



Concept Paper:
**Policy Options for Community-Defined
Evidence Practices (CDEPs)**

Advised by the Community-Defined Evidence Practice (CDEP) Integration Advisory Group

April 2021



Department of Behavioral Health



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Acknowledgments

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About CPEHN:

The California Pan-Ethnic Health Network (CPEHN) is a multicultural health policy organization dedicated to improving health of communities of color in California. CPEHN's mission is to advance health equity by advocating for public policies and sufficient resources to address the health needs of the state's new majority. We gather the strength of communities of color to build a united and powerful voice in health advocacy. More about CPEHN can be found here: www.cpehn.org

About the California Reducing Disparities Project (CRDP):

The California Reducing Disparities Project (CRDP) is a first of its kind, PEI (Prevention and Early Intervention) initiative funded by the Mental Health Services Act (MHSA, or Proposition 63). This statewide initiative aims to pair community driven mental health solutions with rigorous data for each of the 35 pilot projects. In doing this, the data and evaluation works to identify solutions for the communities in California that have historically been underserved, excluded, and offered inappropriate care. More about CRDP can be found here: www.cultureishealth.org

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Remembering
Janet King
(Lumbee Nation)



APRIL 4, 1957 - FEBRUARY 12, 2021

Dedication

This paper is dedicated to Janet King and her inspirational leadership and vision for justice. Throughout her life, Janet was an unwavering voice for cultural humility, dignity, and bold systemic transformation. Janet was a teacher, a fighter, and a pillar of the movement for racial justice and community wellness. Janet's contributions to this paper and to the California Reducing Disparities Project are immeasurable. Our lives are forever changed by Janet's tenacity and love for her community.

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Preface

There has been extensive research on behavioral health disparities in Black, Indigenous, and People of Color (BIPOC) and Lesbian, Gay, Bisexual, Transgender, Queer, and Plus (LGBTQ+) communities. In the early 2000s, several federal agencies published reports that inspired the movement for culturally and linguistically competent care. Works of this time include but are not limited to the Office of the Surgeon General in the U.S. Department of Health & Human Services’ 2001 report, “Mental Health: Culture, Race, and Ethnicity,”ⁱ the New Freedom Commission’s 2003 report, “Achieving the Promise: Transforming Mental Health Care in America,”ⁱⁱ and the Institute of Medicine’s 2000 report, “Unequal Treatment Confronting Racial and Ethnic Disparities in Health Care.”ⁱⁱⁱ Twenty years later, California is still working to meet many of these recommendations.

Today, the national movement for racial justice also demands that we, as Californians, build upon the legacy of these seminal works in health disparities and cultural and linguistic competence to form a stronger anti-racist framework. Greater valuation and acceptance of the behavioral health practices that BIPOC and LGBTQ+ communities use is a key anti-racism strategy in behavioral health.

This concept paper is an initial attempt to outline policy opportunities and approaches for greater valuation and acceptance of the behavioral health practices BIPOC and LGBTQ+ communities have used for many years, and in some cases millennia, to support their behavioral health and wellbeing.

The changes recommended in this paper fall under the jurisdiction of various state authorities, agencies, and local communities. Policymakers have a responsibility to work with communities to identify and take action on the changes within their authority and influence.

Throughout this paper, we use the term “behavioral health” to encompass mental health and substance use, recognizing that the disparities within these issues are both stark and intertwined.

Background

Behavioral health inequities in BIPOC and LGBTQ+ communities are unconscionable, intergenerational, and given the lack of investment, seemingly intractable.^{iv} COVID-19 has exponentially amplified these behavioral health disparities in BIPOC and LGBTQ+ communities.^v In light of the extensive research on why these disparities exist, not least of which is the role of structural racism in behavioral health, the State and local governments have an increasing responsibility to address inequities in both physical health and behavioral health.

Structural racism is the systemic distribution of resources, power, and opportunity in society to benefit people who are White, cisgender, and heterosexual, excluding BIPOC and LGBTQ+ people. It primarily results from how institutions and structures are designed, rather than personal animus (or lack thereof). California has a long history of structural racism, including the 1909 eugenics law that made it legal for a health professional to sterilize a person of the BIPOC and/or LGBTQ+ community and permitting Ku Klux Klan rallies in the Central Valley as late as the 1930s. The persistence of structural racism and its impact on the health and opportunities of BIPOC and LGBTQ+ communities depends on differential racialization, which refers to the process by which the dominant society racializes certain groups at different times in response to shifting needs.^{vi} Differential racialization explains legal structures that a dominant society devises for each group—such as English-only laws for Latino people, alien land laws for Asian and Pacific Islander people, and Jim Crow laws for Black people. As a result, groups must contend with different sets of discriminatory laws and practices. Structural racism (not race) is not just in the past; the impact of white supremacist laws and policies is felt through all our institutions.

Today, structural racism has resulted in the exclusion of behavioral health interventions developed and tested by and for BIPOC and LGBTQ+ communities' health and wellbeing.

The National Institute of Mental Health (NIMH), the lead federal agency for research on mental health, recently found that Black people who apply for research funding with the institute are less likely to receive the funding compared to White people, even when controlling for factors such as educational background, publications, citations, research awards, and seniority.^{vii} Implicit bias and structural racism in grant scoring explain these disparate outcomes. Research institutions and clearinghouses, which review the existing evidence on different programs, policies and practices, continue to overlook questions related to race, ethnicity, culture, sexual orientation, and gender identity during the formation of behavioral health interventions.

Key Questions for Equitable Research:

1. Who is the community?^{viii}
2. How are mental health and illness defined by the community?^{ix}
3. What constitutes desirable outcomes for the community?^x
4. How are interventions designed by the community to address these issues?^{xi}
5. How is culture manifested in these interventions?^{xii}
6. How is culture a social determinant of health?
7. What infrastructure is required to evaluate interventions through the lens of racial, ethnic, and LGBTQ+ communities?
8. What research methods and measures are most appropriate for establishing empirical support for these practices?^{xiii}
9. How is the dominant culture's approach to health and measurement a poor fit, ineffective or harmful?

Structural racism is also embedded in the common sense of the superiority of White, heteronormative culture over others, especially in behavioral health. Psychiatry has historically been utilized to justify the mistreatment of BIPOC and LGBTQ+ people.

Psychiatry classified homosexuality as a mental disorder until 1973 and continues to pathologize transgender identities today. The Diagnostic and Statistical Manual (DSM), the handbook used by health care professionals in the United States and much of the world as the authoritative guide to the diagnosis of mental disorders, is largely centered on the beliefs, norms, and values of White society, while also being illness focused and not encompassing the entirety of a community's experiences.

In the field, practitioners are also more likely to diagnose Black people with serious mental illness over a diagnosis like depression because of the dominant culture's implicit bias, which is defined as those beliefs that "operate outside of conscious awareness and control but nevertheless influence our behaviors."^{xiv xv} Many physical health and behavioral health providers do not collect—or are inadequately collecting—information on sexual orientation and gender identity (SOGI), rendering LGBTQ+ populations invisible to policymakers and others who make decisions that affect their health.^{xvi} Healthcare continues to exclude undocumented people, primarily Latinos, and Asian and Pacific Islanders, from behavioral health benefits because of racialized ideas of citizenship. As a result, they are the least likely groups to seek mental health care.^{xvii} The dominant culture discounts the Native American community in conversations about the future of health care policy when it could instead learn from the community's ability to achieve resilience for generations because of their connection to traditional knowledge and medicine. And finally, Asian and Pacific Islander communities continue to suffer from the "model minority" stereotype, the false idea that all Asian American and Pacific Islander communities are destined to succeed due to their racial background (despite the wide range of countries, ethnicities, nationalities and identities of this group), which negatively impacts their behavioral health and plays into the complex systems that uphold the dominant culture.^{xviii}

Through the data, it is clear that the dominant culture's policies and programs have proven harmful to BIPOC and LGBTQ+ communities. As part of this system, the dominant culture does not sufficiently take into account race, racism, sexual orientation, gender identity, culture, lived experience, or the history of legalized discrimination against BIPOC and LGBTQ+ communities, all of which impacts behavioral health, in their policies and programs.^{xx} Even worse, culture, which varies greatly across BIPOC and LGBTQ+ communities, is often considered a 'risk factor' by the dominant culture.

The State is responsible for including evidence-based practices into their plans, but these policies have been formed by the dominant culture with only themselves in mind. Structural racism has acted as a barrier to even considering if the dominant culture could learn from the health practices used in BIPOC and LGBTQ+ communities, some of which have been in practice for centuries.

However, the dominant culture must be careful to not merely appropriate the health practices of BIPOC and LGBTQ+ communities, which is defined as the unacknowledged or inappropriate adoption of the customs, practices, or ideas of one group by members of another and typically more dominant group.^{xxi} It is also not sufficient to 'culturally adapt' interventions using only the dominant culture's paradigm.^{xxii} Thus, the State faces a formidable challenge in creating a more equitable behavioral health system because historically, the vast majority of evidence-based practices were not designed for or appropriately standardized on BIPOC and LGBTQ+ communities. Instead, ensuring that everyone has a fair and just opportunity to be healthy will require efforts and investments in new research, practices and policies for BIPOC and LGBTQ+ communities who currently experience poor behavioral health outcomes and fewer opportunities for good health. Even in the face of structural racism and oppression, however, BIPOC and LGBTQ+ communities continue to enrich the character of California through their culture, history, values, and teachings.



Community-Defined Evidence Practices

Through decades of data, there is a clear need for new strategies to help reduce behavioral health disparities in BIPOC and LGBTQ+ communities. Community-defined evidence practices (CDEPs) can offer a role in the State's efforts to reduce behavioral health disparities and advance behavioral health equity. The term "community-defined evidence practice" derives from what a community considers healing as well as their cultural, linguistic or traditional practices. A common definition of CDEPs describes "a set of practices that communities have used and determined by community consensus over time and which may or may not have been measured empirically but have reached a level of acceptance by the community."^{xxiii} A healing practice that has been used for centuries or even millennia is also a reasonable example of empirical evidence. For example, Native Americans were practicing population health, cognitive behavioral therapy, and group therapy (talking circles) for hundreds of years before it was discovered by Western medical model practitioners.^{xxiv xxv} CDEPs in BIPOC and LGBTQ+ communities are part of their very culture, history, values, and teachings.

CDEPs originate within the community, often through organizations that serve them, and can range from behavioral health treatments to community outreach to other services and supports.^{xxvi} Examples of these types of practices include but are not limited to: traditional healing, life coaching, circles of care, mindfulness, radical inclusivity, and culturally and linguistically appropriate outreach.^{xxvii} Again, many have been in practice for years, even centuries before the Western medical model existed. However, communities and populations are not homogeneous and often differ by region. One community-defined evidence practice is not necessarily effective in similar communities. CDEPs must be embraced based on local experiences.

CDEPs are provided by numerous qualified health practitioners, including those who do not have a medical or behavioral health license. In fact, being a qualified health professional from the dominant culture (e.g., a doctor of medicine or psychologist) may be a deficit that may not help the CDEP given the different paradigms and epistemologies. Examples of other types of qualified health professionals include peer specialists, community health workers, trained facilitators, promotoras, and traditional healers. Many CDEPs also serve BIPOC and LGBTQ+ communities who are Limited English Proficient (LEP).

The Office of Health Equity (OHE) in the California Department of Public Health (DPH) has invested significantly in these types of critical services through the California Reducing Disparities Project (CRDP) in order to build an evidence base for their effectiveness.^{xxviii} The goal of the CRDP is to use a rigorous, community-participatory evaluation process to demonstrate that selected community-defined evidence practices (CDEPs) are effective at preventing or reducing the severity of mental illness in African-American, Asian and Pacific Islander, Lesbian, Gay, Bisexual, Transgender, Queer and Plus (LGBTQ+), Latino and Native American communities as opposed to traditionally funded behavioral health services based on Western clinical models. The CRDP project is also providing evidence to support the assertion that there are different approaches to behavioral health and wellbeing outside of the Western medical model.

The Community-Defined Evidence Practice Integration Advisory Group

Despite a growing body of evidence, CDEPs do not receive the same support, funding, application, or understanding by policymakers and the dominant culture as their evidence-based practice counterparts. This disparity is due to misunderstanding, implicit bias and the dominant culture's lack of interest in learning about other epistemologies and paradigms. Western medicine has historically resisted and fought other holistic practices like chiropractic medicine, acupuncture, nurse practitioners, and community helpers. Advocates for CDEPs can expect the same resistance. To gain a deeper understanding of CDEPs, and to establish respect among policymakers and the general public, the Office of Health Equity in the California Department of Public Health (DPH) funded the California Pan-Ethnic Health Network as part of the California Reducing Disparities Project to convene a broad sector of behavioral health stakeholders in Summer 2020 to identify and discuss opportunities to educate policymakers and the general public about the importance of CDEPs and strategies that could sustain them.

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These stakeholders have extensive knowledge of the public behavioral health system, including the ideological and policy barriers inhibiting the acceptance of community-defined evidence practices (CDEPs). The Community-Defined Evidence Practice Integration Advisory Group identified these barriers, along with solutions and strategies to increase the acceptance of community-defined evidence practices by policymakers and the general public.

Barriers

- 1. Ideology/Implicit Bias/Structural Racism:** As the country faces an ever-evolving pandemic and a growing call to fix the deeply embedded systemic and structural discrimination faced by racially, ethnically, culturally, and linguistically diverse communities, it is clear that racism has a profound impact on the mental and physical health of communities. For example, research on epigenetics, the study of how your behaviors and environment can cause changes that affect the way your genes work, offers clear evidence that the stress and trauma caused by structural racism has an impact on the physical and mental health of BIPOC and LGBTQ+ communities several generations later.^{xxix} Structural racism continues to exist in our public systems, including our behavioral health system. The dominant culture does not accept community-defined evidence practices (CDEPs) or pilots as rigorous as evidence-based practices and continues to exclude them from the delivery system and sustainable funding sources. Structural racism and implicit bias are barriers to the dominant culture's willingness to even try to learn from CDEPs used in other cultures.
- 2. Awareness/Access:** CDEPs are not valued by the dominant culture, and as such, there is no deliberate effort to fund them. There are varying levels of understanding and acceptance of the efficacy of CDEPs, largely driven by the primacy of the Western medical model in behavioral health. One barrier to the dominant culture's acceptance of the efficacy of CDEPs is the lack of willingness to learn about other cultures' approaches to efficacy. BIPOC and LGBTQ+ communities have for years used a 'strength-based' approach instead of a 'weakness-based' or 'deficit-based' approach used by the Western medical model. In one example of a CDEP framework, a program may result in a young BIPOC or LGBTQ+ person becoming more knowledgeable, resilient and having closer connection to their culture and history, while at the same time the evidence may show the youth did not significantly decrease some consumption behaviors for drugs or alcohol.^{xxx} In this case, the Western medical model might think the intervention was a failure, when in fact an increase in their strengths will have permanent and positive outcomes. Mental Health Services Act (MHSA) funding can pay for CDEPs, but they are rarely included in delivery systems as a core service. County systems are also mired in state and federal regulations that make it difficult for community-defined evidence practices to easily integrate, and create barriers to contracting with county behavioral health departments and difficulties collecting actionable data. As a result, CDEPs are not yet a customary benefit or service under the MHSA or the Medi-Cal program.
- 3. Jurisdiction:** The delivery of behavioral health treatment is fragmented due to a history of exclusion and discrimination. Turf wars exist over scope of practice, whereby the dominant culture wants BIPOC and LGBTQ+ people to be certified or licensed in what the dominant culture values or protects (i.e. finances or areas of employment). This fragmentation also happens along the lines of race, ethnicity, and gender. For example, specific care for BIPOC and LGBTQ+ communities is limited to piecemeal, short-term pilots housed under various state departments and jurisdictions but they rarely receive sustainable contracts in the public behavioral health system. Furthermore, the Western medical model's primacy and norming of "what works" for the dominant culture contributes to fragmentation and inequities.
- 4. Complexity in Funding Rules:** Behavioral health funding drives the availability of services. Funding for the county safety net, including county behavioral health, has declined due to the economic impact of COVID-19. Furthermore, counties continue to fail to invest county general fund resources in behavioral health, instead prioritizing continued resources for policing and incarceration. While the Mental Health Services Act (MHSA) tax revenues have continued to grow, the dominant culture's decisions for which programs are "worthy" of the funding stream is less generous, and there are few efforts by the dominant culture to direct funds toward CDEPs for BIPOC and LGBTQ+ communities. There is also no strategic funding approach to addressing behavioral health disparities that engages multiple levels of government, the private sector, and communities.

Policy Options

- 1. Facilitate relationships and partnership between county and health plan leadership and community-based behavioral health providers.** Stronger linkages between organizations implementing community-defined evidence practices (CDEPs), counties, health plans and providers are needed in order to increase awareness and access to the full continuum of behavioral health services (including access to CDEPs) for referring clinicians, schools, peer specialists, local community-based organizations, managed care providers, county providers, and consumers. There could be dedicated funding for advocates placed or entrenched in the behavioral health care system to advocate for CDEP integration and access. However, the dominant culture, including policymakers, must first create a clear infrastructure to facilitate such relationships and collaboration. This could include multi-stakeholder collaboratives with resources for investment. A current example of this in California is the California Accountable Communities for Health Initiative (CACHI).^{xxxii}
- 2. Make Medi-Cal reforms, including the California Advancing and Innovating Medi-Cal (CalAIM) framework, more flexible to allow for the addition of community-defined evidence practices (CDEPs) to the suite of outpatient behavioral health services available to BIPOC and LGBTQ+ Medi-Cal consumers.** Despite individual actions and intentions, California's health care system, as designed, often makes health outcomes worse for BIPOC and LGBTQ+ communities by perpetuating the very inequities it seeks to address. For example, in 2014, California implemented portions of the Affordable Care Act that expanded the range of behavioral health services available to adult Medi-Cal enrollees in both fee-for-service and Medi-Cal managed care. This implementation created a behavioral health benefit for people who have "mild-to-moderate" impairment of mental, emotional, or behavioral functioning. However, six years after California implemented the benefit, data shows that BIPOC communities use outpatient behavioral health services with their health plan at less than half the rate of White Medi-Cal consumers, while use in LGBTQ+ communities is so low that publicly available data shows no stratification by Sexual Orientation and Gender Identity (SOGI).^{xxxiii} This is despite the copious amounts of data demonstrating an increased need for behavioral health care in LGBTQ+ and BIPOC communities.

The State will soon resume the process of determining changes to the structure of Medi-Cal and write new contracts for Medi-Cal managed care health plans that administer its behavioral health benefit to over 10 million children, families, adults, seniors and persons with disabilities. In these new contracts, the State has the opportunity to outline its strategic approach to address behavioral health disparities using key metrics to ensure that Medi-Cal managed care contracts and their funding aligns with specific health equity goals. For instance, the State could expand the scope of services available and see that CDEPs are reimbursed in Medi-Cal through a State Plan Amendment as an additional service under the Medi-Cal preventive services benefit.^{xxxiii xxxiv} They could also include specific language regarding the need to address racial, ethnic, linguistic, and LGBTQ+ behavioral health disparities and the effectiveness of CDEPs. This would help codify CDEPs as an acceptable and reimbursable service under Medi-Cal.

California could even explore the development of a health plan or similar entity that, instead of covering a county, would cover a population. These entities could cover all the health needs of a specific population, providing CDEPs and other more community specific/effective approaches.

Alternatively, California could include these CDEPs as part of the in lieu-of services (ILOS) that Medi-Cal managed care plans can offer under the California Advancing and Innovating Medi-Cal (CalAIM) framework. However, if included, California would have to be careful to avoid creating perverse incentives and outcomes caused by conforming CDEPs to the Medi-Cal framework. The spirit and the integrity of CDEPs should not be altered to fit within the Western medical model framework that has historically not been culturally or linguistically responsive. Without the transformation of the Medi-Cal framework itself, the barriers faced by BIPOC and LGBTQ+ communities will continue.

- 3. Advocate for the State and local agencies to conduct internal audits of exclusionary practices and create action plans to drive internal change and accountability.** There is a clear need for California to develop a plan to educate counties, Medi-Cal managed care plans, the dominant culture, and state agencies on examples of systemic racism. Since the onset of the COVID-19 pandemic, the nation has witnessed how the brunt of the COVID-19 pandemic has fallen on BIPOC and LGBTQ+ communities. As a result, cities and counties across the country have been making declarations on racism as a public health emergency or crisis. The imperative to address systemic inequities is urgent, particularly against the backdrop of COVID-19 disparities, continued violence against BIPOC and LGBTQ+ communities, and protests against anti-Black racism sparked by the murder of George Floyd. Behavioral health leaders around the country have spoken out on the connection between racism and behavioral health. The American Psychological Association expressed that “COVID-19’s disproportionately lethal impact on Black, Latinx and Native American people has revealed just how unequal our nation’s health outcomes are.” The American Association for Marriage and Family Therapy stated that they were “outraged by the continued racial trauma, violence, and loss that our communities of color are experiencing in this country.” The National Association of Social Workers vowed to “continue (their) efforts to ensure respect, inclusion, fairness and equity in our social work practices and social justice actions for and with the individuals, communities and families that NASW members serve. In California, the California Alliance of Child and Family Services (CACFS) and the California Council of Community Behavioral Health Agencies (CBHA) recently joined calls for the State to declare racism as a public health crisis in California.^{xxxv}

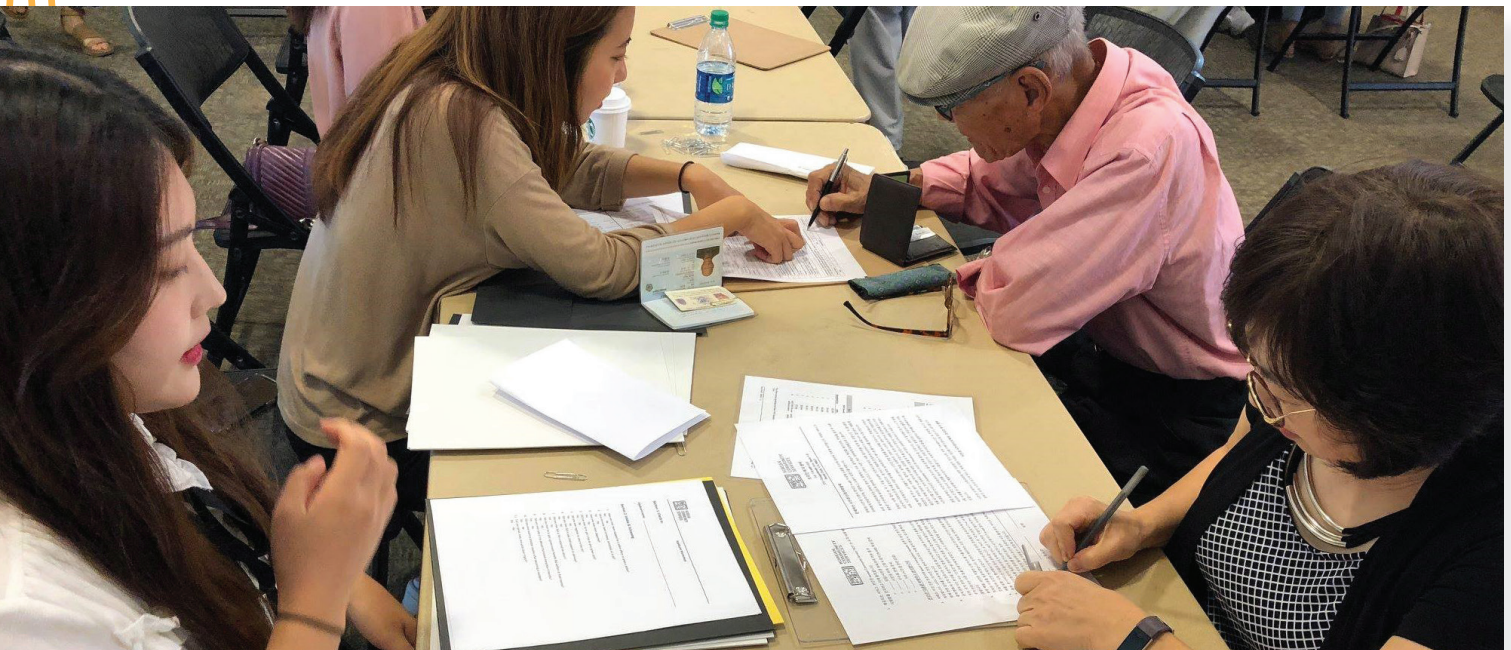
Support of these actions is a first step in acknowledging the realities of systemic, institutional, and structural racism that leads to abuse of power and racial injustice. California policymakers should review, adapt and adopt action steps to address the impact of structural racism, and identify goals and objectives to assess the state program.

Concrete steps should include:

- Acknowledging the effects of intergenerational racism on population health, especially anti-Black racism
- Assessing governments’ internal policies and procedures with a racial equity lens
- Advocating for laws and regulations that center and promote racial equity
- Ensuring inclusivity and diversity in leadership, workforce, hiring and contracting
- Promoting educational efforts to address and dismantle racism
- Identifying clear goals and objectives including specific benchmarks to assess progress
- Securing adequate resources for anti-racism activities
- Building partnerships and alliances with local organizations that are actively confronting racism
- Engaging actively and authentically with BIPOC and LGBTQ+ communities
- Promoting all policies that prioritize the health of BIPOC and LGBTQ+ communities
- Centering the role of Ethnic Service Managers in behavioral health
- Elevating the role of county cultural competence advisory boards
- Establishing a Health Equity Ambassador at the Board of Supervisors level
- Ensuring that key stakeholders are also decisionmakers
- Assigning an unbiased Diversity, Equity and Inclusion auditor to ensure the process is equitable, fair and transparent

- 4. Leverage the Mental Health Services Act and Medi-Cal, with some modifications, to build toward broader structural reform.** Although the Mental Health Services Act (MHSA) pays for access to community-defined evidence practices (CDEPs), this dedicated funding stream could be improved to better suit the needs of BIPOC and LGBTQ+ communities. CDEPs should be a customary benefit or service under the MHSA or the Medi-Cal program.

The innovation (INN) component of the Mental Health Services Act (MHSA) provides California's communities an important opportunity to introduce either new mental health practices or approaches, or make changes to existing practices or approaches with the potential to significantly improve mental health services and outcomes. Prevention and Early Intervention (PEI) focuses on services like education, support, and outreach to help inform and identify individuals and their families who may be affected by a mental health issue. MHSA PEI and INN, funding streams for CDEPs, usually pay for services that are not reimbursable under Medi-Cal. Though these funding streams may comprise a smaller share of the overall funding, they should be leveraged to create necessary structural reforms, including but not limited to improving Medi-Cal billing requirements in both the county behavioral health system and Medi-Cal managed care delivery systems. Again, CDEPs could be added as benefit to insurance, whereby the design of the benefit should be based upon CDEP criteria and not of the typical Western medical model. Specific incentives or requirements that encourage the funding of CDEPs within Innovations, Prevention and Early Intervention, and Medi-Cal managed care could be implemented.



Strategies

- 1. Communication Campaign:** Educate policymakers, the dominant culture, universities, and the general public about the rigor and outcomes of community-defined evidence practices (CDEPs). Organizations implementing CDEPs through the California Reducing Disparities Project are currently going through a rigorous process of building their evidence base.^{xxxvi} One of the major outcomes of the CDEPs evaluated under the California Reducing Disparities Project is the very high degree of passion and acceptance among participants. The consensus among participants is that the Western medical model is not sufficient. As part of this process, California should incorporate information on the CRDP project- the history, implementation, and results into university curriculums (e.g., medical schools, public administration, government studies, health policy, social work, public health, ethnic and indigenous studies). The full results of the statewide evaluation will be available in 2022 but organizations implementing CDEPs have begun to share the positive results.^{xxxvii}

Other Practices: The Psychology Applied Research Center at Loyola Marymount has written extensively about the methods underpinning the study and evaluation of community-defined evidence practices (CDEPs) in California. The dominant culture, in its efforts to better understand the role of culture in health, could learn from experts on the issue by reading “Making the Invisible Visible: Identifying and Articulating Culture in Practice-Based Evidence,” one of many publications on the positive role of culture in measurement and health with a particular focus on its implementation in the California Reducing Disparities Project. ^{xxxviii}

- 2. Performance Outcome Measures that are Culturally and Linguistically Significant:** Develop behavioral health performance measures that account for culturally centered, community-defined, consumer-focused indicators of wellbeing. Despite a number of reporting mechanisms and measures, California’s behavioral health system cannot answer how effective existing services are. This is in part because the measures currently reported do not include the interplay of culture and behavioral health that is required to measure the true wellbeing of BIPOC and LGBTQ+ communities. Current behavioral performance measures are out of alignment with these communities. California should develop a new process for statewide behavioral health outcomes and performance so that it includes culturally significant measures (e.g., social connectedness, belonging to culture and/or community, etc.). The California Department of Health Care Services (DHCS) could convene county behavioral health departments, Medi-Cal managed care plans, providers, consumers, the local and State evaluators in the California Reducing Disparities Project, and the Office of Health Equity in the Department of Public Health (DPH) for help in drafting and standardizing the new performance measures. This is a strategy that would address systemic racism in the behavioral health system.

Other Practices: Many implementing CDEPs under the California Reducing Disparities Project have developed tools to measure the positive impact of culture on behavioral health and wellbeing.^{xxxix} For example, one implementing CDEP worked with five other urban American Indian and Alaska Native health organizations in northern California to modify and validate the use of the Cultural Connectedness Scale, a tool originally developed for First Nations/Indigenous youth in Canada by Dr. Angela Snowshoe, consisting of 29 items that measures culture on 3 sub-scales - identity, traditions, and spirituality. The scale is used to measure the degree of cultural connectedness with the objective of demonstrating its link to mental health and wellbeing.^{xi}

In their research, the implementing CDEP, along with three large sample studies in two countries (Canada and the United States), found that increases in Native American/Indigenous culture were associated with better mental health and wellbeing.^{xii} The evidence of these studies shows that Native/Indigenous culture is an important social determinant of health.^{xiii} Second, since increases in Native/Indigenous culture can be measured, and culture is an important social determinant of health, then increases in connection to culture is also an important program/intervention objective. Lastly, since connection to culture can be measured and increased, it is also a stand-alone health outcome. The implementing CDEP and their colleagues are currently completing another adult study to replicate these results and evaluate physical health outcomes as well.

- 3. Technical assistance for state departments, counties, Medi-Cal managed care plans, and community-based organizations:** Build the capacity of counties and Medi-Cal managed care plans to become public-facing technical assistance providers to small and mid-size community-based organizations interested in providing CDEPs as part of the full continuum of behavioral health care. While community-based organizations are trusted by the community, they often lack the institutional knowledge to partner with local and State departments. In the California Reducing Disparities Project, technical assistance providers work with organizations implementing CDEPs to develop their administrative, programmatic and evaluation capacities, although funding for these services sunsets in 2022. Counties and Medi-Cal managed care plans are critical partners in supporting community-based organizations to sustain culturally or linguistically appropriate behavioral health services; they have specialized knowledge and expertise in contracting, regulations, and other core skill topics related to administration and management of services and programs.

Agency staff who value and understand the community, like county ethnic service managers, could assume a leadership role in providing additional technical assistance to community-based organizations on these various topics.

There should also be an equal focus on developing counties, state departments, and Medi-Cal managed care plans' understanding of the cultural experience behind CDEPs before the start of trainings on fitting CDEPs into the dominant service delivery model. The California Department of Health Care Services (DHCS), counties, and Medi-Cal managed care plans should receive training on valuing CDEPs and how to implement policies that would allow them to fund CDEPs without compromising their integrity, cultural and linguistic responsiveness, and spirit. What can service delivery providers, such as counties, Medi-Cal managed care plans, the dominant culture, and the Department of Health Care Services, learn from CDEPs?

Other Practices: The Los Angeles County Department of Mental Health, as a result of a Board of Supervisors Motion, is working with a non-profit organization to implement a curriculum to specifically help small and mid-size grassroots organizations to become county mental health contractors.^{xliii} Currently, Fresno county behavioral health department is contracting with a local community-based organization to help assess and identify barriers in the existing purchasing process preventing grassroots organizations from becoming part of the system of care. Sacramento and Santa Barbara are also working on similar projects. The California Department of Health Care Services (DHCS) recently released a proposal focused on technical assistance, trainings, and consultation services for learning collaboratives between counties and communities. The focus of the program will be to increase county behavioral health departments, staff from the California Department of Health Care Services (DHCS), the Office of Health Equity in the California Department of Public Health, and community-based organizations understanding of the core needs of Medi-Cal enrollees in order to design behavioral health services that are culturally and linguistically responsive, data-driven, and inclusive of community-defined evidence practices.^{xliv}

4. **Medi-Cal Integration/State Plan Amendment:** Submit a State Plan Amendment (SPA) to add community-defined evidence practices to the Medicaid State Plan. California could seek federal approval for behavioral health services based on community-defined evidence through a State Plan Amendment as an additional service under the Medi-Cal preventive services benefit. The Centers for Medicare & Medicaid Services (CMS) allows providers without medical or social work licenses to provide services under either the preventive services benefit, or as "other licensed practitioners" under Social Security Act Section 1905(a) with an approved State Plan Amendment. Under the preventive services benefit, community-defined evidence practices (CDEPs) would be recommended by a physician or other licensed practitioner.^{xlv xlvi} In addition, the State Plan Amendment should:
 - List provided services to ensure they meet the definition of "preventive" as stated in section 4385 of the State Medicaid Manual (including those required to involve direct patient care).
 - Identify the type(s) of non-licensed practitioners who may furnish the services.
 - Include a summary of what the State identifies in these practitioners to be qualified to furnish the services, including any required education, training, experience, credentialing, supervision, oversight and/ or registration.
 - Outline a strategic plan with key metrics to address BIPOC and LGBTQ+ behavioral health inequities.

A health plan or similar entity that covers a population instead of a county, where CDEP services and their professionals are included, is also a viable model. California is currently working to pilot an Indian Health Plan (IHP) Substance Use Disorder- Organized Delivery System (SUD-ODS) by and for Native American/ Indigenous communities. This model is specific to meeting the Substance Use Disorder (SUD) needs of Native American/Indigenous communities but other models exist to meet every part of a community's health needs (not just behavioral health). California should learn about these models and determine if they should be created to meet the health needs of a specific BIPOC or LGBTQ+ community.

California should form a CDEP advisory committee- comprised of experts in CDEPs, the California Department of Public Health (DPH), the California Department of Health Care Services (DHCS), providers, and consumers- for help in drafting the SPA. Together, stakeholders could work to develop a plan to reimburse for behavioral health services based on community-defined evidence. The CDEP advisory committee should also ensure criteria for the types of providers eligible to provide CDEP services is based upon culture-based approaches, historical knowledge, and mutual respect and understanding between the CDEP professional and community member, not merely based upon a medical or behavioral health license.


As part of this process, California should provide more funding for evaluations of CDEPs and traditional healing (e.g., cost-benefit analyses, cost-effectiveness analyses). BIPOC and LGBTQ+ participants of the California Reducing Disparities Project should serve as decisionmakers (or have greater influence) of the final criteria, policies and procedures.

California and key stakeholders must also work to ensure that other policies and procedures include a plan to address racial, ethnic, and LGBTQ+ behavioral health disparities. For example, the newly minted peer certification law in California should include a component on equity to ensure that practitioners implementing CDEPs can also act as certified peers, which would result in greater inclusivity and reaching more BIPOC and LGBTQ+ consumers.

Other Practices: Medicaid programs in other states have increased access to the use of behavioral health services based on community-defined evidence under the preventive services benefit. Arizona has pursued this approach for reimbursement of Tribal Traditional Healing Practices through its Section 1115 waiver.^{xlvii}

5. **Medi-Cal Integration/In-Lieu of Services:** Expand the category of reimbursable in lieu-of services under California Advancing and Innovating Medi-Cal framework, in which the State proposed to allow Medi-Cal managed care plans to be reimbursed for services that address health-related needs, like supportive housing and other social services. California could specifically allow Medi-Cal managed care plans to use in-lieu-of-services to address a broader array of issues, including CDEPs. Medi-Cal managed care health plans could learn from those entities that have invested in CDEPs through the Mental Health Services Act, including a select number of county behavioral health departments and the Office of Health Equity in the California Department of Public Health.^{xlviii}

Other Practices: Some states invite or encourage Medi-Cal managed care plans to provide what are known as "value-added" services beyond the standard benefits to adults to improve the overall health of plan enrollees. New Mexico has used this value-added approach to pay for traditional healing, in which plans each paid \$250 or \$300 per year towards spiritual and traditional healing practices for Native American members.^{xlix} The use of behavioral health services based on community-defined evidence to engage communities known to face disparities, as well as screen and refer consumers to behavioral health services, would serve as an important value-add to Medi-Cal managed care plans.

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6. **Mental Health Service Act (MHSA) Plan Requirements:** Require the Innovations (INN), Prevention, and Early Intervention (PEI) components of the Mental Health Services Act (MHSA) to demonstrate how it will address disparities in BIPOC and LGBTQ+ communities. Though reducing disparities is an explicit goal of the MHSA, an ongoing review of approved Innovation plans by those responsible for approving them the Mental Health Services Oversight and Accountability Commission (MHSOAC) found that more than half of the Innovation plans identified reducing disparities as their project’s goal but did not explicitly support CDEPs. To remedy this, California must invest in developing innovative programs and modalities that have cultural significance outside of the delivery system. This funding stream should be used to test and evaluate new CDEPs or adaptations of CDEPs, but is not a sustainable funding stream because the funding is one-time.

The Mental Health Services Oversight and Accountability Commission (MHSOAC) can play a powerful role in the redirection of MHSA funding toward community-defined evidence practices (CDEPs). Because the Mental Health Services Oversight and Accountability Commission has the power to approve Innovations plans and oversee PEI requirements, it could lead a revision of the MHSA plan requirements. To remedy gaps, the Mental Health Services Oversight and Accountability Commission could drive toward statewide changes in Innovations, possibly even allowing for counties to opt into a statewide plan.

Similarly, requirements for Prevention and Early Intervention (PEI) reporting could include outcomes that are more important to disparities reduction efforts, such as connection to culture. Though CDEPs speak to the goals and intent of PEI, regulations and outcome measures do not always align with the work. PEI regulations are set to be revised due to recent legislation and could become narrower. Regulations will need to be expanded in these circumstances, or CDEPs would likely need to adapt part of their program to better meet the regulations. Again, the Mental Health Services Oversight and Accountability Commission should ensure that future changes to the PEI regulations allow for the inclusion of CDEPs.

Other Practices: Counties across California are leveraging Innovation funds to test and evaluate different aspects of community-defined evidence practices. For example, Fresno County recently proposed an Innovations plan to evaluate whether community-defined evidence practices under the California Reducing Disparities Project (CRDP) can be adapted through community planning to adhere to MHSA-PEI funding requirements without compromising the effectiveness of the original community-defined evidence practice.¹ Other counties have implemented Innovation plans to test and evaluate the efficacy of community-defined evidence practices in their communities, including Ventura County, which is currently evaluating a program that integrates indigenous healing practices traditionally used by Mixteco / indigenous communities to improve symptoms of mental health associated with stress, anxiety and depression. Most recently, Santa Clara recently proposed a pilot to increase Vietnamese and African American/African Ancestry’s mental health by destigmatizing mental health services in the context of their culture.

7. **Ensure updates to county cultural competence plans incorporate CDEPs.** California’s Department of Health Care Services has established plans for cultural competence, a defined set of standards county behavioral health departments must meet to align with the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care. DHCS defines cultural competence as the following:

- Services and programs at all levels should have the capacity to provide services sensitive to the target populations’ cultural diversity.
- Systems of care should:
 - Acknowledge and incorporate the importance of culture, the assessment of cross-cultural relations, vigilance towards dynamics resulting from cultural differences, the expansion of cultural knowledge, and the adaptation of services to meet culturally unique needs.
 - Recognize that culture implies an integrated pattern of human behavior, including language, thoughts, beliefs, communications, actions, customs, values, and other institutions of racial, ethnic, religious, or social groups.
 - Promote congruent behaviors, attitudes, and policies enabling the system, agencies, and mental health professionals to function effectively in cross-cultural institutions and communities.ⁱⁱ

California requires all county behavioral health departments to develop a cultural competence plan, after which the State is supposed to interact with the counties based upon the issues and needs presented in the plans. In one such guidance, the California’s Department of Health Care Services (DHCS) indicated that “future CCP requirements will evolve as more experience through plan development and implementation progresses. While efforts are being made on an ongoing basis to achieve cultural competence, as our competence improves, our standards will need to improve.”ⁱⁱⁱ Despite this guidance, DHCS has failed to make this evolution easy by not systematically improving the way behavioral health care is delivered to BIPOC and LGBTQ+ communities.

DHCS has not reviewed the findings of these plans for many years to ensure they meet basic requirements or reduce racial, ethnic, cultural, and linguistic behavioral health disparities, despite the requirement to do so. Prior to 2010, the Department of Mental Health provided guidelines and reviewed plans. However, when the Department of Mental Health was folded into DHCS, this work ceased happening. California policymakers do not currently ensure the plans meet the requirements or address disparities. It is not sufficient for counties to develop these plans if state policymakers are not meaningfully interacting and reviewing these plans to learn county and community best practices and understand the experiences of local BIPOC and LGBTQ+ communities.

Even though California has committed to updating the State’s standards for cultural and linguistic competence beginning in 2023, California policymakers should first ensure the Department of Health Care Services (DHCS) themselves have developed an anti-racist framework.ⁱⁱⁱⁱ Cultural competence plans can be a vehicle for anti-racist work by explicitly incorporating CDEPs as a requirement. Increasing culture competence is also broader than teaching about differences in culture, language, community behaviors, and history. Increasing cultural competence should include helping the dominant culture understand they can both learn and benefit from other cultures. In some respects, the obstacle is addressing historical racism, reversing the thinking of the dominant culture that “we know best or we do it better,” without ever trying to learn about what the other communities do, why, and how they work well. The State’s standards for cultural and linguistic competence should address this obstacle. Service delivery providers, such as counties, Medi-Cal managed care plans, and the Department of Health Care Services should be trained on what they can learn from CDEPs as part of the cultural competence plan requirements.

Other Practices: Several counties in California have leveraged the county cultural competence plans to implement strategies to engage BIPOC and LGBTQ+ communities in behavioral health services based upon their community strengths and assets. Solano County leveraged cultural competence standards to partner with UC Davis Center for Reducing Health Disparities and develop rigorous quality improvement plans that successfully increased culturally appropriate services for three priority populations: Latino, Filipino and LGBTQ+ populations.



Conclusion

Although California has a national reputation for advancing progressive health care policies, BIPOC and LGBTQ+ communities continue to experience behavioral health disparities resulting from structural racism's impact on the dominant culture's design of programs and policies. California's behavioral health system has a stated commitment to addressing disparities, yet very few payment and delivery reform efforts are directly tied to programs and services outside the dominant culture's frame.

It is imperative that California meaningfully address the impact of structural racism on access and quality of behavioral health care for BIPOC and LGBTQ+ communities. The solutions and strategies put forth in this concept paper represent a clear desire among a diverse set of stakeholders for California to assume a leadership role in addressing behavioral health inequities in BIPOC and LGBTQ+ communities. To center cultural, linguistic, ethnic and racial equity in behavioral health, California must take steps to increase investments in the study, evaluation, promotion and integration of community-defined evidence practices, those which significantly account for the role of culture, race, ethnicity, sexual orientation and gender identity in health.

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- ^{xxxiii}Senate Bill (SB) X 1-1 (Hernandez, Statutes of 2013) added the following language to the California Welfare & Institutions Code (WIC): WIC §14132.03(a). "The following shall be covered Medi-Cal benefits effective January 1, 2014: (1) Mental health services included in the essential health benefits package adopted by the state(...). To the extent behavioral health treatment services are considered mental health services pursuant to the essential health benefits package, these services shall only be provided to individuals who receive services through federally approved waivers or state plan amendments pursuant to the Lanterman Developmental Disability Services Act(...)." WIC §14189. "Medi-Cal managed care plans shall provide mental health benefits covered in the state plan excluding those benefits provided by county mental health plans under the Specialty Mental Health Services Waiver. The department may require the managed care plans to cover mental health pharmacy benefits to the extent provided in the contracts between the department and the Medi-Cal managed care plans."
- ^{xxxiv}Implementing regulations specified that outpatient mental health services are as follows:
- Individual and group mental health evaluation and treatment (psychotherapy);
 - Psychological testing, when clinically indicated to evaluate a mental health condition;
 - Outpatient services for the purposes of monitoring drug therapy;
 - Outpatient laboratory, drugs, supplies, and supplements (excluding medications listed in Attachment 2); and,
 - Psychiatric consultation
 - Outpatient laboratory, supplies and supplements; and
 - SBIRT for alcohol use disorders
- ^{xxxv}See statement by the Geide, M. (n.d.). Racism As A Public Health Crisis. Retrieved February 04, 2021, from <https://www.cacfs.org/racism> and [https://www.cccbha.org/](https://www.cccbha.org/Affiliations/Collaborators:CaliforniaCouncilofCommunityBehavioralHealthAgenciesandthe;CaliforniaAllianceofChildandFamilyServicesathttps://www.cccbha.org/) and <https://www.cacfs.org/racism>.
- ^{xxxvi}Bellarmino College of Liberal Arts > Psychology > Psychology Applied Research Center > Projects > CRDP Phase II <https://bellarmine.lmu.edu/psychology/parc/projects/crdpphaseii/> CRDP Phase II. (n.d.). Retrieved February 04, 2021, from <https://bellarmine.lmu.edu/psychology/parc/projects/crdpphaseii/>
- ^{xxxvii}Media. (2021, February 03). Retrieved March 01, 2021, from <https://cultureishealth.org/support-our-work/media/>
- ^{xxxviii}Publications and presentations. (2021, February 11). Retrieved March 01, 2021, from <https://cultureishealth.org/resources/publications-and-presentations/>
- ^{xxxix}Evaluation guidelines and resources. (2021, January 22). Retrieved March 01, 2021, from <https://cultureishealth.org/resources/evaluation-guidelines-resources/>
- ^{xl}Snowshoe, A., Crooks, C. V., Tremblay, P. F., Craig, W. M., & Hinson, R. E. (2015). Development of a cultural connectedness scale for First Nations youth. *Psychological Assessment, 27*(1), 249-259. <http://dx.doi.org/10.1037/a0037867>
- ^{xli}King J, Masotti P, Dennem J, Hadani S, Linton J, Lockhart B, Bartgis J. The Culture is Prevention Project: Adapting the Cultural Connectedness Scale for Multi-Tribal Communities. *Am Indian Alsk Native Ment Health Res.* 2019;26(3):104-135. doi: 10.5820/aian.2603.2019.104. PMID: 31743417.
- ^{xlii}Masotti, P., Dennem, J., Hadani, S., Banuelos, K., King, J., Linton, J., Lockhart, B., & Patel, C. (2020). The Culture is Prevention Project: Measuring Culture As a Social Determinant of Mental Health for Native/Indigenous Peoples. *American Indian and Alaska native mental health research (Online), 27*(1), 86-111. <https://doi.org/10.5820/aian.2701.2020.86>
- ^{xliiii}Los Angeles County Board of Supervisors' Motion on the Community Based-Mental Health Incubation Academy. Retrieved at <http://file.lacounty.gov/SDSInter/bos/sup-docs/123156.pdf>
- ^{xliv}United States of America, California Department of Public Health's Office of Health Equity (CDPH-OHE) and DHCS' Medi-Cal Behavioral Health Division (DHCS-MCBHD), Community Mental Health Equity Project (CMHEP). (n.d.). Community Mental Health Equity Project (CMHEP). Sacramento, CA: Community Mental Health Equity Project (CMHEP).
- ^{xlv}(42 CFR 440.130(c)),
- ^{xlvi}Hernández-Cancio, S., Albritton, E., Fishman, E., Tripoli, S., & Callow, A. (n.d.). A Framework for Advancing Health Equity and Value Policy Options for Reducing Health Inequities by Transforming Health Care Delivery and Payment Systems [Scholarly project]. Retrieved February 04, 2021, from https://familiesusa.org/wp-content/uploads/2018/06/FamiliesUSA_Policy-Options_Report.pdf

^{xlvii}Proposed AZ 1115 Waiver Language: AHCCCS Reimbursement for Traditional Healing Services. However, a facility governing body may serve as the Qualifying Entity or designate another Qualifying Entity from the Tribe(s) served to endorse qualified Traditional Healing Providers.

Arizona's section 1115 WAIVER Renewal request (2016-2021). (2016). Retrieved February 04, 2021, from <https://www.azahcccs.gov/shared/FiveYear.html>

^{xlviii}Welfare and Institutions Code 5840.5.

^{xlix}Centennialcare: The New Mexico Medicaid Managed Care Program Medical Assistance Division [Scholarly project]. (2018, September). Retrieved February 04, 2021, from [https://www.hsd.state.nm.us/uploads/files/Final%20w%20MCOsBCBS_First\(1\).pdf](https://www.hsd.state.nm.us/uploads/files/Final%20w%20MCOsBCBS_First(1).pdf)

^lMHSA FY 2020-2023 Fresno Innovation Program Concept Paper: California Reducing Disparities Projects Evolutions. (2020). Retrieved February 4, 2021, from <https://www.co.fresno.ca.us/home/showpublisheddocument?id=51165>

^{li}California Department of Mental Health Cultural Competence Plan Requirements

^{lii}CCPR Modifications. Retrieved at https://www.dhcs.ca.gov/formsandpubs/MHArchives/InfoNotice10-17_Enclosure1.pdf

USA, DHCS, CA Dep of Mental Health. (2010). California Department of Mental Health Cultural Competence Plan Requirements CCPR Modification.

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CCPR Modifications. Retrieved at https://www.dhcs.ca.gov/formsandpubs/MHArchives/InfoNotice10-17_Enclosure1.pdf

USA, DHCS, CA Dep of Mental Health. (2010). California Department of Mental Health Cultural Competence Plan Requirements CCPR Modification.

^{liii}Unites States of America, State of California, Budget Change Proposal, Health Care Services. (n.d.). California Advancing and Innovating Medi-Cal (CalAIM) Initiative - Budget Change Proposal DF-46 (REV 10/20) (DF-46 (REV 10/20)). Sacramento, CA: CA Department of Health Care Services.