

Assessing Mental Health Disparities among Latinos in the San Joaquin Valley

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Table of Contents

Acknowledgements.....	1
Introduction.....	2
Background.....	2
Measuring the Mental Health Needs of Latinos	4
Risk and Protective Factors Associated with Latino Mental Health.....	5
How Mental Health Services Are Currently Funded in California.....	6
Latinos Access to Mental Health Services in the Valley.....	15
Summary of Findings.....	19
Recommendations.....	20
Conclusions.....	22
References.....	22
Appendix A. Definition of Mental Health Disability.....	28
Appendix B. Annotations for County Plans.....	29

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Introduction

In 2000, at least 7.9 percent or 103,785 Latinos of all ages living in the eight counties of the San Joaquin Valley (Fresno, Kern, Kings, Madera, Merced, San Joaquin, Stanislaus, and Tulare) experienced either serious emotional disturbance (SED) or serious mental illness (SMI) (California Department of Mental Health Statistics and Data Analysis [CDMH-SADA], 2003). Because of limitations on mental health services and delivery system capacities, it is often hypothesized that a sizable proportion of the population in need of these services are not receiving them. Using data provided by San Joaquin Valley county mental health agencies, we provide evidence supporting this hypothesis. Further, projected population growth for Latinos in the San Joaquin Valley region over the next decade could easily result in further disparity in the unmet mental health needs for this population, and more than likely will be compounded by other factors preponderant among the Latino population in the Valley, including low socioeconomic status, and cultural and linguistic barriers.

The public and private sources that currently fund mental health services in the state do not appear to meet the needs of the Latino population. Service access is often contingent upon access to transportation, the existence of culturally relevant and/or linguistically appropriate services, as well as meeting qualification requirements such as residency status. The passage of the Mental Health Services Act of 2004 (MHSA) is changing the service delivery landscape of mental health services in California. However, the changes enacted by the MHSA are restricted by its intent, which is to fund services that are preventative in nature and focus on innovation. Although these strategies may address the needs of some Latinos in the Valley, they may fall short of the current and growing needs for mental health services for this population as a whole.

Given the current financial situation and the escalating unmet need for mental health services among Latinos in the San Joaquin Valley, it is important to assess the proper allocation of funds and service utilization for this group. The Valley counties currently have a unique opportunity to directly respond to inadequacies in mental health services for Latinos via implementation of the MHSA. This policy brief describes the mental health needs of Latinos in the San Joaquin Valley, current public and private funding sources for mental health assessment and services in the state, and key features of the MHSA as it relates to Latino residents. It also identifies perspectives on mental health treatment and

presents state mental health policy as it relates to the Latino population. The challenge of providing the proportion of services needed by Latinos living in the Valley is discussed, and recommendations for future policy and research are presented.

Background

Mental disorders are defined as “health conditions that are characterized by alternatives in thinking, mood, or behavior (or some combination thereof associated with distress and/or impaired functioning” (U.S. Department of Health and Human Services, 1999, p. vii), and are measured based upon observation and duration of symptoms. (See Appendix A.) National and state prevalence estimates of mental illness or mental disability have largely been based on the measures constructed by the following sources:

- The Epidemiologic Catchment Area Survey (ECA) (1985), which measured mental illness as the presence or absence of psychiatric disorders as defined in the Diagnostic and Statistical Manual of Mental Disorders (DSM-III);
- The National Comorbidity Survey (NCS) and the National Comorbidity Survey Replication (NCS-R) (2005), measured mental illness using the DSM-III diagnostic categories;
- The National Household Interview Survey (NHIS) (2006) measures mental disability, as a state of being limited, due to a chronic mental or physical health condition across several domains, including activity limitation, work limitation or the need for assistance with activities of daily living; and
- The California Health Interview Survey (2005), which measures mental health and mental disability based on emotional well-being, and whether help has been sought for these issues.

Although these surveys capture descriptive information about persons with mental health problems, they do not necessarily address the Latino population’s understanding of what constitutes a mental health issue. For example, in a supplemental document from the U. S. Surgeon General’s 1999 report on mental health, it is surmised that the extent of Latinos’ mental health needs may not be captured by surveys that rely heavily upon psychiatric constructs, which may not be culturally relevant or even well understood cross-culturally. Furthermore, it discusses the possibility that psychiatric

frameworks do not measure “symptoms, symptom clusters, culturally patterned expressions of distress and disorder” (USDHHS, 1999, p. 133). Therefore, Latinos’ understanding of culturally bound syndromes such as *susto* (fright), *nervios* (nerves), *mal de ojo* (evil eye), and *ataques de nervios* (attack of nerves) may not be collected by current household surveys. Collecting these dimensions of understanding are vital in order to more accurately assess and treat mental health conditions among Latinos and educate this population about the distinctions between mental distress and mental disorder.

Measuring the Mental Health Needs of Latinos. The rate of mental disorders among Latinos varies, depending on source and study objectives. The most commonly used formula for assessing the need for mental health services for Latinos has been a proportional representation formula based on general population figures. According to Vega and Lopez (2001), this approach assumes that “mental health problems are fairly evenly distributed in all groups” (p. 191); however, the utilization of mental health services typically varies according to county, region, and service delivery strategies. Nevertheless, population-based formulas are used often, even though they do not factor in utilization rates, the cultural and linguistic appropriateness of services, or other barriers to access beyond acute care for extremely serious mental health disorders (e.g., involuntary hospitalization).

General population formulas, however, do lend insight into the hypothetical need for services among Latinos and are useful for illustrating the potential need for mental health services and treatment (Cabassa, Zayas, & Hansen, 2006). For example, based on the 2000 census, the California Department of Mental Health Statistics and Data Analysis (CDMH-SADA, 2003) estimated 810,619 Latino youth and adults experienced SED or SMI. These estimates have proven useful in projecting need across the state and in specific geographic areas. The SMI and SED estimates have already been critical in establishing baselines for service needs reflected in county MHSA plans.

Similar to prevalence estimates of mental disorders, data for serious forms of mental illness also vary according to source and study. In June 2006, the National Institute of Mental Health (NIMH) reported that six percent of mental illnesses were severely debilitating. They further noted that bipolar disorder, drug dependence, and obsessive-compulsive disorder are the most seriously disabling mental disorders. Although neither the ECA nor the NCS collected data on drug dependence, they did report estimates for bipolar disorder (1.7percent) and obsessive-compulsive disorder (2.4percent). Data collected by the NCS-Revised may reveal more precise estimates for the prevalence of mental disorders among Latinos (NCS,

2005) but should be evaluated with caution because the participant cohort included English-speakers only, thus excluding recent immigrants and less-acculturated members of the Latino community.

Vega and Lopez (2001) acknowledge that efforts to quantify the prevalence of mental disorders among Latinos in the U.S. are imprecise; yet their usefulness for demonstrating need for mental health services and treatment is uncontended. Investigations based on survey research and general population formulas have allowed researchers to draw important conclusions about the proportional rates of psychiatric disorders among Latinos. The differences in their mental health rates are associated with length of residency in the U. S., risk and protective factors, and the persistent and serious underutilization of mental health services (Burnam et al., 1987; Alderete et al., 2000; Hernandez et al., 2004; Breslau et al., 2005).

Risk and protective factors associated with Latino mental health. Currently, effective and affordable service provision depends on the homogenization of diagnosed need. However, the literature cites specific risk and protective factors that may not be quantified in numerical fashion but are nonetheless important factors in the assessment and treatment of mental health conditions among Latinos.

Poverty, lack of insurance, restricted access to services (Sullivan & Rehm, 2005) and structural barriers to care, such as lack of transportation (Anderson & Gittler, 2005) reportedly compromise the mental health of Latinos. Documented status and weakened social support due to migration are also known to hinder their psychological status (Kim-Godwin & Bechtel, 2004). An increased risk of depression is also prevalent among inhabitants of rural areas (Schmaling & Hernandez, 2005) and Latinos exposed to political violence (i.e., war, torture, forced disappearances, and extrajudicial killings) (Eisenman et al., 2003).

Place of birth is associated with developing a mental health problem more so than socioeconomic status (SES) or ethnic background (Escobar, 1998; Vega et al., 1998). U.S.-born Latinos are twice as likely as foreign-born Latinos abuse substance and experience mood/anxiety disorders (Grant et al., 2004; Sullivan & Rehm, 2005). Being born outside the U.S. is not necessarily a protective factor against mental distress as acculturation to the larger, more dominant U.S. culture is associated with negative health-related behaviors. These include smoking, drug use, drinking, poor dietary and nutritional habits as well as teen pregnancy and adverse birth outcomes, such as low birth weight, prematurity, and neonatal mortality (Lara et al., 2005).

The social stigma associated with mental illness, the lack of bilingual/bicultural service providers, and the experience of racial discrimination (Finch & Vega, 2003; Escobar, 1998; Sullivan & Rehm, 2005) are also associated with risk for mental health conditions (Farley et al., 2005). Even if treatment is pursued, an individual's preferences and practices, combined with the nature of the clinician-patient relationship, can obscure the evaluation of patients' need for services. A lack of cultural congruence between patient and provider is known to result in the underutilization of services and diminished health outcomes (Yeh et al., 2005).

Discussion of risk factors in the literature is interspersed with discussion about observed "protective factors" among Latinos (Alderete et al., 2000). They include sociocultural behaviors such as social networking and strong family relationships, which appear to mitigate the development of mental illnesses among Latinos. Social and emotional support systems also have been noted to diminish the need for help from more formal systems (Vega et al., 1998; Finch & Vega, 2003).

How Mental Health Services Are Currently Funded in California

The U.S. relies on both public and private funds to support the delivery of mental health services. Historically, public funds have been used to cover the majority of these costs (USDHHS, 1999). In 2003, it was estimated that 57 percent of mental health expenditures were funded by the public and 43 percent was funded by private sources, 24 percent of which was contributed by private insurance (President's New Freedom Commission on Mental Health, 2003). However, the proportion that private insurance pays for mental health expenditures is decreasing (Grazier, Mowbray & Holter, 2005). This reduction has been attributed to several factors, including the industry's widespread adoption of managed health care, the implementation of medical necessity criteria, cost containment strategies such as mental health carve-outs, contracting out of mental health services, reductions in psychosocial care and reduced inpatient services in favor of outpatient services supported with pharmaceutical treatment (Grazier & Eselius, 1999; Eisenberg & Schaffer, 2004; Grazier, Mowbray & Holter, 2005; and Kapphahn, Morreale, Rickert & Walker, 2006).

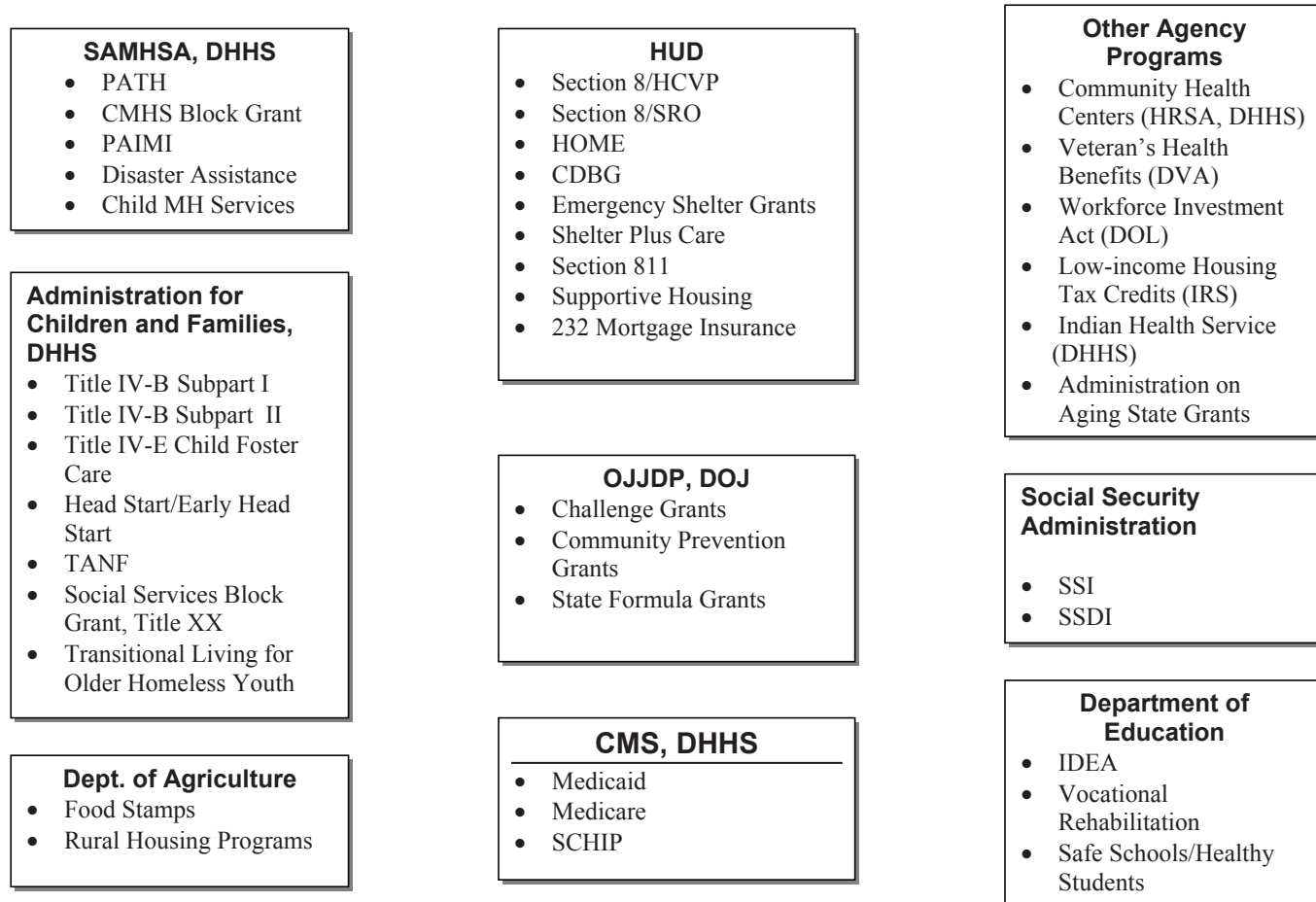
Although estimates of the proportion of private funding of mental health services is available, specifics about the numbers and conditions of Latinos funded by private insurance is not. It has been proposed, however, that persons with severe forms of mental illness of all ages most often fit functional

and financial criteria for publicly funded programs, concentrating those with highest need for mental health services in the public sector (VanMaren, 2000; Mark et al, 2003; Grazier, Mowbray & Holter, 2005). The trend of restricted private funding and increased public funding of mental health services has serious implications for how the mental health needs of Latinos living in the San Joaquin Valley will be addressed, since a high proportion of them are of low-income and/or uninsured.

Publicly Funded Sources

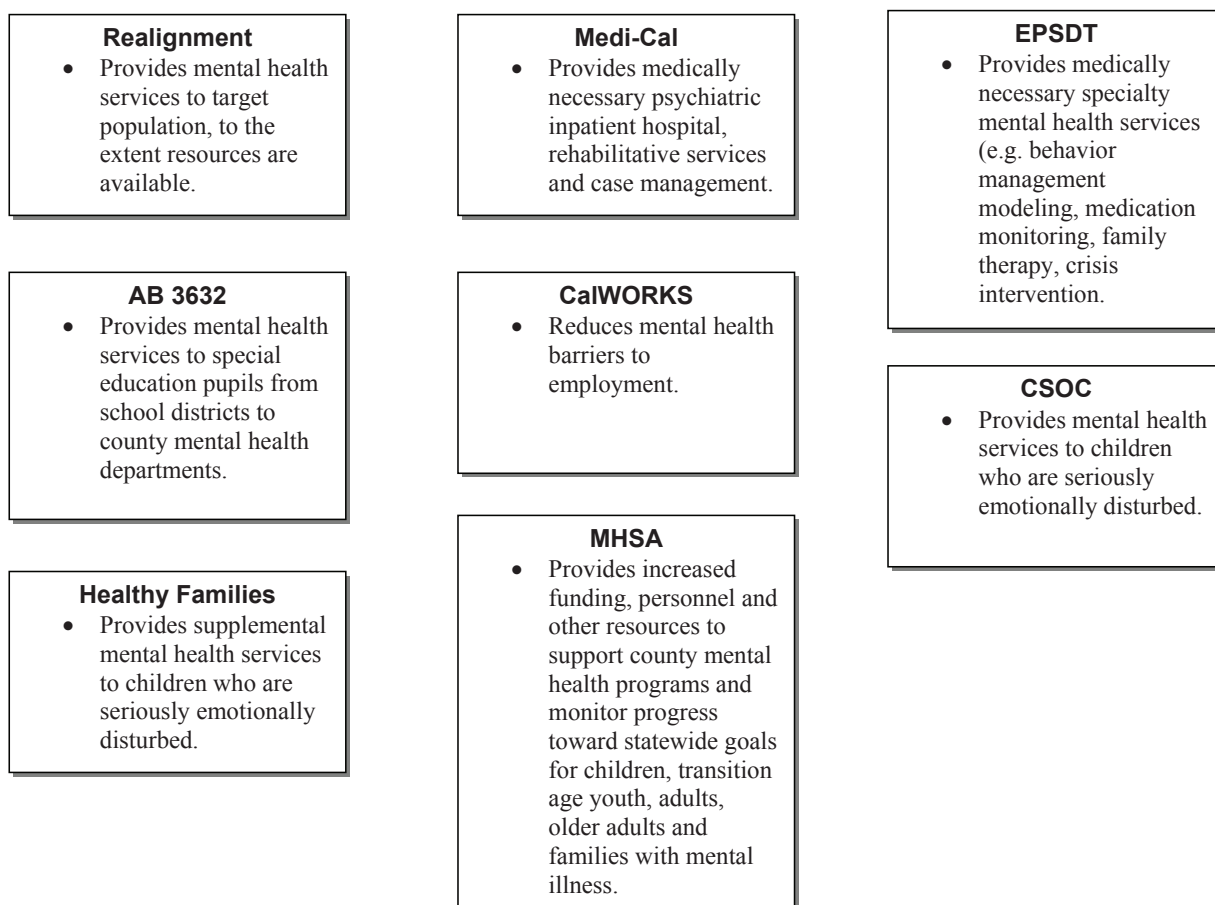
Public mental health services are subsidized by a variety of federal and state programs. (See Figures 1 and 2.) These public sources currently deliver the bulk of care for persons who are severely emotionally disturbed or suffer from persistent, severe mental illness, many of whom meet disability criteria (VanMaren, 2000). Some programs are funded by matching or share of cost between counties, the state, and the federal government. Others have been legislated by the State of California or mandated by judicial ruling. Following is a description of funding sources California uses for local mental health services. (See Figure 3 for description of dollar amounts and percentages of funding from these sources.)

Figure 1. Major Federal Programs Supporting and Financing Mental Health Care



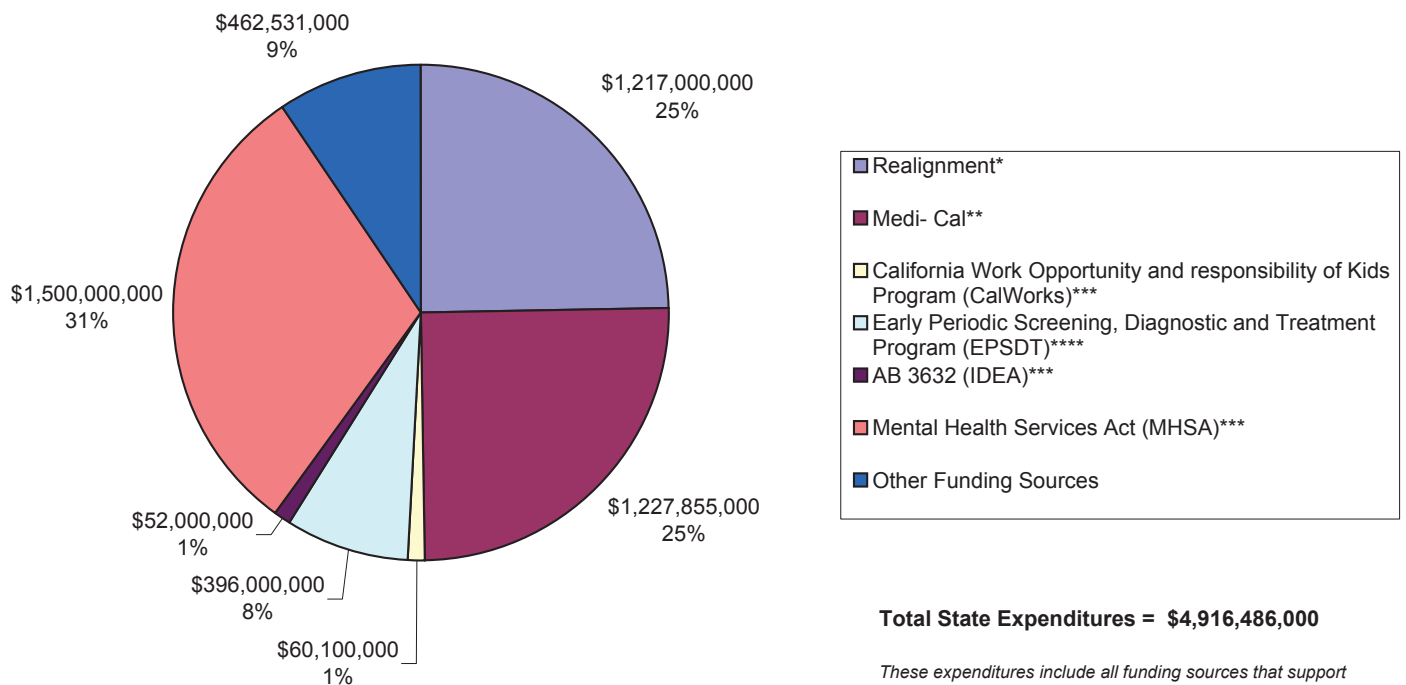
Source: Supplement to The President's New Freedom Commission on Mental Health Report, January 2003, p. 3.

Figure 2. Major State Programs Supporting and Financing Mental Health Care



Sources: Healthy Families, 2000; VanMaren, 2000; CDMH, 2003; CA Legislative Analyst's Office, 2006; Ryan, n.d., United Advocates for Children of California, 2007.

Figure 3. California Mental Health Public Funding Sources 2007-2008



*Source: California Department of Mental Health: Mental Health Service Act Implementation Study

**Source: California Department of Health Care Services: Medi-Cal Expenditures by Service Category November 2007 Estimates

***Source: Legislative Analyst's Office: Analysis of the 2007-2008 Budget Bill: Health and Social Services: Department of Mental Health (4440)

****Source: Department of Alcohol and Drug Programs Budget Act Fiscal Year 2007- 2008: Highlights

< Children's System of Care and Healthy Families not included >

Realignment Funds. Realignment funds support mental health services for persons in all age groups with severe and/or persistent mental illness. Realignment funds were legislated into being by the Bronzan-McCorquodale Act of 1991 in response to federal requirements for financing indigent health care as well as state budget shortfalls that threatened the existence of county mental health programs. This source provides the largest share of mental health services funding. This legislation shifted the revenue streams for county mental health programs from the State General Fund to two dedicated sources--a one-half cent increase in state sales tax and a state vehicle license fee. These dollars were pooled at the state level and then distributed back to the counties based on historical local funding patterns, county population size and county poverty levels with at least some of the allocation targeted to reducing county financing inequalities. Within each county program, services are provided on a sliding fee basis. Unused funds can be rolled over from one program year to the next. Although the revenues generated by Realignment still fall short of the established need, they provide counties a stable source of funding for mental health services (California Department of Mental Health Oversight and Accountability Commission [CDMH-OAC], 2003; National Alliance for Mental Illness of Santa Cruz County [NAMI-SSC], 2005; California Council for Mental Health Agencies [CCMHA], 2006; California Legislative Analyst's Office, 2006).

Medi-Cal. Medi-Cal provides funding for medically necessary psychiatric in-patient hospital, rehabilitative and case management services to persons with severe persistent or episodic mental illness who meet eligibility criteria. Medi-Cal is the second largest revenue source for county mental health programs. Several changes have affected the current structure and condition of public mental health services in the state. They include the Medi-Cal Rehabilitation Option, which supports services to maintain persons with severe mental illness in their communities, and the Medi-Cal Specialty Mental Health Consolidation, which operates under a federal program waiver, allowing the state to “carve out” dollars for general mental health care under managed care contracts between the state and counties. Under Consolidation, funding for Medi-Cal participants with general mental health care needs become the responsibility of the California Department of Health Services instead of the California Department of Mental Health. This consequently leaves counties in charge of administering local mental health services to eligible recipients (CDMH-OAC, 2003; NAMI-SSC, 2005; CCMHA, 2006; California Legislative Analyst's Office, 2006).

Early Periodic Screening, Diagnostic and Treatment (EPSDT) Program. EPSDT funds specialty mental health services (i.e., behavior management training, medication monitoring, family therapy, and crisis intervention) to children and adolescents 21 years or younger who are enrolled in Medi-Cal. Potential participants are determined to require medically necessary treatment to correct or ameliorate a mental disorder. Based on an interagency agreement between California DHS and CMH in 1995, counties were to be reimbursed by the state to cover costs related to specialty mental health services through EPSDT. This allowed them to meet the required 50 percent federal match for this program. Effective fiscal year 2002-03, counties are required to pick up a 10 percent share of cost for EPSDT services beyond a threshold level established in the original interagency agreement. As a result, counties must use Realignment monies to pay for EPSDT services beyond the threshold level established by the state (NAMI-SSC, 2005; CCMHA, 2006).

AB 3632. AB 3632 is state legislation that implements the federal mandates of the Individuals with Disabilities Education Act (IDEA) of 1990. IDEA entitles children with emotional and physical disabilities who are less than 22 years of age to free, appropriate public education. It also provides mental health services if an emotional disability interferes with academic performance. Due to the state's fiscal problems, the funding necessary to implement IDEA has not been made available to counties who are legally bound to implement the state mandates. Subsequently, counties have used a mix of funding sources, including Realignment Funds, Medi-Cal, and CDMH funding to support IDEA implementation at local levels. Reimbursement payments to counties for implementing IDEA are beginning to resume but not at the levels needed to fully meet the federal mandate (NAMI-SSC, 2005; San Mateo County Network of Care for Mental Health, 2006; California Legislative Analyst's Office, 2006).

California Work Opportunity and Responsibility to Kids Program (CalWORKs). One of the functions of CalWORKs is to reduce mental health barriers to employment. If a person enrolled in the program has a severe mental illness that prevents them from securing employment and is eligible for Medi-Cal, counties can use General Fund monies to finance mental health services for CalWORKs recipients, allowing them to meet the required 50 percent federal match for funding (CCMHA, 2006).

Children's System of Care (CSOC). The CSOC encourages the development and coordination of services for children with severe emotional disturbances in order to comprehensively address their physical, emotional, social, and educational needs to maintain them in their local communities. Counties

are reimbursed for CSOC activities with state General Funds derived from supplemental allocations of federal Substance Abuse and Mental Health Services Administration (SAMHSA) block grant dollars. CSOC assists counties in organizing interagency collaboratives and coalitions to coordinate service planning, service delivery, and evaluation of services for seriously emotionally disturbed children and their families (CDMH, 2003; CCMHA, 2006).

Healthy Families. Healthy Families is a low-cost insurance program that provides health, dental and vision coverage to children who are uninsured and do not qualify for free Medi-Cal. Healthy Families funds the diagnosis and treatment of mental illness, including outpatient and inpatient services to children and adolescents up to 19 years of age. Realignment Funds are used to make a 65 percent federal match (California Healthy Families, 2000; CCMHA, 2006).

MHSA 2004. The MHSA requires tax revenues it generates to be used for services and activities based on the principles of prevention, wellness, recovery and resilience to address untreated mental illness among specific population groups. It allows for the funding of county infrastructure, technology and training activities necessary to support, but not supplant, these efforts. Priority attention is given to identifying mental illness among children in order to reduce the long-term effects and costs of untreated serious mental illness. Funds may be expended to implement innovative service programs for children, youth, adults, and older adults, as well as culturally and linguistically competent approaches for reaching out to historically underserved populations. The Act also requires funds be used to identify and enroll persons not covered by federally sponsored programs or private insurance plans. It also emphasizes that funds be expended in the most cost-effective manner and based on currently known “best practices” in mental health services. The MHSA is expected to generate increased amounts of revenue over time. Approximately \$275 million in taxes was raised in 2004-05. Another \$750 million was raised in 2005-06, and approximately \$800 million was generated in 2006-07 (League of Woman Voters, 2004). The MHSA explicitly bars state government from reducing General Fund support, entitlements to services, and formula distributions of funds now dedicated for county mental health services below the levels provided in 2003-04.

In summary, Latinos with mental health conditions are eligible for publicly funded programs if they meet local and state or federal eligibility criteria. Most of these programs require proof of citizenship or legal residency to receive services. The need for mental health services among Latinos

is expected to escalate as this portion of the population grows and as disparities in access to treatment increase, especially for persons with low incomes (President's New Freedom Commission, 2003; Eisenberg & Schaffer, 2004). The MHSA's commitment to cultural competence includes outreach and engagement efforts so that the populations served more closely reflect the racial and ethnic diversity of California counties. Since Latinos represent the largest constituency of "minority" residents in the state and the region, the outreach and engagement strategies reflected in the MHSA plans hold the best promise for reducing the historical underutilization of mental health services by this group.

Key Features of the MHSA

Under the terms of the MHSA 2004, fundable services include prevention and early intervention activities, as well as direct services and the necessary infrastructure, technology, and training elements to support the delivery of these services. In order to be eligible for MHSA funds, each county was required to submit an Integrated Three-Year Program and Expenditure Plan to the CDMH in early 2005. Each plan was to contain major elements required by the MHSA legislation (Community Services and Supports, Prevention and Early Intervention, Education and Training, Innovations, and Capital Facilities and Technology) and identify specific strategies for addressing the mental health needs of children, transition age youth ages 16 through 25, adults, and seniors. The MHSA promotes recovery and wellness principles for persons with SED and SMI, as well as the use of best practices for treating mental disorders through:

Full Service Partnerships (FSPs): Flexible funds that can provide non-traditional environmental resources for individuals with serious mental illness or serious emotional disorders through currently existing mental health delivery systems and/or local community agency collaborations

General System Development Funds: Funds to improve services for individuals in FSPs, including funds to enhance services and support for all individuals and families in innovative ways (e.g., support groups, one-stop centers, or consumer network building) that will enrich the overall mental health systems

Outreach and Engagement Funding: Funds used to target individuals and families receiving little or no service, due to access barriers or types of stigma (e.g., cultural, familial, or societal) associated with going to mental health

In order to reduce disparities and barriers and increase access to mental health services by “minority” populations, the MHSA also requires counties to commit to the principles of cultural competence and to implement outreach and engagement efforts to underserved populations. Cultural competence includes culturally appropriate and linguistically responsive assessments and evaluation of need, and services designed to respond to the clients’ and families’ culture, race, ethnicity, age, gender, sexual orientation and religious/spiritual beliefs (CDMH, 2005).

Since Latinos represent the largest constituency of “minority” residents in the state and the region, the outreach and engagement strategies reflected in the MHSA plans of the eight San Joaquin Valley counties directly address the needs of this group. Although the intent of all counties is to more adequately address the needs of underserved populations, the projected need for mental health services among Latinos in the San Joaquin Valley outstrips the current and projected capacity of county mental health systems.

Latinos’ Access to Mental Health Services in the Valley

Prevalence estimates of Latinos with SED and SMI in the San Joaquin Valley and the reported numbers of Latinos with SED and SMI featured in this report were based on percentage estimates posted by the California Department of Mental Health (CDMH) in 2003 and individual county 2005-2008 Community Support Services (CSS) plans for MHSA funding posted on the internet in 2007. (See Appendix B) State prevalence of need and county estimates of service provisions provide a basis for examining the current and anticipated need for Latino mental health services in the Valley.

The estimates developed by the CDMH were based on 2000 census data and provide county-specific population figures of SED and SMI (CDMH, 2003). Most counties utilized these estimates in their 2005-2008 CSS plans. The data tables that have been compiled (Table 1A and Table 1B) contain figures that were formerly individually cited in the County CSS plans. These categories included *Fully Served*, *Underserved/Inappropriately Served*, and *Unmet/Unserved*. For the purpose of this article, the estimates were dichotomized into SED/SMI Served, 2005 (this category is a combination of Fully Served and Underserved/Inappropriately Served found in the county’s CSS plans) and Estimated SED/SMI Unserved, 2005.

Table 1A. Estimates of Service and Need for General Population

County	Total Population, 2000	Estimated SED/SMI Population, 2000	SED /SMI Served, 2005	Estimated SED/SMI Unserved, 2005
Fresno	749,407	58,459 (7.3%)	21,157 (36%)	37,302 (64%)
Kern	661,645	50,117 (7.6%)	15,454 (31%)	34,663 (69%)
Kings	129,461	10,611 (8.2%)	3,439 (32%)	7,172 (68%)
Madera	123,104	10,611 (8.2%)	2,842 (28%)	7,415 (72%)
Merced	210,554	15,431 (7.3%)	5,492 (36%)	9,934 (64%)
San Joaquin	563,598	40,408 (7.2%)	10,998 (27%)	29,410 (73%)
Stanislaus	446,997	31,688 (7.1%)	12,818 (40%)	18,870 (60%)
Tulare	368,021	27,633 (7.5%)	8,619 (31%)	19,014 (69%)

Notes:

- Mental Illness is defined in the MHSA guidelines as Seriously Emotionally Disturbed (SED) and Seriously Mentally Ill (SMI).
- SED/SMI Served includes SED/SMI individuals being fully served, underserved, and inappropriately served.
- General population and estimated SED/SMI totals and percentages were derived from original prevalence data based on the 2000 census developed by the State of California Department of Mental Health Statistics and Data Analysis (2003).
- Totals for SED/SMI served were based on totals reported in county plans. (See Appendix B.)

Table 1B. Estimates of Service and Need for Latino Populations

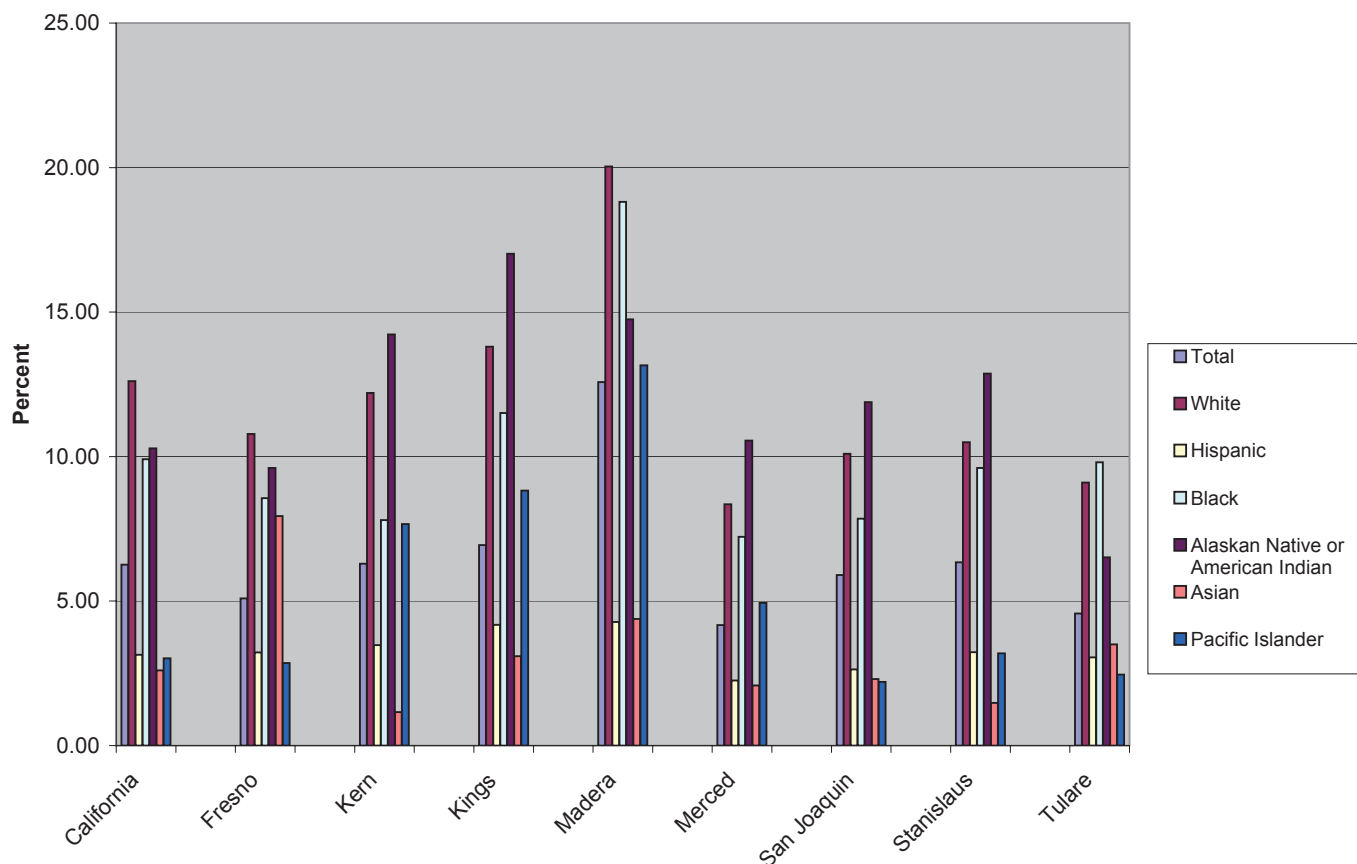
County	Latino Population, 2000	Estimated Latino SED/SMI Population, 2000	Latino SED/SMI Served, 2005	Estimated Latino SED/ SMI Unserved, 2005
Fresno	351,636 (44%)	27,583 (7.8%)	8,539 (31%)	19,044 (69%)
Kern	254,036 (38%)	20,879 (8%)	5,142 (25%)	15,737 (75%)
Kings	56,461 (43%)	4,805 (8.5%)	1,502 (31%)	3,303 (69%)
Madera	54,515 (74%)	4,657 (8.5%)	1,147 (25%)	3,510 (75%)
Merced	95,466 (45%)	7,328 (7.7%)	1,796 (25%)	5,532 (75%)
San Joaquin	172,073 (31%)	13,041 (7.6%)	1,718 (13%)	11,323 (87%)
Stanislaus	141,871 (32%)	10,504 (7.4%)	3,680 (35%)	6,824 (65%)
Tulare	186,846 (51%)	14,991 (8%)	4,211 (28%)	10,780 (72%)

Notes:

- Mental Illness is defined in the MHSA guidelines as Seriously Emotionally Disturbed (SED) and Seriously Mentally Ill (SMI).
- SED/SMI Served includes SED/SMI individuals being fully served, underserved, and inappropriately served.
- Latino population and estimated Latino SED/SMI totals and percentages were derived from original prevalence data based on the 2000 census developed by the State of California Department of Mental Health Statistics and Data Analysis (2003).
- Totals for SED/SMI served were based on totals reported in county plans. (See Appendix B.)

Based on the CDMH estimates, the percentages of Latinos living in the Valley with SED and SMI in 2000 ranged from 7.4 percent to 8.5 percent. (See Table 1B.) However, the population receiving mental health services reported by the individual counties in their CSS plans reflects that only a small proportion of them were receiving the services they required. Estimates of Latinos who remain unserved in 2005 ranged from 65 percent in Stanislaus County to 87 percent in San Joaquin County. (See Table 1B.) These estimates are disconcerting when compared to the general population's percentage of unserved SED/SMI which ranged from 68 percent in Kings County to 73 percent in San Joaquin County. The marginalization of Latinos receiving mental health services is further illustrated in the Medi-Cal projections published by the California Department of Finance. They reported that in California, 12.6 percent of White Medi-Cal participants were served between 2005 and 2006, compared to only 3.1 percent of Latino Medi-Cal participants (California Department of Finance, 2007a). This disproportional paradox between Latinos and Whites can also be witnessed throughout the eight counties of the San Joaquin Valley. (Figure 4.)

Figure 4. Percentage of People Eligible for Mental Health Medi-Cal Services Who Are Currently Being Served 2005-2006



Source: California Department of Finance, Race/Ethnicity Population with Age and Sex Details 2000-2050 Sacramento, California, July 2007.

These percentages reflect the enormity of need for mental health services among Latinos in the region. Not reflected here is the anticipated population growth of Latinos, who are expected to be the “minority majority” of residents in six of the eight San Joaquin Valley counties by 2010 (California Department of Finance, 2007b).

Since those in need of mental health services are often unable to fulfill their roles in larger society, it can be assumed their problems will come to the attention of their families, schools, health care providers, and larger systems such as law enforcement and criminal justice. Some studies have noted a correlation between insufficient mental health services and increased burdens on society such as decreased job productivity, violent behaviors, and homelessness (Soeteman, Hakkaart-Van Roijen, Verheul, & Busschbach, 2008; Van Asselt, Dirksen, Arntz, & Severens, 2007). Mental health impairment is often reflected in disrupted social relationships with others rather than self-reported need. This, in turn, creates a burden of care not only for those with mental health problems but also for persons who care for them. This may be particularly true for Latinos, who highly value the concept of family, and family members often represent the “front line” of care for their relatives who experience SED or SMI. In addition, neither population estimates nor household surveys necessarily take into account the numbers of Latinos who fall into categories of high need, including incarcerated individuals, war veterans, refugees, or individuals with drug or alcohol problems (USDHHS, 2001).

Summary of Findings

Prevalence estimates of need for every county in the San Joaquin Valley outweigh MHSA county plans for service provision to this population. Although outreach and engagement efforts provided through the MHSA will help increase the numbers of Latinos served, the projected need for services for this group outstrips these efforts. Low educational and socioeconomic status, acculturative stress, and culturally based linguistic differences as well as culture-bound syndromes have direct implications for psychosocial assessment, treatment, and educational efforts for this population. Currently, Latinos with mental health conditions are eligible for publicly funded programs only if they meet local and state or federal eligibility criteria. Most of these programs require proof of citizenship or legal residency to receive services. In addition, no publicly funded program addresses the mental health needs of undocumented Latinos who work and reside in the Valley and may experience a diagnosable emotional

disturbance or onset of severe mental illness. Their needs are more than likely to remain unaddressed in today's political climate.

The undocumented population withstanding, national and state survey data do not accurately capture the extent of need for mental health services among Latinos in the San Joaquin Valley. The prevalence and projected service use data available demonstrate that mental health services do not match the estimated need for this group in the Valley. These data also do not address the larger question of what constitutes culturally relevant treatment for Latinos in the San Joaquin Valley nor how counties prepare to address these needs, some of which may fall outside the purview of the MHSA. Currently, the estimated population growth of Latinos in the San Joaquin Valley threatens to exceed the modest efforts of the MHSA in addressing the mental health needs of this group. It is established that specific risk factors increase the likelihood of mental health conditions among Latinos, but more knowledge is needed about how protective factors may mitigate acute or chronic forms of mental disturbance or mental illness. Learning more about protective factors as well as culturally relevant treatment for mental health disorders among Latinos could result in preventative interventions from which more Latinos, regardless of their legal status, can benefit. This, in turn, can extend the true intent of the MHSA and other federally and state-funded mental health programs.

Recommendations

Implementation of the MHSA provides an opportunity to examine current policy on the delivery of mental health services for all populations. However, the anticipated growth of the Latino population forces state and county leaders to examine the feasibility of the MHSA fulfilling its mission to change the service delivery landscape of mental health services in California. Based on the findings of this brief, the following recommendations are offered.

- Counties utilize national and state population projection formulas to estimate the mental health needs that occur in their respective geographic locations. This presents a problem due to the inaccuracy that the results portray when aggregating national and state data. These estimates do not account for individuality and uniqueness in the various county communities. Consequently, there is insufficient regional data to illustrate the specific mental health needs in the Valley, especially for Latinos. County-level data are needed in order to construct feasible

community outreach programs and accurately monitor the number of un-served and poorly served individuals. Only then can county administrators truly evaluate the benefits of the newly constructed programs, including those supported by the MHSA.

- Current data collection instruments do not fully capture or address the Latino population's understanding of mental health in a fashion similar to the dominant culture. In fact, levels of acculturation diffuse a measurer's capacity to capture Latinos ability to assess behaviors and symptoms of mental illness beyond colloquial descriptions. The innovative approach of the MHSA provides opportunity to learn more of this population's conceptualization of mental illness in order to better assess, measure and address the mental health needs of this group.
- Even the best of data does not reduce the challenge of actively engaging Latinos in mental health treatment and prevention services. Many are not familiar with treatment protocols and may not be educated or served in a culturally or linguistically appropriate manner. The experience of seeking services is further restricted by the limited availability of funding, especially for Latinos that are marginalized from the dominant culture or undocumented and therefore ineligible for any form of public assistance. The MHSA's commitment to cultural competence, outreach and engagement of the unserved provides a unique opportunity for counties to serve a previously disenfranchised population.
- The awareness of Latinos in regard to the symptomatology of mental illness and the principles of recovery and wellness are limited at best. A cursory search of print and electronic resources on mental health and mental illness reveals an abundance of English language reference literature that far exceeds that of Spanish language materials. Likewise, there are a number of studies that demonstrate how descriptors of mental illness are anchored in culturally bound syndromes that are neither measured nor addressed by conventional means. Even fewer address culturally based protective factors that may moderate the severity of mental illness. The MHSA provides a rich opportunity to translate and augment current knowledge so that Latinos are better prepared to recognize and seek help for mental health conditions that are disruptive and increase the burden of care for individuals, families, and communities.
- Currently, the number of Latinos eligible for publicly funded mental health services far exceeds the need. The intent of the MHSA is to support current services rather than supplant them,

although emphasis is placed in prevention and education in order to reduce long-term effects and cost of serious mental illness. However, it does not address the needs of persons with chronic mental illness, even if they are discovered in the process of outreach and engagement. This places the state and counties at a crossroads in terms of service allocation and the types of services that should be offered. The current consensus is that counties are experiencing challenges in organizing infrastructure and human resources to serve persons identified with mental illness, including bilingual bicultural personnel to serve Latinos (Abbott, Jordan, & Meisel, 2008). Serious consideration for funding infrastructure is needed so that county mental health programs can sustain services and support the innovative promises of the MHSA.

Conclusions

There are a number of issues identified in this brief, including obvious structural and cultural barriers that restrict access to mental health services by Latinos. The intent of the MHSA is to innovate service delivery, reduce access barriers and identify underserved populations. As a result, a clear understanding about the extent of need among Latinos and the disproportionate share of services currently allocated to Latinos with SED and SMI has been achieved. But even in the best case scenario, this need may not be addressed simply due to the expanding Latino population in the Valley. All of these issues raise worries about continued gaps in mental health services to Latinos unless counties and the state re-evaluate current methods of resource allocation and service delivery. There is hope, however, that the steady stream of funding, outreach and engagement efforts, workforce development activities, and the promotion of culturally competent practices will benefit California as a whole and provide ample opportunity for Latinos to achieve parity in availability and utilization of mental health services over time.

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Appendix A. Definition of Mental Health Disability.

Mental health disability is a constructed measure used in the National Health Interview Survey (NHIS, 1994-95) and the National Health Interview Survey on Disability (NHIS-D, 1994-95). This measure includes:

1. having a limitation in any activity in any way due to a mental health problem (core questionnaire);
2. having any of 7 mental health symptoms that seriously interfere with day-to-day activities (working, going to school, or managing day-to-day activities); and
3. having any of these 7 symptoms or any of 9 mental health disorders that cause work disability (an inability to work or a limitation in the kind or amount of work a person can do).

The 7 mental health symptoms are:

1. frequently depressed or anxious
2. have a lot of trouble making and keeping friendships
3. have a lot of trouble getting along with other people in social or recreational settings
4. have a lot of trouble concentrating long enough to complete everyday tasks
5. have serious difficulty coping with day-to-day stress
6. frequently confused, disoriented, or forgetful
7. have phobias or unreasonably strong fears, that is a fear of something or some situation where most people would not be afraid

The nine mental health disorders are:

1. Schizophrenia
2. Paranoid or delusional disorder, other than schizophrenia
3. Manic episodes or manic depression, also called bipolar disorder
4. Major depression (major depression is a depressed mood and loss of interest in almost all activities for at least 2 weeks)
5. Antisocial personality, obsessive-compulsive personality, or any other severe personality disorder
6. Alzheimer's disease or another type of senile disorder
7. Alcohol abuse disorder
8. Drug abuse disorder
9. Other mental or emotional disorders that seriously interfered with ability to work, attend school, or manage day-to-day activities.

Source: Jans, L., Stoddard, S. & Kraus, L. (2004). *Chartbook on Mental Health and Disability in the United States*.

Appendix B. Annotations for County Plans

Fresno County. Totals for SED/SMI served and Latino SED/SMI served were compiled, based on numbers reflected in Chart A, pp. 57-58 of *Fresno County's MHSA 3-Year Program and Expenditure Plan – Part I & Part II*. See: <http://www.fresnomhsa.org/approvedplans.html>

Kern County. Totals for SED/SMI served and Latino SED/SMI served were compiled, based on numbers reflected in Chart A, pp. 34-35 of the *Kern County Mental Health Services Act Community Services and Supports Plan: Part II*. See: http://www.co.kern.ca.us/kcmh/mhsa/csspdfs/submit/PART_II.pdf

Kings County. Totals for SED/SMI served and Latino SED/SMI served were compiled, based on numbers reflected in Chart A, pp. 25-26 of the *Kings County Mental Health Services Act Community Services and Supports: Three-year Program and Expenditure Plan requirements, 2006*. See: <http://www.countyofkings.com/mhsa/pdfs/MHSAfinal.pdf>

Madera County. Totals for SED/SMI served and Latino SED/SMI served were compiled, based on numbers reflected in Table 4, p. 37 of the *Madera County Mental Health Services Act: Three-year Plan for Community Services and Supports, 2005*. See: http://www.madera-county.com/mentalhealth/pdf/mhsa_final_plan.pdf

Merced County. Totals for SED/SMI served and Latino SED/SMI served were compiled, based on numbers reflected in Chart A, pp. 52-54 of the *Merced County Mental Health Services Act: Community Services and Supports Three-Year Program and Expenditure Plan, 2005, Part II, Sect. II*. See: <http://www.co.merced.ca.us/mentalhealth/mhsacssp.html>

San Joaquin County. Totals for SED/SMI served and Latino SED/SMI served were compiled, based on numbers reflected in Tables 5-8, pp. 74-76 of the *San Joaquin County Mental Health Services Act (MHSA) Three year Program & Expenditure Plan Community Services and Supports*. See: <http://sjmhsa.net/mhsaplan.html>

Stanislaus County. Totals for SED/SMI served and Latino SED/SMI were compiled, based on numbers reflected in Chart A, pp. 32-34 of the *Stanislaus County Mental Health Services Act (MHSA) Three- Year Program and Expenditure Plan: Community Services and Supports, 2005*. See: <http://stanislausmhsa.com/ThePlan.htm>

Tulare County. Totals for SED/SMI served and Latino SED/SMI served were compiled, based on numbers reflected in Tables 1-4, pp. 53-55 of the *Tulare County Adopted Mental Health Services Act Community Services and Supports: Three Year Program and Expenditure Plan for 2005-06, 2006-07, 2007-08*. See: <http://www.co.tulare.ca.us/government/mhsa/css.asp>