

African American Utilization Report

Goals and Recommendations

Winter 2011



**Comments, questions and requests for additional
copies may be directed to:**

Alameda County Behavioral Health Care Services
2000 Embarcadero Cove, Suite 400
Oakland, CA 94606
(510) 567-8100
www.acbhcs.org

**“It takes
a deep
commitment
to change,
and an
even deeper
commitment
to grow.”**

Ralph Ellison

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Alameda County Behavioral Health Care Services (BHCS) greatly appreciates the community-wide interest and participation in this process, which included representation from the following groups and organizations:

- *Alameda County Board of Supervisors*
- *BHCS staff*
- *Community-Based Providers*
- *Consumer Advocacy Groups*
- *Faith-Based Organizations*
- *Hospice Organizations*
- *Mental Health Board*
- *Mental Health Consumers and Family Members*
- *Military Veterans*
- *Policy and Media Groups*
- *Public Health Departments*
- *School Districts*

African American Utilization Report

Project Manager

Gigi R. Crowder, LE
BHCS Cultural Competency Coordinator and Ethnic Services Manager

Committee Members

Pastor Jerry Blackmon
New Jerusalem Church

Rachel Bryant
BHCS Transition-Age Youth Advisory Board Facilitator

Steven Bucholtz
Wellness Educator, BHCS Wellness, Recovery and Resiliency Hub

DJ Mustafa
Adult Consumer Advocate

Dynell Garron-Lewis
Director of Family Resource and Support Centers, Brighter Beginnings

Dr. Lisa Gifford
Alameda County Mental Health Board and Hospice Advocate

Shelley Hamilton
Manager, Center for Child Protection, Children's Hospital, Oakland

Robyn Hodges

District 4 Policy Analyst,
Alameda County Board of Supervisors

Katrina Killian

BHCS Consumer and Family Advocate

Jerome Knox

West Oakland Mental Health Council

Darnell Levingston

Consumer Advocate and
HIV/AIDS Educator

Dr. Jasper Lowery

Pastor, Urojas Church,
Street Outreach for Healthy Oakland

Veronica Lowery

Community Advocate

Cherise Martinez-McBride

Berkeley Unified School District

Barbara McClung

BHCS and Oakland Unified School
District Liaison

Shirley Posey

Consumer and Family Advocate

Dayvell Rose

Consumer and Veterans/Homeless
Issues Advocate

Quinta Seward, Ph.D.

Policy Director, Safe Passages

Michael Shaw

Director, Urban Male Health
Initiative, Alameda County Public
Health Department

Freddie Smith, LCSW

BHCS Project Manager for Primary
Care Integration

Rudy Smith, LCSW

President, Bay Area Black
Social Workers Association;
Case Manager, Measure Y Project

Eldridge Tolefree, Jr.

BHCS Transition-Age Youth
Advisory Board

Gwen Wilson, LCSW

Founder and Director,
Goals for Women

Colette Winlock

Director, Black Women's Media
Project; Mental Health and Recovery
Consultant

Jaleah Winn

Wellness Educator, BHCS Wellness,
Recovery and Resiliency Hub

Wendi Wright

BHCS Mental Health Services Act
(MHSA) Program Specialist

Facilitation Team

**Kirkland A. Smith
& Associates**

Kirkland Smith

President

Marveta Allen

Executive Assistant

Robert Lewis

Consultant

Sheila McWilliams

Administrative Assistant

Travis Mozeke

Consultant

Kenya Sullivan

Writer/Subject Matter Expert



Alameda County Behavioral Health Care Services

Our Mission is to maximize the recovery, resilience and wellness of all eligible Alameda County residents who are developing or experiencing a serious mental health, alcohol or drug concern.

We Envision a community where all individuals and their families can successfully realize their potential and pursue their dreams, and where stigma and discrimination against those with mental health and/or alcohol and drug issues are remnants of the past.





Our Values

Access

We value collaborative partnerships with consumers, families, service providers, agencies and communities, where every door is the right door for welcoming people with complex needs and assisting them toward wellness, recovery and resiliency.

Consumer & Family Empowerment

We value, support and encourage consumers and their families to exercise their authority to make decisions, choose from a range of available options and to develop their full capacity to think, speak and act effectively in their own interest and on behalf of the others that they represent.

Best Practices

We value clinical excellence through the use of best practices, evidence-based practices, and effective outcomes, including prevention and early intervention strategies, to promote well being and optimal quality of life. We value business excellence and responsible stewardship through revenue maximization and the wise and cost-effective use of public resources.

Health & Wellness

We value the integration of emotional, spiritual and physical health care to promote the wellness and resilience of individuals recovering from the biological, social and psychological effects of mental illness and substance use disorders.

Culturally Responsive

We honor the voices, strengths, leadership, languages and life experiences of ethnically and culturally diverse consumers and their families across the lifespan. We value operationalizing these experiences in our service settings, treatment options, and in the processes we use to engage our communities.

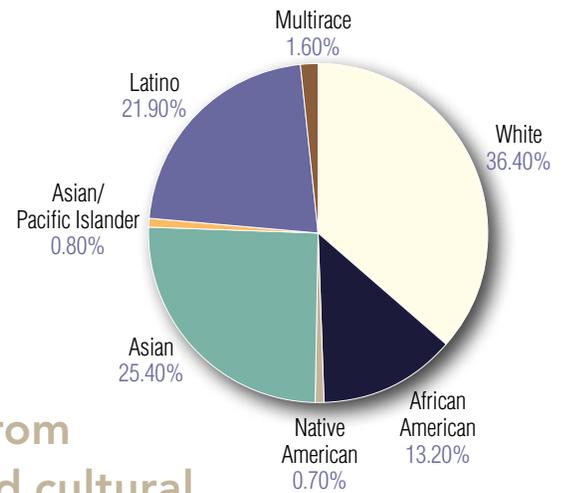
Socially Inclusive

We value advocacy and education to eliminate stigma, discrimination, isolation and misunderstanding of persons experiencing mental illness and substance use disorders. We support social inclusion and the full participation of consumers and family members to achieve fuller lives in communities of their choice, where they can live, learn, love, work, play and pray in safety and acceptance.

Alameda County Strategic Vision

Alameda County Demographics

Source: American Community Survey, 2008



“Our County is rich with diversity. Our communities are from diverse ethnic and cultural backgrounds, economic status and lifestyles. We celebrate our differences and appreciate our commonalities. We support and encourage the building of healthy communities where individuals, children and adults can thrive and can be all they can be. We do this by protecting the general public health, providing place/population-based services, protecting vulnerable populations, and providing a safety net for families/individuals and assistance towards self-sufficiency.”

Alameda County Board of Supervisors, 2008



“It is with great pride that we send out this message of hope and promise.”

Gigi R. Crowder, LE
Project Manager,
African American
Utilization Report



Foreword

I am a native of Oakland, a family member, a consumer advocate and a strong believer in social justice. As an employee of Alameda County Behavioral Health Care Services and a member of the African American Utilization Report Committee, our goal is to share this report with all those with an interest in improving behavioral health care outcomes for African American consumers in Alameda County.

BHCS approached this project by assembling a 28-member, cross-sector Utilization Report Committee to identify the community's greatest concerns and challenges surrounding mental health and drug and alcohol abuse services. We began from the premise that, according to current utilization data, the County is serving African Americans at a disproportionately higher rate, yet the outcomes are inconsistent. Why? This question framed our investigation into how and if behavioral health care services are being delivered appropriately, in a culturally responsive and sensitive manner, and in ways that promote positive, lifelong outcomes.

This report was undertaken to both confront the issues and identify solutions to the discrepancies in mental health and substance abuse services specifically as they affect Alameda County's African American community. It is the Committee's hope that this report fosters constructive dialogue toward transforming our system of care into one that effectively serves all ethnicities appropriately.

This report focused on identifying real-life solutions to what are challenging and difficult discussions. Through this and other initiatives, BHCS is taking a leadership role in addressing the issues and seeking solutions to the complex mental health and substance abuse needs of African Americans in Alameda County.

We welcome your review and comments regarding these recommendations, and your continued involvement in building an effective and culturally responsive system of care.

A Letter to the Community

Marye L. Thomas, M.D.

Director, Alameda County
Behavioral Health Care Services



Former Surgeon General, Dr. David Satcher, affirms in his report on “Mental Health: Culture, Race, and Ethnicity”, that although major mental disorders like schizophrenia, bipolar disorder, depression, and panic disorder are found worldwide, across all racial and ethnic groups, there are striking disparities in access to quality mental health care among these groups.

As statistics show, most behavioral health care programs in California serve African Americans at a disproportionately higher rate than other ethnic communities, and these services are provided in extremely restrictive (often involuntary) settings such as hospitals and jails. Here in Alameda County, low income African Americans with serious mental illness (and co-occurring disorders) represent 25% of our population, yet receive 40% of all mental health services. Despite this “over-provision” of services, across the lifespan, positive mental health outcomes among African Americans in Alameda County and across the state are inconsistent, which leads us to conclude that many African Americans are being inappropriately served. In embracing the Strategic Vision adopted by the Alameda County Board of Supervisors in 2008 (see page 6), BHCS recognized that we needed to scrutinize our service delivery system and determine ways of improving outcomes for African American consumers, their families and the County’s African American community at large.

“Cultural biases against mental health professionals in particular and health care professionals in general prevent many African Americans from accessing care and receiving adequate treatment.”

National Alliance on Mental Illness

The Mental Health Services Act (MHSA) provided funding and opportunities to begin addressing these disparities in ways that in the past would have otherwise been difficult. In the six years since its passage, BHCS has listened to consumers, their families and community stakeholders who deserve a voice in determining their path to recovery and the services needed to support them on that path. Toward that end, we embarked on a collaborative effort with consumers, families and other members of the African American community to examine the disparities in behavioral health services and ways that we could improve services to address these issues.

Because this “over use” is so pervasive, it calls for addressing these issues across our entire system, using quality improvement efforts and programming, rather than simply funding small disparate services. The recommendations in this report will inform the way we plan, develop and deliver culturally responsive, effective behavioral health care services to African American individuals and their families now and in the future.

BHCS has adopted wellness, recovery and resiliency as important tools for eliminating the stigma and discrimination faced by people with mental health and substance use problems. How these tools can and will be used and adapted to tackle the compounding effects that racial discrimination and stigma have on African American behavioral health consumers is a challenge that we face.

I would like to thank the members of the African American Utilization Committee for their commitment, collaboration and partnership in helping us think through what advancements, best practices, and changes are necessary within behavioral health services as we implement the principles of wellness, recovery, resiliency and the hope they provide to the many diverse communities that make up Alameda County.



Priorities by Age Group

“Behavioral Health Care is not a ‘one size fits all’ system. A valid understanding of ethnic group experiences can only be acquired by a self-enlightened, non-defensive, open and skilled professional network of providers.”

CHILDREN & YOUTH (BIRTH TO AGE 16)

- Ensure mental health diagnosis is accurate and unbiased.
- Reduce ad-hoc and piecemeal services for those experiencing complex mental health issues.

TRANSITION-AGE YOUTH (TAY) (AGES 16 TO 29*)

- Decrease social isolation and marginalizing of African American TAY at risk for serious mental health issues due to social determinants.
- Provide culturally responsive treatment and services for those already being served in the TAY system of care.

ADULTS (AGES 29 TO 59)

- Promote culturally responsive, strength-based and coordinated services to empower adult consumers to recover from serious mental health and substance abuse issues.

OLDER ADULTS (AGES 59+)

- Increase the accuracy of diagnosis of mental health issues among older African American adults.
- Increase the links between primary care and mental health support.



Summary of Recommendations

Continue to innovate in building a system of care that intrinsically provides appropriate services for all consumers and their families in Alameda County, recognizing each ethnicity's distinct social, cultural and spiritual affinities.

Implement African American cultural sensitivity and behavioral health awareness training for all County staff, including BHCS, Public Health Services, Social Services and Criminal Justice employees and contractors.

Develop collaborations and supportive infrastructure between BHCS, Public Health and other County agencies to earlier engage consumers who are experiencing or are at risk for serious mental health issues, specifically in departments with an over-representation of African American adults, e.g., Criminal Justice and Social Services.

Enlist and educate the African American faith community to reduce stigma and provide effective services to support consumers and family members.

Increase the accuracy and reduce bias of diagnoses and treatment options among children and youth by promoting the use of Clarifying Assessments, community-based consultations, and best interventions for trauma practice.

Strengthen the cultural relevancy of services by increasing the number of multidisciplinary, culturally appropriate case management teams in the field.

Ensure that new programs and infrastructure are developed with input from African American subject matter experts.

Expand peer-to-peer support programs, community capacity building and therapeutic activity group (TAG) programs throughout the TAY and Adult systems of care.

Increase the links and communication channels among BHCS, providers and the primary care community across all ages; provide screenings for Post Traumatic Stress Disorder (PTSD) and depression within the primary care setting.

Provide primary care providers with culturally relevant training on Differential Diagnosis, to address co-occurring conditions linking mental health, substance abuse and physical health issues, especially in older African American adults.

Recognize the impact of historical trauma across the African American community, and explore solutions to instill a belief and trust in the effectiveness of the County system of care.

**For the purposes of this report, due to delayed access to treatment for African American TAY, the upper age range for this group has been increased from 24 to 29.*

Methodology

In December 2008, BHCS selected 28 people from a highly qualified and passionate pool of applicants to serve on the African American Utilization Report Committee.

The Committee was divided into four subcommittees, as follows, based on the structure of the BHCS system of care and individual areas of interest and expertise:

1. Children & Youth, Birth to Age 16
2. Transition-Age Youth, Ages 16 to 29*
3. Adults, Ages 29 to 59
4. Older Adults, 59 years +

To ensure inclusion and transparency, the Committee contracted with Kirkland A. Smith and Associates (KASA) to develop a comprehensive planning process that would enlist broad community collaboration involving African American consumers, family members, service providers,

clergy, community leaders, cultural brokers, system partners and other interested stakeholders. To keep the flow of information current and relevant, Committee materials and meeting notes were posted on the BHCS website, and County staff and facilitators were available to respond to public queries and input.

Prevalence and User Disparities Among African American Children and Adults in Alameda County

	% Prevalence Population	% Frequent Users Served	Service Disparity
African American	23%	43%	+20%
Asian/Pacific Islander	20%	12%	-8%
Caucasian	23%	28%	+5%
Latino	27%	14%	-13%
Native American	1%	1%	N/A
Other	6%	2%	-4%

Source: BHCS System Data, 2008

The process began by providing the historical context behind behavioral health services in the African American community. The majority of this preliminary research was pulled from "Racism and Mental Health" by Carolyn B. Murray, University of California, Riverside.



*For the purposes of this report, due to delayed access to treatment for African American TAY, the upper age range for this group has been increased from 24 to 29.

Definition of Disparity

In spite of advances in diagnosis and treatment, medical evidence has proven that racial and ethnic minorities typically tend to receive a lower quality of care than non-minorities, and that minority patients experience greater morbidity and mortality. BHCS adheres to the Institute of Medicine (IOM) definition of disparities in health care, which the IOM defines as “racial or ethnic differences in the quality of care that are not due to access-related factors or clinical needs, patient preferences, and appropriateness of intervention.”

Additional context was provided by the following subject matter experts:

- **Carl Bell, M.D.**, founder and CEO of the Chicago Community Mental Health Council, Inc., an internationally recognized psychiatrist, lecturer and author. Dr. Bell presented his research on mental wellness, violence prevention and traumatic stress caused by violence, as well as the social determinants that promote health care disparities in the African American community, including poverty, education gaps, violence and trauma experiences.
- **Joy Degruy Leary, Ph.D.**, a noted clinical psychologist and author, presented highlights from her book “Post Traumatic Slave Syndrome,” which explores the ways in which slavery, oppression and racism have impacted the African American community’s current mental status. Her premise is that the trauma carried through over multi-family generations may influence mental wellness and response to treatment now.
- **Tony Iton, M.D., J.D., MPH**, former director of the Alameda County Public Health Department, addressed the social determinants to health, including housing, racial discrimination and limited educational opportunities, and the ways in which these environmental factors often result in devastating consequences and disparities among all of the County’s ethnic communities. A major proponent of place-based strategies, Dr. Iton advocates addressing the underlying non-behavioral issues that shape healthy communities, specifically access to resources, power and influence.
- **Kenya Sullivan, MSW**, presented on the increasing rate of suicides in the African American community and the need to look more closely at “suicide by proxy.” This form of suicide, which is rarely reported as such, is becoming more common as hopelessness among young black males results in more violent behavior and puts them at high risk for being killed by law enforcement or rival peers.

“66% of African Americans receiving behavioral health care services in Alameda County reside in Oakland, the most multi-cultural city in Alameda County. Next to Los Angeles, Alameda County has the second largest population of African Americans in the State of California.”

BHCS System Data, 2008

Methodology

- **Desiree Rushing**, a respiratory therapist and well-known activist who has lived with HIV for more than 25 years, discussed the trends and impact of HIV/AIDS on mental health consumers. Acknowledging the need for ongoing mental health support starting from diagnosis forward, she cites stigma as one of the biggest mental health issues among African Americans, and the lack of involvement by faith-based organizations in addressing this issue.
- **A Clergy Roundtable** generated feedback from more than 25 diverse religious and spiritual leaders. Voicing concerns about the unhealthy trends in the African American community that result in poor health outcomes, the group was specifically concerned with issues around violence and substance abuse. Appreciating the need to better understand the community’s mental health issues, a large focus of the discussion centered on reducing stigma, a pervasive force in many black churches that makes it difficult for consumers and family members to get the support they need to address mental health concerns before they develop into crisis situations.
- **Wade Noble, Ph.D.**, a pioneer in the field of African Centered Psychology, shared his insights with the Committee into ways to better engage African Americans using tools and practices congruent with their African roots.
- **A Committee Tour of Santa Rita Jail** in Pleasanton, California demonstrated the over-representation of African American males in Alameda County’s penal system and the high recidivism rates experienced in the black community. Typically, more than three-quarters of the inmates in the Jail’s mental health unit are African American.
- **Focus Groups** were facilitated with African American consumers, including young adults, homeless adults and older adults utilizing County services. The Committee also solicited input from family members, providers, religious and spiritual leaders, advocates, medical professionals, BHCS system of care directors and other key staff.

The recommendations in this document were carefully considered using the data collected from an appreciative inquiry approach. The Committee heavily relied on the U.S. Surgeon General's Report of the New Freedom Commission issued in 1999. Based on "Practiced-Based Evidence" strategies, these recommendations are typically community centered and rely on a shared "call to action" that will support capacity building in a holistic, culturally effective manner with the ultimate goal of reducing disparities and improving outcomes for the African American community.

It is important to note the following when reading through this report:

- Many of the recommendations for the African American community can be applied to other ethnic and cultural groups.
- In addition to improving mental health services, these recommendations would also advance alcohol and other drug (AOD), physical health and social services for African Americans.

- BHCS has limited resources and clearly identified mandates for serving specific populations. These recommendations call for partnerships with a number of key groups, including family members, faith communities, recreational programs, AOD providers, primary care physicians, social services providers, law enforcement, the courts and the criminal justice system. The age-group-specific findings include additional partners that should be considered and engaged at various points across the life span.
- Many African Americans suffering from mental health problems likely experience co-occurring alcohol and other drug (AOD) and physical health issues. BHCS has current efforts underway to better integrate mental health and AOD services through the Co-Occurring Initiative and building partnerships with primary care providers.



"A Committee-sponsored retreat for African American Transition-Age Youth encouraged them to 'Tell their Stories.' Designed to be relevant and empowering, participants ended the weekend being better equipped to share their personal experiences and input with decision-makers as they work through the issues urban youth face in maintaining their mental wellness."

Overview of the Issues

“African Americans are disproportionately misdiagnosed, resulting in incorrect treatment. African Americans, at twice the rate of whites, are prescribed the older generations of antidepressants or antipsychotic medications and as a result suffer irreversible disability caused by long-term use of antipsychotic medications. Finally, communities of color, at significantly higher rates than whites, receive higher doses of high side-effect medications, are subject to involuntary medications, and are disproportionately subjected to restraints.”

University of California, Davis
Center for Reducing Health
Disparities, 2007

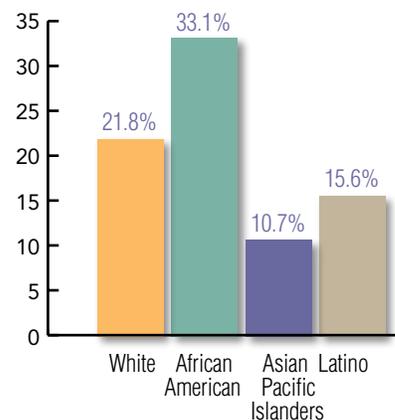
Across the U.S., adult African American consumers with serious emotional or mental health conditions are often wrongly diagnosed and end up being “treated” in the criminal justice system. In addition, African American youth often receive inappropriate mental health diagnoses and services while in foster care and juvenile justice settings. Compounding these issues, African American adults are less likely to receive mental health assessments and, once assessed, often are misdiagnosed and “labeled” with mental health conditions that are much more severe than indicated. African Americans are also often overlooked for early mental health issues, such as depression and anxiety, and contributing factors such as environmental stress and historical trauma are rarely acknowledged.

African Americans have an even higher rate of service utilization in local alcohol and other drug (AOD) programs. Statistics indicate that more than 70% of all consumers served in the BHCS

system have co-occurring diagnoses (Minkoff and Cline, 2006). Much of this substance abuse can be attributed to self-medication due to trauma and attempts to mask mental health issues.

Surveys by the U.S. Department of Health and Human Services imply that the rate of serious mental health issues among African American men is similar to that of Caucasian men. However, most African American men with major depressive or mood disorders do not receive treatment, and less than half of those with severe symptoms receive care. (Williams, González, Neighbors, Nesse, Abelson, Sweetman, et al., 2007).

Alameda County Adults 18–39 Needing Professional Help for Mental Health Issues



Source: California Health Interview Survey, 2007



Still Held by Chains

A poem by Kameron, age 11

I noticed when the first bell rang
a serenity some would say,
but not to this boy,
at least not today.

Glimmering were the clear beads
of tears streaming down his face.

Today his favorite teacher must
have judged him by his race.

His face down in his hands pocket
full of sand, he knelt there crying
weeping in the wet cold sand.

Finally his brother said
it's time to take a stand.

Hand in hand they walked
and talked for hours one might
say, but by the end of the day
things were quite okay.

The bells of freedom ringing,
a joyous choir singing but not
from here or far away will one
hear that sound around the
rough edges of hate, deep inside
the heart, the thumping and the
pumping of his soul inside
the dark, hold on keep on
striving just like Noah's ark.

They turned around,
a quiet motion returned
to the stone walls,
even though they walked
inside these halls they could
still remember outside these
hard cold walls.

Children & Youth

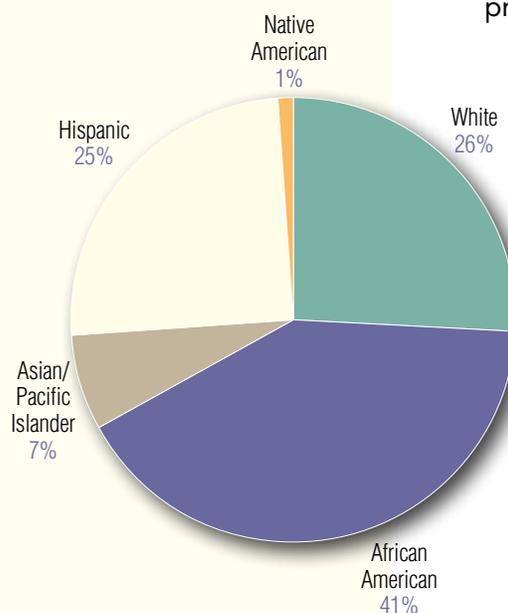
*"Over a 15-year span,
suicide rates increased
233% among African
Americans aged
10 to 14."*

Bailey and Hayes, 2006

Birth to Age 16

GOALS

- Ensure diagnoses of African American children and youth are accurate and unbiased.
- Make mental health programs for children and youth culturally responsive and equipped to appropriately address their age-specific mental health needs, acknowledging the high incidence of trauma many experience.
- Reduce ad-hoc and piecemeal services.
- Build multidisciplinary collaboration among all stakeholders, including the child, family members, providers, primary care physicians and other service providers.



Children Entering the Child Welfare System in Alameda County

Source: Alameda County Children and Family Services, 2007



BACKGROUND

Alameda County data suggests African American children and youth may be inappropriately diagnosed with serious emotional disturbance (SED) and serious mental illness (SMI). These diagnoses are often made when African American children and youth exhibit “problem” behaviors, and their mental health provider lacks the knowledge and/or tools to develop an understanding of the cultural context, root cause and other contributing factors, such as historical trauma. This type of misdiagnosis can be especially stigmatizing and may follow the individual through their pivotal developmental years.

In addition, many children and youth with complex issues receive services from an array of different health and mental health providers. Given that African American children and youth are over-represented in foster care, out-of-home placements and the juvenile justice system, it is difficult for any one provider to deliver effective care and treatment in the absence of communication and collaboration with the other providers. In many cases, the child, youth or family is not able to provide the background or historical context that ensures quality care.

RECOMMENDATIONS

- Promote the use of Clarifying Assessments, which evaluate the child in all areas of function and behavior, to identify the most appropriate referral and treatment pathways.
- Encourage African American learning communities and elicit outside subject matter experts to test the use of Clarifying Assessments among different age groups.
- Adopt community-based consultations by calling on expert(s) from the child’s community to provide insight into a specific behavior, symptom and possible influencers or triggers, prior to assigning a diagnosis.
- Solicit providers trained in African Centered Psychology to identify cultural nuances/practices/norms specific to the African American community.
- Endorse and promote the use of Cognitive Behavioral Intervention for Trauma (CBIT) programs for all County-funded school-based services.
- Support and increase the number of interdisciplinary, culturally sensitive case management teams in the field and encourage participation by primary care, mental health, education, foster care and juvenile justice representatives.
- Support efforts by the federally-funded Every Child Counts and Early Connections workgroups to develop and implement culturally responsive infrastructure, tools and strategies to increase referrals and information-sharing among family members, providers and other service agencies.
- Educate and encourage providers to integrate Clarifying Assessments and CBIT models into their practices, and to share “lessons learned” with colleagues and peers.
- Solicit input from the child and family members and include them in treatment planning.
- Ask consumers and family members about any care or medication that they may be receiving from other providers, and encourage the use of consent forms when appropriate.

Ages 16 to 29*

Transition-Age Youth

“Research suggests that African Americans tend to experience better treatment outcomes when paired with clinicians of similar race and background, but less than 4% of social workers and 2% of psychiatrists and psychologists in the U.S. are African American.”

National Association
of Black Social Workers

GOALS

- Ensure that culturally and age-appropriate programs are available to African American Transition-Age Youth (TAY) that promote social connections, healthy decisions and the development and attainment of meaningful life goals.
- Decrease social isolation and marginalizing of African American TAY who are at risk for serious mental health issues due to social determinants.
- Provide culturally responsive treatment and services for individuals already being served in the BHCS system of care.

BACKGROUND

African American TAY between 16-29* years of age experience a myriad of challenges as they transition from teen years into adulthood. This is the age when a first psychotic episode is most likely to occur, and it is often difficult for the young person and their families to differentiate between the signs and symptoms of serious mental health issues and the typical risks and behaviors that occur at this age.

Drop-out rates among African American high school students are high, and many TAY leave school to find that they do not have the adequate education or training to get a job or earn a living wage.





When a young person reaches 18, their eligibility for public programs such as Medi-Cal can be disrupted, making them vulnerable to losing their health insurance. In addition, the foster care system “ages-out” youth at the age of 18, who may well lack the support to pay rent and live independently, often resulting in homelessness.

Research shows that many African American TAY struggle with trauma, exposure to violence, unemployment, isolation, substance use, homelessness, incarceration and distrust of established systems; this is particularly true for young people at-risk for serious mental health problems and co-occurring issues.

As a result of these environmental and social determinants, there is a need in Alameda County for more services targeted to the specific needs of TAY, and for substance abuse programs using a recovery and resiliency approach.

RECOMMENDATIONS

- Develop stronger collaborations between BHCS and other County departments to earlier engage African American TAY experiencing or at risk for serious mental health issues.
- Expand TAY-specific mental health social rehabilitation and peer-to-peer counseling programs.
- Educate providers on Youth Development Models, as these youth-as-teacher programs have proven beneficial to treating African American males who may be judged as defiant and aggressive because of a lack of cultural awareness.
- Enlist community capacity building and therapeutic activity group (TAG) programs throughout the system, emphasizing new programs that are strength-based, innovative and sensitive to the needs of urban youth and/or delivered by staff with similar life experiences.
- Provide training on the signs and triggers of TAY behavioral health issues to all counseling professionals serving this age group.
- Develop partnerships with local educational institutions to promote career development among African American TAY.

**For the purposes of this report, due to delayed access to treatment for African American TAY, the upper age range for this group has been increased from 24 to 29.*



John's Path

"John" is emblematic of young adult African American males in Alameda County who the system has not appropriately or effectively served. Many young adult consumers like John may experience serious mental health and substance abuse issues starting at a very early age, resulting in severe drug addiction, violent behavior, social isolation and discrimination, and repeated arrests.

Through age 13

John and his younger brother are shuffled from group home to group home. John describes this time as miserable. Over the years both have been put on heavy doses of various antipsychotic medications.

Age 14

John is placed in his first foster care home. Violent and unpredictable behavior results in John's return to the group home while his younger brother stays in foster care. Reassigned to a group home in Contra Costa County, John visits his brother and foster family on occasional weekends and holidays.

Age 15

John does well in the new group home. Based on progress, his case worker fosters him at her home in Oakland.

Age 16

The new living situation doesn't work out. After a year he is again reassigned to a group home in Oakland, where he attends remedial high school classes and does well.

Age 18

John's group home "emancipation" hearing is attended by his first foster care giver, who he now refers to as "aunt;" a recently reunited cousin; his group home counselor; and several social services case managers. He is offered subsidized housing and gets a job offer from a fast food chain. He plans to start junior college focusing on criminal justice courses.

John graduates from high school, the first person to achieve a diploma in his case worker's ten-plus years of working with kids in foster care/group home settings. His foster aunt, his recently reunited sister and her boyfriend and son, and two group home managers attend the ceremony. The Saturday after graduation John calls his foster aunt and tells her the group home told him he must "be out by noon." At 12:10 pm that day, she picks him up at the curb with all of his belongings. His room has been reassigned to a new resident and the place he had called "home" for more than two years is now off limits. He is now on his own, with just \$110 in graduation money and the promise of an apartment, a job and a used car.

Age 20

Within two years, John has lost his job, his apartment and his car and ends up homeless. He is kicked out of shelters because of violent behavior, has multiple run-ins with police, and has spent at least two 14-day stays in a psychiatric facility. He is currently in jail waiting to hear his fate.

A number of culturally responsive early intervention, prevention, and anti-stigmatization programs are being designed and are in various stages of implementation that will address these issues, provide more positive outcomes and prevent the negative consequences that John has experienced.



Ages 29 to 59

Adults

GOALS

- Ensure that mental health programs are culturally responsive and equipped to address the needs of African American adults.
- Promote culturally responsive, strength-based and coordinated services that empower African American adult consumers to recover from serious mental health and substance abuse issues.

“Nationally, 63% of African Americans believe that depression is a personal weakness.”

Mental Health America
Survey, 2007

BACKGROUND

African American adult consumers in Alameda County often live in poverty, and many have experienced traumatic situations that impair their psychological well-being and contribute to depression, post-traumatic stress, perceived aggression, anti-social behavior and social withdrawal. Most experience co-occurring conditions and may use substances as a way to self-medicate. Compounding these issues, African American males often receive mental health services in restrictive environments, and these services are rarely delivered by clinicians of similar race and life experience.

This multitude of factors can impact an adult consumer’s ability to articulate their own behavioral health needs. This intertwining of multiple issues increases the likelihood of inappropriate and/or delayed diagnosis of mental health issues, and the provision of high-intensity and crisis-oriented services that often result in long-term recidivism and delay in recovery. The individual and family are generally receiving services from multiple agencies and providers, which also complicates the effective delivery of care.

RECOMMENDATIONS

- Utilize evidence-based practices such as Motivational Interviewing, which has proven to be a culturally effective tool to engage African American consumers with co-occurring conditions.
- Adapt existing Wellness Recovery Action Plans (WRAP) to be culturally appropriate for use with African American consumers.
- Expand peer counseling opportunities among and between African American consumers; enlist African American Pool of Consumer Champions (POCC) members and former BEST NOW (consumer education program) graduates who have expressed an interest in the behavioral health care field in this effort.
- Develop a higher level of communication and coordination of services between County-operated agencies, specifically those with an over-representation of African American adults (Criminal Justice, Behavioral Health Care, Social Services).
- Provide screening for post-traumatic stress and depression in the primary care setting.
- Implement California Brief Multi-Cultural Competency Scale training across the system of care and promote the use of training tools among providers to eliminate biased practices.
- Recruit staff and clinicians to the system of care who have demonstrated experience and positive outcomes in serving African American adults.



Ages 59 and Older

Older Adults

“Differential Diagnosis is an especially important tool when assessing African American older adults, many of whom are experiencing dramatic life changes and co-occurring issues related to both their emotional and physical health.”

GOALS

- Increase the appropriate diagnosis of mental health issues among African American older adults.
- Ensure that programs are equipped to appropriately address the mental health needs of this group, who may experience depression, anxiety and other more serious mental health issues due to isolation, loss and other effects of the aging process.
- Increase communication and coordination between primary care and mental health providers.

BACKGROUND

African American older adults share mental health issues with elderly people of all backgrounds who struggle with the aging process. Depression, anxiety, isolation, loss, deterioration of physical health, substance misuse and abuse, and the effects of poorly managed primary care medications are exacerbated by living in neighborhoods where poverty and crime are prevalent.

These factors may lead to an increase in frequent episodes of emergency care, hospitalizations, the inability to manage independence, and the risk of homelessness. African American older adults who are the primary caregivers for grandchildren and/or adult children with mental health issues experience additional stress.

Many primary care providers who serve this population lack the effective practices and tools to screen and assess older adult mental health conditions, which may lead to inappropriate treatment and medication for both physical and psychiatric issues.



Christine's Story

"Christine" is a biracial African American woman who experienced isolation and discrimination from both the black and white communities for most of her adult life. Following an ever-deeper spiral into drugs, prostitution and mental illness, Christine ultimately found safety and solace at church, and she credits her strong faith for freeing her from the harmful demons and substances that framed her life experience.

RECOMMENDATIONS

- Provide mental health screening, assessments and peer-to-peer counseling for older adults in "safe" community locations where they already congregate, such as primary care clinics, senior centers, and faith-based institutions.
- Incorporate culturally welcoming components in the community-based screening process, including spirituality, music, and peer-led creative and recreational activities.
- Promote awareness and training to primary care providers on Differential Diagnosis, including the importance of screening for post-traumatic stress and depression.
- Increase coordination and communication between primary care providers, pharmacists, County agencies and mental health professionals serving the aging African American population.
- Ensure access to transportation and other incentives so that older adults are motivated to keep their medical and behavioral health appointments.

Christine was born in Texas in 1925 and describes herself as an activist for client spiritual rights. As a teen who "looked like Lena Horne and could sing like Billie Holiday," Christine dropped out of school at the age of 15 and followed a man from Texas to Oakland, who promised her riches and rewards as a nightclub singer. This relationship lasted only a few weeks, and finding herself penniless in the Bay Area, she met a man who introduced her to marijuana, and then to heroine. Thus began Christine's battle with addiction and prostitution that lasted most of her adult life. She says she started hearing voices soon after she began using, and at first thought it was the drugs. However, her older brother had experienced the same condition back in Texas, where his dark moods often lasted for months at a time.

Christine made it to age 40 before her first trip to Napa State Hospital, where she was sent following a violent drug induced episode; over the next ten years, she was repeatedly institutionalized and released. By her early 50's, she was living in a board-and-care in East Oakland and attending a mental health day program two-to-three times a week; she saw her case manager about once a month. A fellow resident introduced her to church, which she continued to attend even when she was feeling poorly or hearing voices. There she learned the power of prayer and spiritual awareness, and while she changed churches whenever she moved apartments, she has continued to find peace and solace at her neighborhood place of worship.

Christine says her spiritual foundation is what has kept her out of mental hospitals and free from the demons and substances that harmed her for most of her life. At 85, she still makes it to her church home whenever she can, and she strongly believes that all consumers should exercise their right to include their individual faith or spiritual practice into the treatment and recovery process.

Christine's story illustrates the significant role that spirituality often plays on the path to wellness, recovery and resiliency. BHCS has begun to implement outreach to and collaboration with the African American faith community.

Moving Forward

Alameda County Behavioral Health Care Services is already implementing several of the recommendations contained in this document, specifically:

- Promoting the use of the California Brief Multi-Cultural Competency Scale (CBMCS) and providing CBMCS trainings to County and community-based providers.
- Encourage the use of Clarifying Assessments among all County providers.
- Developing behavioral health programs that meet Older Adults in familiar community locations.
- Working with the faith-based community in sponsoring Clergy Roundtables surrounding behavioral issues.
- Supporting the Pool of Consumer Champions' *Black Men Speak* project.
- Collaborating with *Healthy Oakland* to promote health and wellness programs within the African American community.
- Partnering with *Youth Uprising* to provide mental health assessment and treatment services to African American Transition-Age Youth throughout Alameda County.
- Partnering with the Health Care Agency's Human Resources Department to develop plans for recruiting, hiring and retaining African American clinicians, particularly men.
- Coordinating with other County departments and African American community organizations, such as the Bay Area Black United Fund, to integrate our respective efforts in addressing other health disparities.
- Partnering with other community and professional stakeholder groups in addressing societal factors of disparity and inequities to achieve long-term systemic change.

BHCS is committed to providing effective and culturally appropriate services to the African American community and will be implementing additional Committee recommendations in the coming months.

BHCS would like to thank all of the members of the African American Utilization Report Committee; the Alameda County Board of Supervisors and their staffs; Alex Briscoe, Director of Health Care Services Agency; and the many other dedicated contributors who made this report possible. Special thanks to Beat Rhymes and Life and its founder, T. Tomas Alvarez; and to the Alameda County African American Family Support Group, for their participation and support.

Additional input to this document by all community stakeholders is welcome and encouraged. Please address correspondence to:

Alameda County Behavioral Health Care Services
Attn: African American Utilization Report
2000 Embarcadero Cove, Suite 400
Oakland, CA 94606

Sources

Adaptation Guidelines for Serving Latino Children and Families Affected by Trauma, (2008). Chadwick Center for Children & Families, San Diego, CA.

Alameda County Behavioral Health Care Services for Children and Youth, Strategic Plan 2009-12. Available at: http://www.acbhcs.org/csoc/doc/csoc_strategic_plan_0809.pdf

Alameda County Behavioral Health Care Services Resource Directory (2009). Available at: <http://www.acgov.org/pdf/ACResourceDirectory.pdf>

Alameda County Behavioral Health Care Services, *Transition/Transform Transition Age Youth Services Strategic Plan*. Available at: <http://cmhda.org/go/Portals/0/CMHDA%20Files/Committees/TAY%20Subcommittee/Meeting%20Reports/Alameda%20County.pdf>

Alameda County Behavioral Health Care Services Utilization Data, 2008

Alameda County Data Unit, African American TAY Mental Health Services Report. Available at: http://www.acbhcs.org/News/tay_report_final_check.pdf

Alameda County Probation Department. "A Look into Probation", 2008. Available at: <http://www.acgov.org/probation/documents/CoversheetandSections.pdf>

Alameda County Social Services Agency, Department of Children and Family Services 2001 Annual Report. Available at: http://www.alamedasocialservices.org/public/pdfs/annual_reports/dcfs_2001.pdf

Bailey, A. & Hayes, J.M. (2006). *Who's in prison? The Changing Demographics of Incarceration*. California Courts, Volume 8 (1).

Bay Area Regional Health Inequalities Initiative (BARHII) Report (2008). Available at: http://www.barhii.org/press/download/barhii_report08.pdf

Bazelon Center for Mental Health Law (2008). *Moving On: Analysis of Federal Programs Funding Services to Assist Transition-Age Youth with Serious Mental Health Conditions*. Washington, DC.

Bell, C., M.D., (2009) Presentation "Risk Factors are not Predictive Factors..."

California Department of Education, Educational Demographics Unit. Available at: <http://www.cde.ca.gov/ds/ds/cb/dataquest.asp>

Cohen, C.I., Magai, C., Yafee, R., Walcott-Brown, L., (2005). *Comparison of Users and Non-Users of Mental Health Services Among Depressed Older, Urban African Americans*. American Journal of Geriatric Psychiatry, 13: (7) 545-553.

Constructing A Racial Equity Theory of Change. Aspen Institute Roundtable of Community Change, 2009

Coon, D.W., Thompson, L.W. & Gallagher-Thompson, D. (2007). *Adapting Homework for an Older Adult Client with Cognitive Impairment*. Cognitive and Behavioral Practice, 14: 252-260.

Department of Health and Human Services, Office of the Surgeon General (US). *Mental health: a report of the Surgeon General*, 1999. Available at: <http://www.surgeongeneral.gov/library/mentalhealth/home.html>

Frazier, C., Mintz, L.B. & Mobley, M. (2005). *A Multidimensional Look at Religious Involvement and Psychological Well-Being Among Urban Elderly African Americans*. Journal of Counseling Psychology, 52 (4), 583-590.

Guerrero, R. (2006). *Engaging Cultural and Linguistics Competence in MHSA*; presented to CA OAC, California Department of Mental Health, Chief, Office of Multicultural Services.

Healthy Transition Act of 2009 (Introduced in House) HR 2691 IH, 111th CONGRESS, 1st Session, H.R. 2691

Holzer, C. E., Goldsmith, H. F., & Ciarlo, J. A. (1998). *Effects of rural-urban county type on the availability of health and mental health care providers*. In R. W. Manderscheid & M. J. Henderson (Eds), *Mental health, United States*, Rockville, MD: Center for Mental Health Services.

Manteuffel, B., Ph.D., Stephens, R.L., Ph.D., MPH, Sondheimer, D.L. MSNS, MPH, CPNP and Fisher, S.K. Ph.D., (2008) *Characteristics, Service Experiences and Outcomes of Transition-Aged Youth in Systems of Care: Programmatic and Policy Implications*.

McGinnis, M.J., MD, MPP; Foege, W.H., MD, MPH (1993) *Actual Causes of Death in the United States*, *Journal of the American Medical Association*, 270(18):2207-2212.

Minkoff K & Cline C, (2006). *Dual diagnosis capability: moving from concept to implementation*. *Journal of Dual Diagnosis*, 2(2):121-134.

Minkoff, K., Mechanic, D. & Snowden, L. *Impact of Risk-based Financing and Capitation of Service Access/Choice and Use*.

Murray, C.B., (1998). Racism and mental health. In H. Friedman (Ed.), *Encyclopedia of Mental Health*, (Vol. 3, pp. 345-357). San Diego, CA: Academic Press

Primm, A.B., Levy, R.A., Choyn, D. & Bondurant, A. (2009). *Improving Outcomes for Adult Depression in Ethnically and Racially Diverse Patients*. Available at: http://cme.medscape.com/viewarticle/702891_print

Sarkisian, C.A., Shunkwiler, S.M., Aguilar, I. & Moore, A.A. (2006). *Ethnic Differences in Expectations for Aging Among Older Adults*. *Journal of American Geriatric Society*, 54: 1277-1282

Snowden, L.R., Wallace, N.T., Kang S.H., Cheng, J.S. & Bloom, J.R. (2007). *Capitation and Racial and Ethnic Differences in Use and Cost of Public Mental Health Services*. Administration and Policy in Mental Health and Mental Health Services Research, Volume 34, Number 5, 456-464.

Oakland Unified School District 2005 CST Reading Scores

Poussaint, A., M.D. & Alexander, A. (2000). *Lay My Burden Down: Unravelling Suicide and the Mental Health Crisis Among African Americans*, Beacon, Boston, MA

Reed, D.F. & Karpilow, K. (2002). *Understanding the Child Welfare System in California: A Primer for Service Providers and Policy Makers*. California Center for Research on Women and Families (CFWF). Snowden, L.R. & Thomas, K. (2000). *Medicaid and African American outpatient mental health treatment*. *Mental Health Services Research*, 2, 115-120

Taylor, R.J. (2000). *Mental Health Services in Faith Communities: The Role of Clergy in Black Churches*. National Association of Social Workers, Volume: 45, Issue: 1, Page: 73.

Teplin, L.A., Ph.D., Abram, K.M, Ph.D., McClelland, G.M. Ph.D., Washburn, J.J. Ph.D. & Pikus, A.K. BS, (2005). *Detecting Mental Disorder in Juvenile Detainees: Who Receives Services*, *American Journal of Public Health*, Vol. 95., No. 10.

The Faith Factor: A Survey of Faith-Based Organizations in East Oakland, West Oakland and Hayward, CA (2008); Commissioned by: Alameda County Public Health Department's Urban Male Health Initiative

Tony Iton, M.D., JD, MPH, (2008). *Working for Social Justice: Transforming Public Health Practice to Achieve Healthy Equity*.

Urban Strategies Council, March 2009 Report: *Homicides in Oakland. 2008 Homicide Report: An Analysis of Homicides in Oakland from January through December 2008*.

Williams, D.R., González, H. M., Neighbors, H., Nesse, R., Abelson, J.M., Sweetman, J. & Jackson, J.S. (2007). *Prevalence and Distribution of Major Depressive Disorder in African Americans, Caribbean Blacks, and Non-Hispanic Whites: Results From the National Survey of American Life*, *Arch Gen Psychiatry*. 64:305-315.

Woodall, A. Oakland Tribune. *Violence in Oakland creates symptoms of post traumatic stress disorder*. Posted: May 2008. Updated: May 27, 2009.

Young Adults with Serious Mental Illness (2008), United States Government Accountability Office. Available at: <http://www.gao.gov/new.items/d08678.pdf>



Alameda County Behavioral Health Care Services
2000 Embarcadero Cove, Suite 400
Oakland, CA 94606
(510) 567-8100
www.acbhcs.org