. Each group member will be asked to agree to a statement of rules and principles that will serve as the basis for achieving agreement within the group.

Attendance: Each group member should understand that his or her attendance and participation are of critical importance to the process. The development of group cohesiveness will be important for the implementation phase of the CRDP.

Strategies for inclusive participation: A brainstorming process is usually helpful to ensure that all points of view are presented and acknowledged. The facilitators will write down each point on display paper, and will then lead the group through a process of combining points to develop more specific issues that can then be addressed with potential solutions. When necessary, votes of the group may be held using a multi-vote system to express priorities. For example, each person gets ten votes to allow them to express the importance of an issue to them. Colored dots or other tools are typically used for this process.

Discussion: Initial discussion will be carried out in small groups of four to six people. The time for discussion should be long enough for full discussion and achievement of small group consensus for presentation to the large group.

Issues and solutions: Each small group will present their discussion to the large group in an issues and solutions format. These will be recorded by the facilitators so that the large group can see where there are commonalities among groups, and where there are topics that need more discussion.

Consensus-building process: The facilitators will implement a gradient system of support to achieve consensus on recommendations.

Agreement on the consensus position: The facilitators will work with the group to make any amendments necessary to achieve consensus, and then ask for agreement on the position.

Acknowledgement of consensus position: Each group member will be asked to "sign off" on the consensus position in some way, such as affixing a personal symbol or signature to a display paper detailing the position.

Leadership structure: Members of the Concilio will be encouraged to attend the regional workgroup meetings, and four Concilio members will be asked to chair the four workgroups. In general, meetings will be led by the consultant/facilitator, who will be charged to make sure that the dialogue is consistent with the agenda and responsive to the Concilio's inquiry. The Concilio members will primarily play a listening role at the workgroup level, learning about community strengths and needs, and attending to strategies that may develop from the regional work.

Conflict resolution: The potential for conflict will be acknowledged at the beginning of the process at both the Concilio and workgroup levels. The groups will be asked to participate in an exercise designed to identify shared and differing perspectives (and possibly values), and to develop an approach as a group that will lead to consensus to the extent possible. Each group member will be asked to consider agreeing to the results of the consensus-building process. When it is not possible for a group member or members to agree with the group position, any member will be able to have their objections recognized as part of the report, and/or to submit a minority report that will be part of the record.

Language accessibility: In order to ensure that consumers, family members, promotoras, health professionals, community advocates, and other interested members of the community contribute to the CRDP process, Spanish-language interpretation will be provided in the public forums held in each of the four planning regions. The workshop will utilize a round-table, small group, or public hearing format to obtain information from individuals whose preferred language is Spanish. Participants will be invited to present information, data, ideas, and responses based on their experience and knowledge of the Latino population in their community. These sessions will utilize simultaneous translation equipment and certified interpreters to ensure that users of Spanish and English will be able to share their knowledge, understand one another, and participate in a dialogue.

Communication plan: A multi-method approach will be taken to maximize opportunities for communication between the group and lead organizations as well as within the strategic planning workgroup. As it is hoped that the relationships created through this project will lead to a sustainable and active network of Latino providers and advocates, the establishment of convenient and effective methods for ongoing participation and communication is critical.

In the initial phases of the project, the focus will be on conducting outreach and identifying group members. For this phase, cultural brokers – individuals with expertise and relationships with key communities – will be consulted regarding appropriate individuals to contact and recommended communication strategies. For the various individuals involved, communications strategies may differ. Participation from various constituents may be maximized if a variety of communication methods are employed, depending on the preferences of the individuals involved. These methods may include face to face contacts, phone meetings, and/or email contacts.

Once a group is formed, communication strategies will be established that will facilitate ongoing discussions. These communication strategies will include: regular phone conferences, a web-based communication tool, email, and phone contacts. To distribute written materials, participants will be offered both electronic, web, and hard copy distribution.

During the regional meetings, facilitators will be present to establish rules and strategies for effective communication.

Web-based technology will allow project coordinators to keep participants updated and will provide a venue for ongoing feedback and discussion. A web application such as Google groups, Facebook, or Twitter will be used. In vivo discussions and announcements of upcoming meetings and events will be posted on the website. In addition, key documents such as meeting minutes, reports, and deliverables will be posted on the website for comment. It is hoped that this website will provide a sustained venue for communication among Latino advocates across California.

Objective #4: Conduct regional meetings in four regions to identify promising practices and develop recommendations for the strategic plan. Establish in-person meeting and conference call schedule.

During the months of August through December, 2010, a regional meeting will be held in each of the four geographic regions. With assistance from members of the Concilio, CRHD will plan and conduct meetings in the Superior and the Central Valley regions. With assistance from members of the Concilio, LBHI will plan and conduct meetings in the Southern and the Bay area regions.

Objective #5: Prepare and distribute meeting materials, agenda, and minutes of each meeting.

In close coordination, the CRHD will prepare all materials for the two regional conferences it will staff. LBHI will also prepare all materials for the two regional conferences it will staff and both partners will share the materials. Timeline for these tasks is December, 2009 through December, 2010.

Program Component 3: Develop and Finalize Reducing Disparities Population Report

After a year of data collection, development of recommendations, and building consensus, the information will be assembled into a draft report for review by the regional workgroups and approval by the Concilio.

Objective 6: Collating and summarizing data from regional meetings

Notes and minutes from regional meetings will be reviewed by the project team, which will develop draft summary community-defined, strength-based recommendations for reducing disparities in mental health outcomes, improving access to programs and services, identifying focus areas for mental health, promoting effective approaches (best practices), and supporting solutions that build on community assets. This will occur between November, 2010 and March, 2011.

Recommendations will be analyzed for common themes in the following areas:

- Strategies for increasing treatment participation by Latina/os by reducing individual and community barriers to care; e.g., by reducing stigma, increasing family and community support for mental health services.
- Strategies for increasing treatment participation by improving access to existing programs and services.
- Recommendations for new programs and modification of service delivery to increase treatment participation.
- Recommendations for new programs and modification of existing services to improve retention in services and reduce drop-out.
- Recommendations for new programs and modification of existing services to improve successful treatment outcomes (other than retention).
- Strategies for design of effective approaches to the evaluation of implemented recommendations.

Objective #7: Obtain feedback from regional workgroups and Concilio.

During March of 2011, the Concilio will hold a teleconference to review a draft of strategies and recommendations. An initial review by the Concilio will precede a review by the regional workgroups, who will provide feedback to the Concilio on the strategies and recommendations.

Following regional workgroup review, the Concilio will engage in the following steps to shape a final draft of the Report:

- Each Concilio member will independently review the listings of strategies and recommendations from the Strategies Planning Workgroups, and assess the strategies and recommendations for feasibility of implementation (including factors such as cost) and likelihood of success.

- The Concilio will then meet and share independent ratings of the strategies and recommendations. RatingsThe feasibility of implementation and likelihood of success of the strategies and recommendations will be rank-ordered.

- Based on the previous rank-ordering, the Concilio will jointly make specific recommendations as to where (i.e., which counties and which part of counties, urban or rural, etc.) and how to implement the strategies and recommendations.

- Project staff will make specific recommendations for how to track the success of the strategies and recommendations once implemented.

The Concilio will hold one joint meeting with the regional workgroups to discuss the final report and recommendations. This meeting will be held as a teleconference, with each region participating from a campus located in their region.

Objective #8: Finalize draft of Reducing Disparities Population report.

During April and May, 2011, CRHD will finalize a draft of the Reducing Disparities report on the Latino population. The report will be reviewed in an all-day meeting, and submitted to the MHSA Multicultural Collaborative in June, 2011. The CRHD project staff will also work with the CDRP facilitator/writer and the California Department of Mental Health to develop a final report on reducing disparities in the Latina/o population, for incorporation with recommendations from other populations comprising the collaborative.

Objective #9: Communicate with collaborating organizations and plan dissemination of project report and recommendations.

Throughout the project period, CRHD will seek to participate in the Multicultural Collaborative, and will establish ongoing communication with DMH and the CDRP Facilitator/Writer. All project information, including meeting notices, agendas, materials, minutes, drafts of reports, and participant lists will be shared with DMH, the Multicultural Collaborative and the CDRP Facilitator/Writer.

Once the recommendations are finalized, staff, consultants, and other participants will create a schedule to share the project report at conferences, workshops, in publications, and in other venues in which members of the target population and policymakers will be able to learn about and benefit from the work of the project.

Objective #10: Disseminate final report.

CRHD is committed to participating on the Multicultural Collaborative and its dissemination team to raise awareness of the resources and needs identified by the project, and the recommendations of the Latina/o population working group (Concilio). CRHD will work with the California Department of Mental Health and the CRDP Facilitator/Writer to make the report and recommendations available in a hard copy, electronic copy, and through the CRHD website.

The report and its recommendations will also be offered to the California Mental Health Planning Council, the MHSOAC, the California Mental Health Directors Association, and the Online Archive of California (OAC), and to community advocacy groups, so that the final report will reflect and be accountable to the participants and their constituencies.

Program Component #4: Contribute to CRD strategic plan.

CRHD will be an active participant in the process of developing and promoting the CRD strategic plan, along with working groups addressing the African-American, Asian-American/Pacific Islander, LGBTQ, and Native American populations.

Objective #11: Collaborate with CRD partners to promote the development and dissemination of an aggregate strategic plan to reduce disparities in mental health.

CRHD will participate in RD strategic planning workgroups, keep in close communication with the CDRP Facilitator/Writer, attend meetings of the MHSA Multicultural Collaborative, and share strategies, experiences, and data with the other four reducing disparities strategic planning population projects. Partners will be invited to observe regional workgroup meetings, and will be invited to subscribe to any electronic communications mechanism (google group, yahoo group, e-list, etc.) that is established by the Latina/o project component.

CRHD will be actively involved in the preparation of the aggregate strategic plan, through participation in and leadership of the CRD partnership, and through review and comment on drafts of the strategic plan. It is the intent of CRHD to promote the plan as a holistic response to the disparities evident in mental health services for the five specific populations identified by the CRD project. CRHD looks forward to teaming with those who addressed other populations to disseminate and promote the California Reducing Disparities Strategic Plan.

Program Component #5: Progress Reports

CRHD is committed to accountability and transparency at all levels of its work.

Objective #12: Report progress of project to DMH

CRHD will submit quarterly narrative progress reports to DMH three times annually, with an annual report at the end of year 1 and year 2. CRHD will comply with all DMH requirements for formatting and reporting elements.

Projected Schedule of Meetings

Jul. 2010	Contract executed
May 2010	Planning meeting and initial identification of Concilio members
Jun. 2010	Contact Concilio members and send invitation letters
Aug. 2010	Concilio Retreat
Sept. 2010	Concilio meeting at LBHI Conference
Oct.	Concilio conference call
Nov.	Concilio Teleconference
Dec. 2010	Concilio conference call
Jan. 2011	Initiation of Regional Workshops with interpreters when needed
Mar. 2011	Concilio Teleconference
Apr. 2011	Regional workgroups continue
May 2011	Finalize Regional workgroups and Concilio conference call
Jun.2011	Concilio Conference call
Jul. 2011	Concilio All Day meeting
Aug. 2011	Concilio Conference Call
Sep. 2011	Dissemination Regional workgroup outcomes
Oct. 2011	Dissemination of Regional Workgroup outcomes – Concilio conference call
Nov. 2011	Concilio Teleconference
Dec 2011	Concilio conference call
Jan. 2011	All-day meeting
Feb. 2011	Concilio conference call

Latino Behavioral Health Institute (LBHI), Subcontractor: LBHI is a non-profit corporation founded by CEO Ambrose Rodriguez, M.P.A., and incorporated in 1996 (EIN No.: 93-1195514). LBHI's mission is to enhance skills of persons interested or involved in providing behavioral health services to the Latino community. The Institute is dedicated to eliminating discrimination against persons in need of behavioral health services, human services or health care.

LBHI accomplishes its mission by providing training, education (interactive and dyadic) and experiential opportunities to persons involved in human services with the Latino community. The Institute's activities are intended for consumers, family members, professional care providers, administrators, educators, researchers and trainers.

Since its inception, LBHI has provided hands-on training in delivery of culturally competent behavioral health services to practitioners. It has also participated in education opportunities for family members of persons requiring behavioral healthcare.

LBHI has held annual national conferences since 1995, addressing Latino behavioral health issues. The Conferences address issues of children, adults, older adults and explored contemporary issues of policy, training, research, clinical and education as related to Latino substance abuse, mental health, health and other human services.

LBHI has been joined in these efforts by the National Institute on Drug Abuse (NIDA), National Institute of Mental Health (NIMH), Substance Abuse and Mental Health Services Administration (SAMHSA), National Hispanic Science Network (NHSN), Los Angeles County Department of Mental Health (LACDMH), Los Angeles County Mental Health Commission (LACMHC), American Society of Hispanic Psychiatry (ASHP), the Southern California Chapter of the American Psychiatric Association (APA), College Hospital (Orange County), Los Angeles County Department of Health Services (LACDHS), Los Angeles County Department of Children and Family Services (LACDCFS), Pacific Clinics, the National Hispanic Consortium on Mental Health, and by the United Farmworkers Foundation.

LBHI will provide key technical skills and leadership to the project. The organization has deep knowledge, expertise and contacts within the Latina/o community in the large Southern California region, and will provide important visibility to the project in this area.

Overall supervision and monitoring of the work of LBHI will be the responsibility of Dr. Aguilar-Gaxiola and Ms. Sala. The lead agency will initiate and document a monthly phone conference or will ask LBHI to provide a written report on progress toward completion of project deliverables. Such documentation will be submitted and approved by CRHD prior to release of any subcontract funds.

Evaluation of the work of LBHI will be conducted in conjunction with preparation of the quarterly and annual written reports to DMH. The evaluation process will consist of, at a minimum, a self-evaluation by LBHI and a written acknowledgement of the self-evaluation findings by CRHD. These will be incorporated into the reports required by DMH.