CHAPTER 20 — POLICIES ADDRESSING Racial Terror

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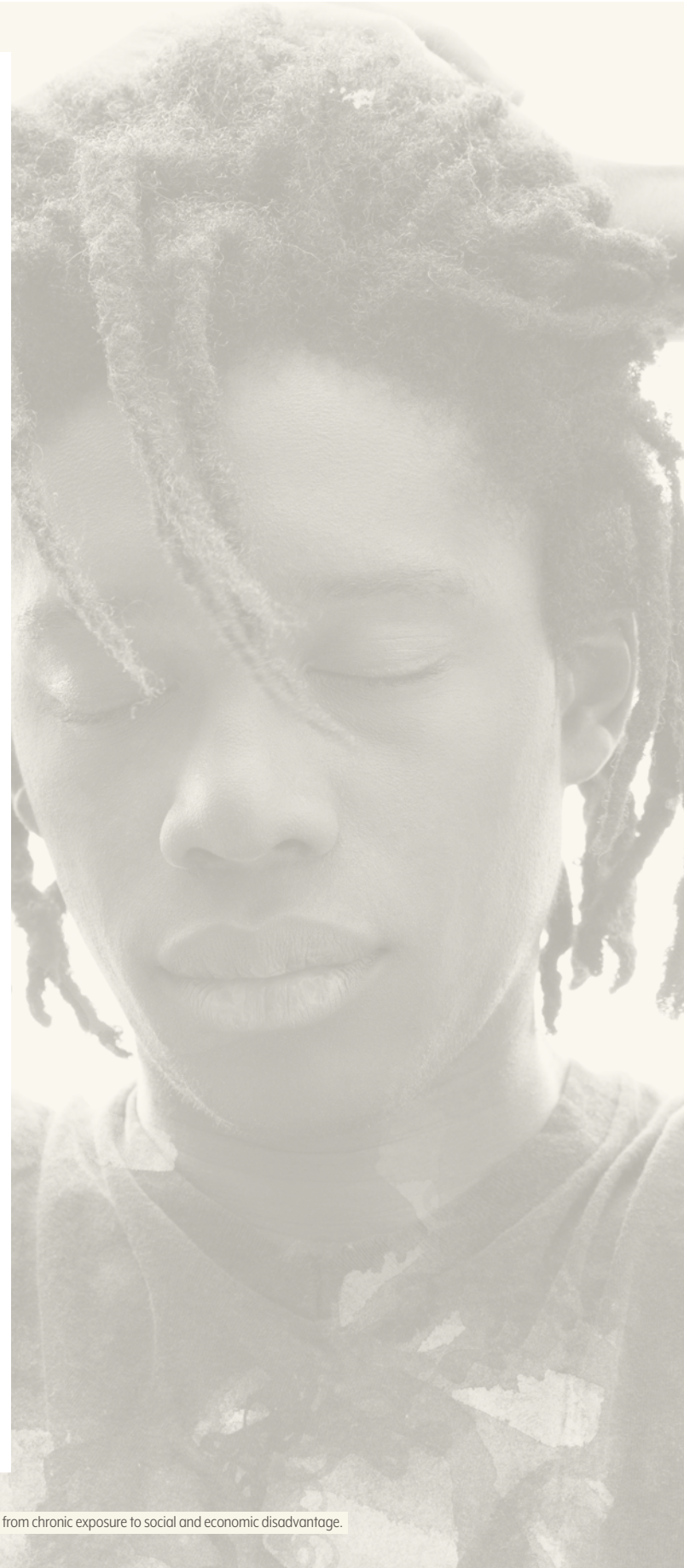


African Americans suffer from weathering—constant stress from chronic exposure to social and economic disadvantage.

I. Policy Recommendations

This chapter details policy proposals to address harms set forth in Chapter 3, Racial Terror.

- Advance the Study of the Intergenerational, Direct, and Indirect Impacts of Racism
- Establish and Fund Community Wellness Centers in African American Communities
- Fund Research to Study the Mental Health Issues Within California's African American Youth Population, and Address Rising Suicide Rates Among African American Youth
- Expand the Membership of the Mental Health Services Oversight and Accountability Commission to Include an Expert in Reducing Disparities in Mental Health Care Access and Treatment
- Fund Community-Driven Solutions to Decrease Community Violence at the Family, School, and Neighborhood Levels in African American Communities
- Address and Remedy Discrimination Against African American LGBTQ+ Youth and Adults, Reduce Economic Disparities for the African American LGBTQ+ Population, and Reduce Disparities in Mental Health and Health Care Outcomes for African American LGBTQ+ Youth and Adults
- Implement Procedures to Address the Over-Diagnosis of Emotional Disturbance Disorders, Including Conduct Disorder, in African American Children
- Disrupt the Mental Health Crisis and County Jail Cycle in African American Communities
- Create and Fund Equivalents to the UC-PRIME-LEAD-ABC Program for Psychologists, Licensed Professional Counselors, and Licensed Professional Therapists (See Chapter 29 for the text of this recommendation.)

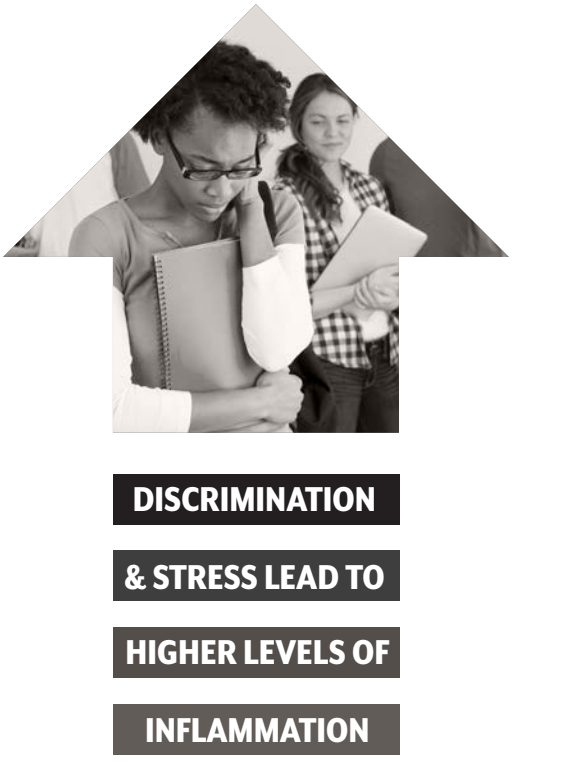
- Eliminate Legal Protections for Peace Officers Who Violate Civil or Constitutional Rights
- Recommend Abolition of the Qualified Immunity Doctrine to Allow Access to Justice for Victims of Police Violence
- Assess and Remedy Racially Biased Treatment of African American Adults and Juveniles in Custody in County Jails, State Prisons, Juvenile Halls, and Youth Camps (See Chapter 28 for the text of this recommendation.)

Advance the Study of the Intergenerational, Direct, and Indirect Impacts of Racism

As documented in Chapter 12, Mental and Physical Harm and Neglect:

> African Americans suffer from weathering—constant stress from chronic exposure to social and economic disadvantage, which leads to accelerated decline in physical health. Social environments that pose a persistent threat of hostility, denigration, and disrespect lead to chronically high levels of inflammation. Studies have shown that Black youth who are exposed to discrimination and segregation have worse cases of adult inflammation due to race-related stressors. In fact, race-related stress has a greater impact on health among African Americans than their diet, exercise, smoking, or being low income. Cortisol, which is a stress hormone, locates itself in bodies in response to racism—consequently African American adults have higher rates of cortisol than their white counterparts . . . .

A growing body of research has begun to document racism's impact on health,[1] but work remains to be done. Of note, the field of pediatrics has not systematically addressed racism's impact on child health, leaving pediatricians inadequately prepared to identify and respond to racism-related risks and harms.[2] Psychologists writing in JAMA Psychiatry noted that the intergenerational impacts of racism have been less studied than research on structural racism and the experience of racial discrimination, and shared research providing some evidence that "like risk for psychopathology, the nefarious effects of structural racism and of the experience of discrimination can be transmitted to subsequent generations."[3] They went on to propose that viewing racism through an intergenerational lens helps to address mental health disparities by creating new opportunities for action and intervention, and offering models of healing, values, and intergenerational resilience.[4]



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The Task Force recommends funding to the California Health and Human Services Agency (or California Department of Public Health within the agency) to further advance the study of the intergenerational, direct, and indirect impacts of racism and to formulate recommendations for enhanced mental health care, including educating mental health care workers. While not focused exclusively on children, in recognition of the harms that racism inflicts upon children, this proposal adopts and directly incorporates recommendations of the American Academy of Pediatrics so that funding would include support for the study of:

1. the impact of perceived and observed experiences of discrimination on child and family health outcomes;
2. the role of self-identification versus perceived race on child health access, status, and outcomes;
3. the impact of workforce development activities on patient satisfaction, trust, care use, and pediatric health outcomes;
4. the impact of policy changes and community-level interventions on reducing the health effects of

racism and other forms of discrimination on youth development; and

5. integration of the human genome as a way to identify critical biomarkers that can be used to improve human health rather than continue to classify people on the basis of their minor genetic differences and countries of origin.[5]

This study could be facilitated through grants to fund the research of established and emerging experts.

Establish and Fund Community Wellness Centers in African American Communities

As discussed in Chapter 3, throughout the history of the United States, racial terror has played a critical role in reinforcing and perpetuating the badges and incidents of slavery. Enslavement was followed by decades of violence and intimidation intended to subordinate formerly enslaved people and their descendants across the United States.[6] Racial terror, especially lynching and the threat of lynching, pervaded every aspect of African American life during and after slavery.[7] "California is no exception; the state, its local governments, and its people have played a significant role in enabling racial terror and [allowing] its legacy to persist here in California."[8]

In addition to physical assault, threats of injury, and destruction of property, racial terror inflicts psychological trauma on those who witness the harm and injury.[9] African Americans continue to experience the effects of trauma induced by racial terror today.[10] That trauma manifests as heightened suspicion and sensitivity to threat, chronic stress, decreased immune system functioning, and an increased risk for depression, anxiety, and substance use.[11]

Despite a significant need for mental health interventions to address the effects of historical and current racial trauma, African Americans experience a range of mental health care disparities. These disparities include problems of access, bias, poorer quality of care, misdiagnosis, inadequate research, and poorer mental health outcomes.

Despite the clear and significant need for mental health interventions to address the effects of historical and current racial trauma, African Americans continue to experience a range of mental health care disparities.[12] These disparities include problems of access, bias, poorer quality of care, misdiagnosis, inadequate research, and poorer mental health outcomes.[13] Further, due to the lack of accessible prevention and early intervention (PEI) programs that prevent serious mental illness in adults, African Americans are more likely to have their first contact with the mental health system through a hospital emergency room or the criminal justice system.[14] For African American children, PEI programs are also lacking, resulting in African American children being over-diagnosed with emotional and behavioral disorders.[15]

Additional barriers include stigma within the community associated with seeking mental health treatment and distrust of the mental health system, which stems from the discrimination that African Americans have experienced when they have sought treatment.[16] The lack of licensed African American mental health professionals or culturally congruent[17] mental health professionals who can provide effective services to California's African American residents increases that distrust.[18]

To address these harms, the Task Force recommends that the Legislature enact legislation to establish and fund Community Wellness Centers (CWCs) within historically African American neighborhoods and in other communities in each city and county where significant numbers of African Americans reside. These CWCs will serve three functions:

First, the CWCs will serve as a source for educating the community about mental health to remove the stigma from experiencing mental health issues and seeking treatment. The CWCs will collaborate with religious leaders, who have traditionally served as a mental health resource for members of their communities,[19] and with community-based organizations (CBOs) to educate community members on mental health issues. The CWCs will also partner with CBOs to offer programs on parenting, processing grief and loss, substance abuse, and intimate partner violence.

Second, the CWCs will provide PEI mental health programs that are supported by community-defined evidence practices (CDEPs).[20] The programs should focus on trauma-informed services anchored in addressing racial stress and trauma. Examples of CDEPs include support groups and healing circles.[21] Support groups and healing circles are examples of CDEPs that have been used by the African American community to address stress from racial terror and trauma. These

practices are rooted in a cultural perspective that has helped African Americans develop resilience in the face of historical and current racial terror and trauma.[22] The CWCs will also function as community gathering spaces for cultural celebrations and other opportunities for the residents to be in community with one another, which is healing unto itself.

In addition to communal practices like racial healing circles, the CWCs will also provide programming that focuses on instilling a positive racial identity in African American children, beginning as early as age three.[23] The development of a positive racial identity is a protective factor against racism. "Racial socialization and racial identity have been documented as culturally strength-based assets—resources that enhance adaptive coping—that are particularly important and protective for Black families."[24] Specifically, a positive racial identity has been linked to higher resilience, self-efficacy, and self-esteem.[25] A recent study indicated that African American adolescents experienced 5.21 racist incidents on average per day, including in schools.[26] These experiences lead to short-term increases in depressive symptoms.[27] Developing a positive racial and ethnic identity has been shown to weaken the effects of both teacher discrimination and other daily discrimination.[28]

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In developing the programming, the CWCs would collaborate with CBOs that promote programs that foster positive racial identity in African American children, like cultural programs and visual and performing arts programs, to offer those programs at the CWCs. The programs would also have a parental education component to provide resources to help parents become more knowledgeable about the importance of fostering a positive racial identity and tools to do so at home. At a minimum, the programs would: 1) expose African American children to historical figures and information about African Americans' accomplishments, capacities, values, and culture; 2) redefine and reframe the concepts of success, strengths, and accomplishments in terms of family commitment, survival of the community, demonstration of spiritual and moral integrity, and the efficacy of civil rights efforts in combatting discrimination, rather than by using standards and definitions based on Euro-American culture and worldview; and 3) expose African American children to Black people in positions of power and control, including those in other countries, using film and other media.

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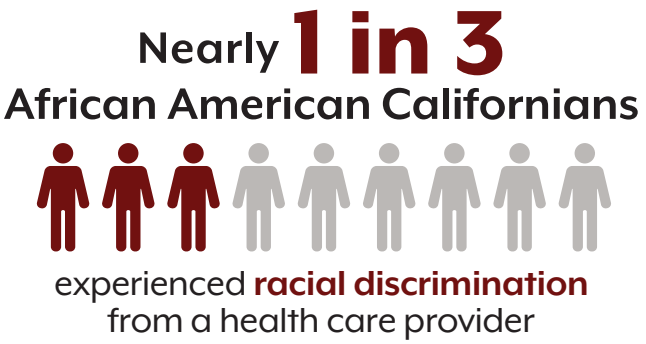
Healing Circles are safe spaces for individuals of African ancestry that draw upon culturally-grounded healing strategies in coping with anti-Black racial trauma/stress and community violence.

Third, the CWCs will serve as access points for screening and referrals to the appropriate level of care for both mental health and medical care. Each CWC should be staffed by a licensed mental health professional who is culturally congruent with the African American culture, who can provide screening and appropriate referrals for people in the community, and who, if requested, can provide urgent mental health intervention. This should include screening for depression and suicide risk for children and adolescents, the group for whom suicide rates have increased the most.[29] The licensed mental health professional should also have knowledge about PEIs, including those supported by CDEPs.

The Task Force relatedly recommends that the Legislature ensure sufficiently increased funding for mental health services provided in traditional clinical settings, including outpatient and inpatient services, to absorb the increased referrals from the CWCs. County departments of mental health across the state should be required to provide CBOs with access to PEI resources at the county level, align county priorities with non-evidence-based intervention opportunities, and provide annual accountability updates to demonstrate the extent to which the cultural and contextual needs of African American residents in their county are addressed.

The staff of the CWCs should also include a culturally congruent general medical provider and a culturally congruent health care advocate. A 2022 survey of Black Californians about their experiences with accessing medical care revealed that about one-third of the respondents experienced racial discrimination from a healthcare provider.[30] About one-fourth of respondents reported avoiding care because of concerns about being treated unfairly or disrespectfully when accessing medical care.[31] The respondents requested that the medical healthcare system implement several changes to improve care for Black Californians. Those improvements included increasing Black representation among health care leadership and the health care workforce, establishing more Black-led, community-based clinics, and expanding community-based education on how to navigate the health care system and advocate for quality care for Black Californians.[32]



To address these concerns, the CWCs will be staffed by a medical provider who is culturally congruent with African American culture and be able to screen adults and children for medical conditions, including those that may present as mental illness,[33] and refer them out for appropriate medical treatment. Further, each CWC should be staffed by a culturally congruent healthcare advocate or a medical social worker who will assist members of the community in navigating the medical and mental health systems to ensure access and provide advocacy when community members experience discrimination or otherwise do not receive respectful and proper care.[34] Additionally, the Office of Health Equity, which is housed in the California Department of Public Health,[35] should be required to collect data regarding the number of people using the medical screening and referral services at CWCs to assess whether there is a need for additional resources for a specific CWC or community.

Fund Research to Study the Mental Health Issues Within California's African American Youth Population, and Address Rising Suicide Rates Among African American Youth

Anxiety, depression, and suicide rates have been rising among African American children and teenagers in recent years.[36] The COVID-19 pandemic compounded these issues by disrupting the lives of adolescents and limiting their social activities.[37] Forty-four percent of African American teenage girls said they need help for emotional and mental health problems such as feeling sad, anxious, or nervous.[38] The rates for suicide for African American children has also increased significantly when compared to the suicide rates for white children. Specifically, suicide rates among white children have dropped from the 1993-1997 to the 2008-2012 periods, but rates have steadily increased among African American elementary school-aged children.[39]

Thirty-seven percent of elementary school-aged children who died by suicide were African American, as were 12 percent of the early adolescents who died by suicide.[40] Between 2014 and 2020, the death-by-suicide rates among African American youth doubled, rising to twice the statewide average.[41] Almost one in four (22 percent) African American seventh graders has considered suicide—more than twice the rate of white students (10 percent) and the highest of any group in seventh grade.[42] As of 2018, suicide was the second leading cause of death among African American children aged 10 to 14, and the third leading cause of death among African American adolescents aged 15 to 19.[43]

Despite the increase in suicidal thoughts, suicide attempts, and deaths by suicide among African American youth, only a small number of research studies have examined death by suicide in African American children; very little is known about causality.[44] "'[C]ommon' risk factors associated with suicidal behaviors recently have been found to not be associated with suicidal behaviors among Black youths."[45] The few studies that have examined the issue suggest that there are a number of factors that could be contributing to the increase.[46] Multigenerational cultural trauma, community violence, adverse childhood experiences (ACEs), stress-response

As of 2018, suicide was the second leading cause of death among African American children aged 10 to 14, and the third leading cause of death among African American adolescents aged 15 to 19.

patterns, systemic and institutional violence, and bullying may play a role.[47] Research also suggests that discrimination plays a significant role in the increase in the risk of suicide among African American youth.

African American youth are less likely than white youth to receive mental health treatment, even after a suicide attempt.

Specifically, one study concluded that discrimination was a universal risk factor for suicidal ideation among African American youth, regardless of their ethnicity or gender.[48] Exposure to online racial traumatic events, such as police killings and videos of people being beaten, is also associated with an increase in depression, post-traumatic stress symptoms, and suicide risk.[49]

Compounding these issues are disparities in access to mental health services for African American youth.[50] African American youth are less likely than white youth to receive mental health treatment, even after a suicide attempt.[51] "Only 16% of Black youth in Medi-Cal have been screened for depression and provided with a follow-up plan if needed."[52] In combination, the higher rates of misdiagnosis among African Americans, psychiatric diagnostic tools that have explicitly racist origins, and a lack of sufficient African American medical professionals lead many African American children and adolescents not to trust the American medical system, which may prevent them from seeking help for mental health issues.[53]

Existing research indicates that "[saving] the lives of Black children and youth [will require] greater investment in protective factors, including social and emotional supports . . . while simultaneously addressing structural racism[,] [the social determinants of their health, mental health stigma, and help-seeking; and [providing] culturally tailored treatment opportunities."[54] The Task Force accordingly recommends a multi-prong approach to researching suicide risk and prevention strategies for African American youth and for addressing their overall mental health.

The Task Force recommends that the Legislature amend the Mental Health Services Act (MHSA) to authorize the Office of Health Equity to establish and fund practice-based suicide prevention research centers throughout California to study suicide risk and prevention in African American youth, building on the example of the National Institute of Mental Health (NIMH), which issued a Notice of Special Interest at the national level to fund research focused on the risk and prevention of suicide in African American youth.[55] The Office of Health Equity is authorized by Health and Safety Code section 131019.5 to lead the effort to reduce health and mental health disparities to vulnerable communities, including African Americans. Like the NIMH, the Office of Health Equity has the authority to direct and fund research on suicide and risk prevention in California, including specific research on suicide risk and prevention in African American youth.

The Task Force recommends that the Legislature enact legislation to mandate annual screening for depression symptoms in all school children beginning in kindergarten, with culturally appropriate screening for African American children, especially those descended from an enslaved person. This recommendation builds on the American Academy of Pediatrics' endorsement of a recommendation to use a self-report screening tool to assess for depression in youth[56] and recognizes that symptoms of depression and anxiety are increasingly seen in younger children.[57] A self-report tool designed to measure core depressive symptoms in children and adolescents can be used for annual screenings without requiring extensive testing for each child.[58] Youth who present with significant depression symptoms should receive further evaluation beyond the mandatory screening required for all students.

Guidelines for assessing depression symptoms in children must note the lack of cultural relevance in empirically-supported approaches to assessing depression in African American children. African American youth may express symptoms differently than other populations.

At the same time, the guidelines for assessing depression symptoms in children and youth must note that there is a lack of cultural relevance in empirically-supported approaches to assessing depression in African American children and adolescents, and that African American youth may express symptoms differently than

other populations.[59] The Task Force recommends that the Legislature fund and support research to develop screening and treatment approaches that are inclusive of African American children and youth and appropriately matched to their needs.

The Task Force also recommends that the Legislature enact legislation to increase funding for public schools throughout California to provide counselors, social workers, and mental health professionals whose practices are culturally congruent[60] with African American culture. Relatedly, the Task Force recommends that the Legislature ensure sufficient state funding for schools to provide "[s]paces and programming aimed at breaking down mental health stigma."[61]

The Task Force recommends that the Legislature enact legislation to fund implementation of programs that address trauma and chronic stress among students, teachers and staff, and the larger school community at high-need schools.

A recent study indicated that students are willing to seek help from school counselors, but that the limited availability of counselors creates a significant barrier to access.[62] In expanding the number of counselors available at each school, the Legislature should require and ensure that African American students have the same counselor-to-student ratio as students at schools in the wealthiest school districts in California. To address and mitigate any stigma some students may experience when seeking help, care must be taken to allow those accessing mental health services to be inconspicuous.

The Task Force additionally recommends that the Legislature enact legislation to provide funding for confidential peer counseling and peer support groups in each school throughout California to help students who are struggling with depression or experiencing discrimination in the school but who may be reluctant to seek help from a school counselor. Studies indicate that peer counseling and peer support groups are beneficial to students experiencing depression.[63] Providing confidential peer support groups at school could be an important PEI protocol for those students at risk for suicide.[64]

The Task Force also recommends that the Legislature enact legislation to provide schools with additional funding to establish healing circles or sharing circles for African American students who may be experiencing discrimination at school.[65] Healing and sharing circles are examples of CDEPs[66] that have been shown to help African Americans process racial trauma.

The Task Force further recommends that the Legislature enact legislation to develop, require, and fund training in "anti-racist and trauma-informed mental health practices" for teachers and school personnel in public schools throughout California.[67]

The Task Force recommends that the Legislature enact legislation to fund training for teachers and school personnel in social and emotional learning programs to teach techniques that can be used to help students cope with their anxiety and manage their emotions.[68]

The Task Force recommends that the Legislature enact legislation to fund implementation of programs that address trauma and chronic stress among students, teachers, staff, and the larger school community at high-need schools.[69]

Expand the Membership of the Mental Health Services Oversight and Accountability Commission to Include an Expert in Reducing Disparities in Mental Health Care Access and Treatment

The entity charged with overseeing the implementation of mental health legislation in California is the Mental Health Services Oversight and Accountability Commission (MHSOAC).[70] The provision establishing the MHSOAC provides for 16 voting members.[71] One of the responsibilities of the MHSOAC is to develop strategies to overcome stigma and discrimination and to increase access to mental health services for underserved groups.[72] In 2017, Governor Brown vetoed legislation that would have added an expert in reducing mental health disparities to the MHSOAC.[73]

The MHSOAC acknowledged in 2022 that structural racism has caused racial disparities to persist in California's mental health system.[74] At its November 17, 2022, meeting, the MHSOAC approved its Racial Equity Plan, which is the MHSOAC's "initial step" to address the demonstrated disparities in access to mental health services and disparities in treatment that result from structural racism.[75]

In this "initial step," the MHSOAC states that it will solicit the help of subject-matter experts in identifying "best practices of policy research that address disparities" and in evaluating and modifying its Racial Equity Plan to meet its "racial equity vision."[76] The acknowledgment that the MHSOAC has to consult with outside experts on the issue of reducing disparities indicates that adding an expert in reducing mental health disparities to the MHSOAC is necessary to address issues of racial disparities.There should be internal capacity and expertise on this subject given the centrality and import of racial disparities, the grace consequences of these disparities, and the MHSOAC's responsibilities.

The Task Force therefore recommends that the Legislature reintroduce legislation to increase the number of voting members from 16 to 17. In addition, the Task Force recommends that the Legislature require and specify that the Governor appoint as a MHSOAC member an expert in reducing disparities in access to mental health services for African Americans, especially descendants of those enslaved in the United States. Appointing an additional member who has expertise in reducing disparities fits with the overall purpose of the MHSA.[77] The proposed appointment also aligns with the Racial Equity Plan approved by the MHSOAC on November 17, 2022.[78]

Fund Community-Driven Solutions to Decrease Community Violence at the Family, School, and Neighborhood Levels in African American Communities

As detailed in Chapter 3 of the report, the racial terror inflicted on the African American community has influenced the use of violence within the community, and as a result, African Americans experience violence at the family, school, and community levels.[79] Exposure to violent crime damages "people's health and development," and pushes "communities into vicious circles of decay."[80] And although rates of violent crime have declined significantly, African American communities are disproportionately affected by it.[81] The data indicates that limited resources and "concentrated disadvantage," in turn, influence the rate of violence within a neighborhood.[82] "Concentrated disadvantage" is a sociological term used to describe neighborhoods or communities with high percentages of residents who are poor and lacking in critical resources, such as access to quality healthcare and education.[83] Investing in programs that increase inclusion and belonging within the community, support education, help residents acquire skills, and increase access to jobs can reduce violent crime within neighborhoods.[84]

The Task Force recommends that the Legislature enact legislation to establish and fund a state-funded grant program to support community-driven solutions to decrease community violence at the family, school, and neighborhood levels in African American communities. The grant program should award grants to CBOs that offer programs to address violence in African American communities and in communities where there is a significant African American population. The grant program would operate similarly to the Ready to Rise Program in Los Angeles and would provide sufficient funding to each recipient organization to ensure that the full panoply of services can be provided at the level needed. The Task Force recommends that the Legislature require that the grant program prioritize funding for programs that use practices that are supported by CDEPs to focus on violence prevention within the youth population. Programs that promote socialization, emotional regulation techniques, and social and cultural competence in early-school-age children have been shown to reduce violence among youth.[85] These include programs that partner with schools to create a trauma-informed, safe, supportive, and equitable learning environment for everyone within the school community.[86]

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Psychologist supporting teenage patient. Programs that promote emotional regulation techniques have been shown to reduce violence among youth.

The Legislature should also prioritize funding for programs that focus on youth empowerment through teaching skills in a variety of areas, such as computer coding, political advocacy, culinary arts, performing arts, and sports. Funding would be provided for equipment and transportation for all children, regardless of means, so that poverty would not serve as a barrier to participation nor as a source of stigma for children who may lack the resources to pay for equipment and supplies.

Programs that provide services to children and families who have been victims of violence or otherwise exposed to violence should also receive priority for grant funding.[87] Peer-to-peer programs, for example, have demonstrated promise in helping victims of violence and their families heal from their experience.[88] The Task Force also recommends that the Legislature specify that funding be prioritized for CBOs that provide mental health support services, including PEI programs like healing circles,[89] peer-to-peer support groups,[90] and other practices supported by community-defined evidence, to African Americans throughout California. The Task Force urges the Legislature not to include a requirement that a client or customer have a mental health diagnosis to qualify for mental health support services funded by the grant program. The Task Force further recommends that the Legislature provide additional funding to CBOs to collect demographic data for the populations served, disaggregated by age, gender, and race.

The Task Force recommends that the legislation also prioritize funding for programs with demonstrated success in gang prevention, gang intervention, and the disruption of gang violence, as well as programs that partner adults within the community with children to escort them along safe routes to and from school to avoid "hot spots," areas in the community where gang activity is likely to take place.[91]

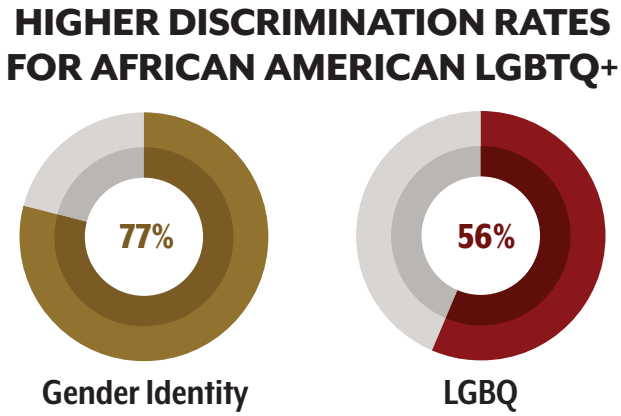
The Task Force recommends that the legislation that establishes and funds the grant program also prioritize funding for programs that invest in rehabilitation of structures and public spaces within neighborhoods to strengthen community connection.[92] Some research studies have indicated that the presence of vacant lots or some types of commercial properties correlate to an increase in crime.[93]For this reason, the Task Force recommends that funding is also prioritized for programs and CBOs that focus on ameliorating these conditions in African American communities and in communities where significant numbers of African Americans reside.

Address and Remedy Discrimination Against African American LGBTQ+ Youth and Adults, Reduce Economic Disparities for the African American LGBTQ+ Population, and Reduce Disparities in Mental Health and Health Care Outcomes for African American LGBTQ+ Youth and Adults

African Americans who identify as LGBTQ+[94] or Same Gender Loving (SGL)[95] live at the intersection of multiple forms of discrimination, as anti-Blackness and anti-LGBTQ+ sentiment compound to result in a higher incidence of discrimination, harassment, and violence in every setting including schools, workplaces, the mental health system, and the health care system. The compounding effects of discrimination for African American LGBTQ+ individuals are reflected in the gaps in education, economic advancement, police interactions, and mental and physical health outcomes.[96] Not only do the outcomes for African American LGBTQ+ individuals lag behind those for white people, but they also lag behind outcomes for African Americans who are non-LGBTQ+.

African American LGBTQ+ Youth

African American LGBTQ+ youth experience higher rates of victimization than non-LGBTQ+ African American youth, with transgender and non-binary youth experiencing higher rates of victimization than their LGBTQ cisgender peers.[97] Seventy-seven percent have felt discriminated against because of their gender identity compared to 56 percent of their African American lesbian, gay, bi and queer peers.[98] Forty percent have been physically threatened or harmed because of their identity.[99]



The educational system in particular has been hostile to LGBTQ+ youth.[100] One study of a national survey of African American LGBTQ+ students found that the majority of African American LGBTQ students surveyed felt unsafe at school because of their sexual orientation while 30 percent felt unsafe because of their race.[101] Transgender and gender non-conforming African American students experienced greater levels of harassment than their cisgender LGBQ+ peers.[102] Because of the harassment they experienced, nearly a third of African American LGBTQ+ students surveyed missed at least one day of school in the previous month because they felt unsafe.[103] The harassment and victimization African American LGBTQ+ students experienced resulted in "lower levels of school belonging, lower educational aspirations, and greater levels of depression."[104] African American students in general are disproportionately disciplined at school, and research shows that African American LGBTQ+ students are at an even greater risk for being disciplined inappropriately or disproportionately.[105]

African American LGBTQ+ students who attended majority African American schools were more likely to experience "out-of-school discipline" than African American LGBTQ+ students at majority white schools.[106] One study indicated that African American LGBTQ+ students were subject to school discipline even when they were being victimized.[107] And African American LGBTQ+ students also experienced discipline based on discriminatory school policies that prevented them from using their preferred name or pronouns, using the restroom or locker room that aligned with their gender identity, expressing public displays of affection, or starting a Gay-Straight Alliance student organization at their school.[108]

Despite the significant levels of harassment and discrimination African American LGBTQ+ students experience because of their LGBTQ+ status and race, these students have few resources available to them. When they complain to teachers and school personnel about being assaulted or harassed, the response is often for the students to just "ignore it."[109] Less than half of the African American LGBTQ+ students who responded to a 2017 school climate survey reported having a supportive school administration.[110] Although there is evidence that Gay-Straight Alliances allow LGBTQ+ students to feel more connected to their schools and improve the overall climate of a school for LGBTQ+ students, LGBTQ+ students at majority African American schools are less likely to have access to a Gay-Straight Alliance.[111] The lack of supportive resources in majority African American schools may be due in part to a lack of funding, as African American schools have disproportionately low levels of funding compared to majority white schools.[112]

One study indicated that African American LGBTQ+ students were subject to school discipline even when they were being victimized.

LGBTQ+ students who experienced an unsupportive and unsafe school environment, one in which they experience both homophobic and racist harassment, had poorer academic outcomes and decreased psychological well-being.[113] These negative effects reverberate beyond high school. African American LGBTQ+ students are less likely to pursue college or other post-secondary education.[114] And many experience greater levels of depression.[115]

In a recent study, 63 percent of African American LGBTQ+ youth reported experiencing symptoms of major depression.[116] Fifty-five percent reported symptoms of generalized anxiety disorder in the past two weeks.[117] In the same study, 44 percent of African American LGBTQ+ youth and 59 percent of African American transgender and nonbinary[118] youth reported that they considered suicide in the previous 12 months.[119] A separate study found that 25 percent of African American transgender or non-binary youth reported attempting suicide sometime within the last year.[120] And although a key factor in suicide prevention is social support from family members, African American transgender and nonbinary youths were "far less likely than their Black lesbian, gay, bi and queer peers to receive [it]."[121]

Despite this urgent crisis, African American youth are less likely than white youth to receive outpatient mental health treatment, even after a suicide attempt.[122] A recent survey reported that 60 percent of African American LGBTQ+ youth who wanted mental health care in the previous year did not receive it.[123] Of these youth, more than half cited affordability as a barrier to mental health care.[124] Over 40 percent of African American LGBTQ+ youth who did not receive mental health care cited concerns around parental permission.[125] African American transgender and nonbinary youth cited concerns with finding an LGBTQ+ competent provider and previous negative experiences with providers as reasons for not obtaining care.[126] Other reasons African American LGBTQ+ youth did not access mental health care included issues related to trust, fear, and ineffectiveness of potential treatment.[127]

To address the issues facing African American LGBTQ+ youth in education and mental health, the Task Force recommends that the Legislature enact the following legislation.

First, the Task Force recommends that the Legislature enact legislation to require the Department of Education to develop an effective anti-bullying and anti-harassment model policy for all ages and grade levels that is anti-racist and LGBTQ+-inclusive. The policy should specifically include language that addresses race, ethnicity, sexual orientation, perceived sexual orientation, gender, gender identity, and gender expression. It is further recommended that the Legislature require the Department of Education to develop an evidence-based model policy for all ages and grade levels to address physical bullying and social bullying. The legislation also should require all local school agencies and school districts in California to adopt and implement the model policies developed by the Department of Education and provide reimbursement for costs associated with implementing the policies.

The Task Force recommends that the Legislature enact legislation requiring all public school personnel, staff, and administrators statewide to receive training and support to increase cultural humility[128] and cultural sensitivity around the treatment of all African American students, including those perceived to be LGBTQ+, as well as African American personnel and staff who identify as LGBTQ+. The training should focus on the specific health and safety of each sub-group within the LGBTQ+ community and intersecting identities, including African American LGBTQ+ students.[129]

The Task Force also recommends that the Legislature enact legislation requiring public school districts to approve and fund a Gay-Straight Alliance at every school within a district where at least one student requests permission to start one. Because of the significant positive impact the presence of a Gay-Straight Alliance has on the overall school environment, the legislation should specifically prohibit local school districts and public schools from denying a student's request to start a Gay-Straight Alliance at their school.[130]

To increase school connectedness and address depression, the Task Force also recommends that the Legislature enact legislation to fund peer-to-peer group programs and healing circles within public schools throughout California for African American LGBTQ+ youth.

To address the mental health crisis that is currently facing African American LGBTQ+ youth, the Task Force recommends that the Legislature pass a resolution stating that African American transgender and nonbinary youth suicide is a public health crisis and enact legislation to fund state-wide research on the issue of suicide risk and prevention in LGBTQ+ youth, including African American transgender and African American nonbinary youth.[131] The Task Force recommends that the legislation funding the research also require that the Office of Health Equity within the California Department of Health collect data on suicide in African American LGBTQ+ youth in California. The legislation should also provide funding to support a public media campaign to disseminate the data the Office of Health Equity collects and the results of the research conducted. These measures are needed to educate African American communities and the larger public on protective factors shown to lower the risk of suicide for African American LGBTQ+ youth.[132]

The Task Force also recommends that the Legislature fund public health and education campaigns that employ voices trusted by African American LGBTQ+ youth to promote mental health wellness and provide information on accessing mental health care within the African American community, including schools, churches, and other spaces where African American LGBTQ+ youth gather.[133]

To address the mental health crisis currently facing African American LGBTQ+ youth, this Task Force recommends that the Legislature pass a measure declaring African American transgender and nonbinary youth suicide a public health crisis and enact legislation to fund state-wide research on the issue of suicide risk and prevention among African American LGBTQ+ youth.

To address disparities in mental health for African American LGBTQ+ youth, the Task Force recommends that the Legislature enact legislation to increase funding to expand publicly-funded mental health treatment programs for African American LGBTQ+ youth. In addition, funding should be provided for CBOs that provide mental health treatment services for African American LGBTQ+ youth. Funding should also be directed to fund the collection of demographic data by publicly-funded mental health treatment programs and CBOs for the population served, disaggregated by age, race, gender, and sexual orientation.

A significant number of African American LGBTQ+ youth who want to access confidential mental health care without a parent's permission are unable to do so. Therefore, the Task Force recommends that the Legislature enact legislation that will allow mental health providers to treat African American LGBTQ+ youth who are under age 18 and may otherwise not receive care because parental permission is required.[134]

African American LGBTQ+ youth also encounter barriers to accessing mental health care when they are unable to find an African American mental health provider or a provider who specializes in working with African American LGBTQ+ youth.[135] The Task Force therefore recommends that the Legislature create and fund recruitment programs in California that recruit diverse candidates for masters and doctoral-level psychology programs and professional counselor and therapist training programs committed to serving

African American LGBTQ+ youth and adults, especially those who reside in African American communities and in other communities where a significant numbers of African Americans reside.

The Task Force also recommends that the Legislature require and fund cultural humility and anti-racist training for all candidates in these programs. That training should include, at a minimum, training protocols on interrogating a mental health professional's personal biases and understanding how racial and heterosexual bias and oppression causes and exacerbates the mental health concerns that impact African American LGBTQ+ youth and lead that population to seek therapy.[136] The Task Force further recommends that the Legislature include adequate funding for the programs to collect and disseminate data disaggregated by race, gender, age, and sexual orientation of the candidates who were admitted into these programs, successfully matriculated through the programs, and are providing mental health services to African American LGBTQ+ youth after graduating.

The Task Force also recommends that the Legislature enact legislation requiring annual competence and cultural sensitivity training that certifies that a mental health professional is qualified to work with culturally diverse populations, specifically, African American youth and African American LGBTQ+ youth.[137]

African American LGBTQ+ Adults

The difficulties African American LGBTQ+ individuals face extend to employment. LGBTQ+ individuals experience high rates of discrimination and harassment in hiring and in the workplace.[138] For example, studies have shown that employers are less likely to reach out to perceived LGBTQ+ job candidates for interviews.[139] Discrimination is heightened for LGBTQ+ applicants who are African American. Seventy-eight percent of African American LGBTQ+ individuals who responded to a survey conducted by the Center for American Progress in 2020 reported that discrimination affected their ability to be hired.[140] For white LGBTQ+ individuals, that number was 55 percent.[141] Even when they are hired, racism and heterosexism affects the ability of 56 percent of African American LGBTQ+ individuals to maintain their jobs.[142]

As detailed in Chapter 10, Stolen Labor and Hindered Opportunity, and Chapter 13, The Wealth Gap, the income disparity between African American and white Californians is significant. The income disparity is worse for African American LGBTQ+ adults. "Across all economic indicators . . . Black LGBTQ adults have a lower economic status than Black non-LGBTQ adults."[143] For example, African American LGBTQ+ adults have higher unemployment rates compared to African Americans who are non-LGBTQ+.[144] Thirty-nine percent of African American LGBTQ+ adults in the United States had a household income of less than $24,000 a year compared to 33 percent of non-LGBTQ+ African Americans.[145] And more African American women who are LGBTQ+ live in low-income households than non-LGBTQ+ African American women.[146]

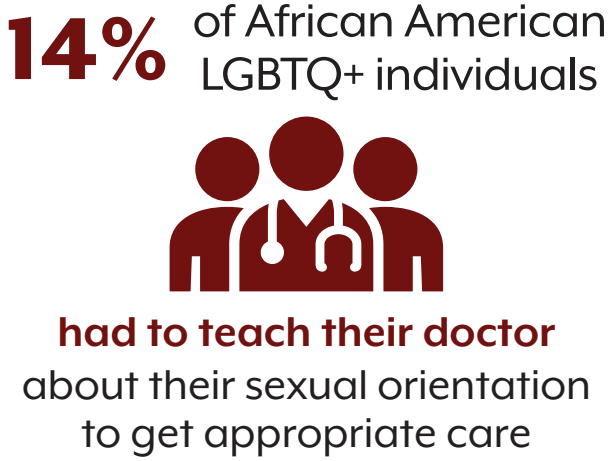
"Across all economic indicators ... Black LGBTQ adults have a lower economic status than Black non-LGBTQ adults." For example, African American LGBTQ+ adults have higher unemployment rates compared to African Americans who are non-LGBTQ+.

Disparities in outcomes for LGBTQ+ African Americans exist in the mental health and healthcare systems as well. "Consistent discrimination takes a significant toll on individuals' mental and physical health. Physiologically, harassment and mistreatment have been shown to lead to cortisol dysregulation, which affects a wide range of bodily functions. As a result, African American LGBTQ individuals often experience mental and physical health challenges."[147]Both African American LGBTQ+ men and women are more likely to have been diagnosed with depression than non-LGBTQ+ African American men and women.[148] African American lesbians have a higher rate of suicide than other LGBTQ+ groups,[149] but they are less likely to seek out traditional professional mental health help than their white counterparts.[150]

Seeking treatment in the mental health and healthcare systems can often cause more harm, however. One barrier to seeking mental health treatment is the concern about being mistreated by mental health providers based on race or sexual orientation.[151] LGBTQ+ individuals can be harmed at every stage in the mental health system including referral, intake and assessment, and intervention.[152] In one survey, African American LGBTQ+ clients who reported that they were very dissatisfied with the treatment they received most frequently felt their providers fell short in addressing race and ethnicity concerns, trauma, sexual orientation concerns, and grief.[153] Specifically, providers did not know how to help with respondents' sexual orientation concerns

or inappropriately focused on their sexual orientation when that was not the reason they sought treatment.[154] Some respondents to the survey also reported that their mental health provider made negative comments about their gender identity or expression.[155] Additional barriers to seeking treatment include mistrust of mental health treatment and lack of resources to pay for treatment.[156]

Medical doctors often lack awareness of LGBTQ+ patients' needs as well. This is in large part because more than half of medical school curricula do not provide information about the health issues and treatment of LGBTQ+ patients beyond work related to HIV.[157] This leaves African American LGBTQ+ individuals facing compounded forms of stigma at the doctor's office, and often encountering substandard care, harsh language, and even physical mistreatment. In a recent survey conducted by the Center for American Progress, 15 percent of African American LGBTQ+ individuals reported some form of negative or discriminatory treatment from a doctor or healthcare provider in the previous year, and seven percent reported being refused care entirely.[158] Fourteen percent of African American LGBTQ+ individuals reported that in order to receive appropriate care they had to teach their doctor about their sexual orientation.[159] Eleven percent reported that the doctor who treated them "was visibly uncomfortable" because of their sexual orientation.[160]



To increase the number of medical and mental health providers treating African American LGBTQ+ individuals, the Task Force recommends that the Legislature enact legislation to fund scholarships and loan forgiveness for physicians and mental health professionals who focus on providing services to African American LGBTQ+ individuals through medical clinics, mental health treatment programs, and community-based organizations that provide mental health services in African American communities and in communities where significant numbers of African Americans reside. The Task Force recommends that the Legislature create and fund recruitment programs in California that recruit diverse candidates for masters and doctoral-level psychology programs and professional counselor and therapist training programs committed to serving the African American LGBTQ+ community. The Task Force also recommends that the Legislature include funding in the legislation for cultural humility and anti-racist training for all candidates in the program. That training would include, at a minimum, training protocols on interrogating a mental health professional's personal biases and understanding the role racial and heterosexual bias and oppression play in causing and exacerbating the mental health concerns that impact African American LGBTQ+ individuals and may lead them to seek therapy.[161] The Task Force further recommends that the Legislature include adequate funding for the programs to collect and disseminate data disaggregated by race, gender, age, and sexual orientation of the candidates who were admitted into these programs, successfully matriculated through the programs, and are providing mental health services to African American LGBTQ+ individuals.

The Task Force recommends that the Legislature enact legislation requiring annual competence and cultural sensitivity training that certifies that a mental health professional is qualified to work with culturally diverse populations, including specifically, African American LGBTQ+ populations.[162] One example of a set of practices that would allow practitioners to develop cultural sensitivity skills in working with the African American LGBTQ+ population is the Gay Affirmative Practice model, which addresses areas of reflection for mental health providers that could help strengthen overall cultural sensitivity in treating members of the African American LGBTQ+ community.[163]

To address the discrimination African Americans who are LGBTQ+ face in hiring and retention, which impacts their economic outcomes, the Task Force recommends that the Legislature amend Government Code section 12999, which requires all employers in California with at least 100 employees to file an annual payee data record with the California Civil Rights Department (formerly the Department of Fair Employment and Housing) showing the number of employees by race, ethnicity, and sex in the job categories specified in Government Code section 12999, subdivision (b).[164] The Task Force recommends that the Legislature amend section 12999 to require employers in California with at least 100 employees to also report the number of employees by sexual orientation in the categories specified in section 12999, subdivision (b). Employees would provide that information voluntarily

and the employer will be required to collect and store the demographic data separately from employees' personnel records. The Task Force further recommends that the Legislature amend section 12999 to require employers to also include in their annual payee data record the number of employees advanced or promoted during the reporting period by race, sex, ethnicity, and sexual orientation. The Task Force further recommends that the Legislature amend section 12999 to require each employer to include in its data payee record the number of unselected job applicants for the categories specified in section 12999, subdivision (b) by race, ethnicity, sex, and sexual orientation. Job applicants would provide this information voluntarily, and the information would be stored separately from the application.

To assist African American LGBTQ+ employees who are terminated from positions, the Task Force recommends that the Legislature enact legislation to provide funding to CBOs that provide free job training services, job counseling, and free continuing education classes to African American LGBTQ+ individuals who were terminated from their positions. It is also recommended that the Employment Development Department include on its provider list job services providers that provide job services and training to African American LGBTQ+ candidates.

Implement Procedures to Address the Over-Diagnosis of Emotional Disturbance Disorders, Including Conduct Disorder, in African American Children

African American children are more likely to be placed in special education classes than white students and are two-to-three times more likely than white students to receive a label of Emotional Disturbance in schools.[165] African American children are also 2.4 times more likely than white children to receive a Conduct Disorder diagnosis.[166] Historically, the adolescents who have been over-diagnosed with Conduct Disorder, a subset of Emotional Disturbance, are "urban," low-income, and African American.[167] Research indicates that white children who exhibit comparable behaviors that would lead to a Conduct Disorder diagnosis in African American children generally receive diagnoses of mood, anxiety, or developmental disorders—conditions that are deemed more treatable.[168]

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Teacher reading a book to a class of preschool children. A 2007 study found that African American children were 5.1 times more likely to be misdiagnosed with Conduct Disorder before eventually being diagnosed with Autism Spectrum Disorder.

Research also indicates that teachers and school staff often have referred African American children, males in particular, for assessment for Emotional Disturbance and special education placements based on a misinterpretation of behaviors that are rooted in cultural differences, such as their posture and how they walk and dress.[169]

Restrictive educational placements, like special education classes, "socialize Black children for prison and contribute to the school-to-prison pipeline."[170] The majority of African American students who receive special education services under a referral of Emotional Disturbance drop out of school, and 73 percent of those students are arrested within five years of dropping out.[171]

Studies suggest that African American children mislabeled with Emotional Disturbance or misdiagnosed with Conduct Disorder may be suffering from other conditions. Specifically, "many youth may express conduct problems in response to underlying mood or anxiety disorders."[172] Depression, for example, has been shown to be a precursor to conduct problems.[173] Research also indicates that African American children are often labeled as

Compared to white students, African American students are

2-3x MORE LIKELY to receive a diagnosis of Emotional Disturbance in schools

emotionally disturbed and underdiagnosed with Autism Spectrum Disorder because Autism Spectrum Disorder can be mistaken as bad behavior.[174] A 2007 study found that African American children were 5.1 times more likely to be misdiagnosed with Conduct Disorder before eventually being diagnosed with Autism Spectrum Disorder.[175]

Conduct problems or concerning behaviors may also be responses to environmental stressors.[176] For instance, racial discrimination from teachers and peers predicted conduct problems and low academic performance for African American adolescents.[177] Poor academic achievement also is a significant contributor to conduct problems.[178] Therefore, clinicians evaluating a child for Conduct Disorder should always consider the child's social context or environment in order to reach an accurate diagnosis[179] Recognizing the distinction between conduct problems that are a normal response to a negative social environment and those that are the result of internal dysfunction, the textual commentary at the end of the criteria list for Conduct Disorder in the DSM-5-TR[180] indicates that the diagnosis would be misapplied where a child's conduct problems are a response to environmental stressors, such as living in "very threatening, high-crime areas," and warns that "reactions to racism that involve anger and resistance-based coping may be misdiagnosed as conduct disorder by uninformed practitioners."[181]

To address both the over-diagnosing of behavioral conditions like Conduct Disorder and the underdiagnosing of other conditions like mood disorders or Autism Spectrum Disorder in African American children, and reduce excessive referrals of African American children to special education, the Task Force recommends that the Legislature amend California's Education Code and California's Code of Regulations,[182] which govern student assessments in conformity with the Individuals with Disabilities Educational Act (IDEA) and its implementing regulations,[183] to require clinicians in California to evaluate first whether the behaviors a child is exhibiting are related to environmental stressors, including the child's social context, before assessing a child for Emotional Disturbance or Conduct Disorder. Requiring consideration of the impact of environmental stressors on a child's behavior would ensure consistent application of the textual commentary to the diagnosis in the DSM-5-TR and minimize the risk of a Conduct Disorder misdiagnosis.

The Task Force also recommends that the Legislature amend California's Education Code and assessment regulations[184] to require that a clinician evaluate a child for Autism Spectrum Disorder or mood disorders, for which early interventions and supports can be critical, and which are less stigmatizing than Emotional Disturbance or Conduct Disorder, before categorizing a child as meeting the legal criteria for Emotional Disturbance or diagnosing a child with Conduct Disorder. The regulations would require a clinician making a diagnosis or special education referral to certify that assessments for environmental stressors, Autism Spectrum Disorder, or other conditions were completed before the assessment of Emotional Disturbance or Conduct Disorder was made. Parents and children would be entitled to appropriate statutory remedies where this step is omitted in an initial evaluation.

To increase the cultural competence of clinicians who diagnose and treat children, the Task Force recommends that the Legislature enact legislation to require those clinicians to complete continuing education or training on conducting culturally sensitive diagnosis and treatment of conduct problems as part of the state's licensing requirements.[185] Currently, psychologists are required to undertake four hours of training in cultural diversity or social justice.[186] The continuing education requirement recommended here is more specific. The requirement would require culturally sensitive training in diagnosing and treating emotional disturbance disorders in children, including African American children in particular, and would apply to all psychologists, psychiatrists, and other mental health professionals involved in diagnosing and treating children and adolescents.

To increase the cultural competence of clinicians who diagnose and treat children, the Task Force recommends that the Legislature enact legislation to require those clinicians to complete continuing education or training on conducting culturally sensitive diagnosis and treatment of conduct problems, as part of the state's licensing requirements.

Consistent with the need for additional training for clinicians who work with African American children, the Task Force recommends that the Legislature amend the MHSA to mandate that the Office of Health Equity provide grants to mental health treatment professionals' member organizations to implement training and continuing education programs for their members on how to conduct culturally sensitive diagnoses, including for Conduct Disorder. The curriculum for the training would impart the need for clinicians to take into account the following considerations

to ensure an accurate diagnosis: 1) the clinician's cultural biases, 2) the child client's cultural background, 3) the cultural biases of any diagnostic assessment measures being used, and 4) a careful differentiation of the client's culture and circumstances from a mental disorder.[187]

To ensure that the children who are appropriately placed in special education programs benefit from their placements, the Task Force also recommends that the Legislature enact legislation requiring the California Department of Education to revise the special education curriculum to include interventions that have been proven to be effective in helping students assessed as meeting statutory criteria for Emotional Disturbance benefit from their special education placements.[188] Three interventions that have been proven to be beneficial for children placed in special education programs include 1) providing quality teacher feedback, including verbal praise, 2) allowing flexibility in the completion of academic tasks, and 3) using behavioral staff as a means of additional academic support.[189]

Disrupt the Mental Health Crisis and County Jail Cycle in African American Communities

The overrepresentation of African Americans in the criminal justice system is well-established. African Americans are 4.2 times more likely than white people to be incarcerated in jail and nearly eight times more likely to be incarcerated in prisons in California.[190] People with mental illness are also overrepresented in the criminal justice system.[191] The most recent available data from the Bureau of Justice Statistics shows that more than one quarter of people in jail met the threshold for serious psychological distress and more than a third had been told by a mental health professional that they have a mental illness.[192] One explanation for these findings is the use of police and the criminal justice system as a response to mental health crises.[193] Police are often involved in responding to mental health emergencies, which can result in incarceration and in many instances the use of force, when mental health professionals would have been better suited to address the situation.[194]

Although African Americans are more likely to be involved in the criminal justice system, once incarcerated if they have not been previously diagnosed with a mental illness, they are less likely than other groups to receive a mental health evaluation, and when they self-report a mental illness, they are less likely to receive treatment.[195] Evidence indicates that the mental health screening tools used in jails reproduce racial disparities, resulting in fewer African Americans screening positive for mental health conditions and being referred to services to address their mental health needs.[196] Once released, formerly incarcerated people are nearly 10 times more likely to be homeless,[197] which can significantly worsen mental health conditions.

Although African Americans are more likely to be involved in the criminal justice system, there is evidence that, once incarcerated, they are less likely to be identified as having a mental health problem and are less likely to receive treatment.

To disrupt the cycle of mentally ill individuals being jailed and released without adequate mental health support, the Task Force recommends that the Legislature enact legislation to implement and fund the following programs and protocols. First, to reduce calls to 911, which increases law enforcement involvement in behavioral health emergencies,[198] the Task Force recommends that the Legislature enact legislation to fund a media campaign to increase awareness within African American communities of 988 as a non-law enforcement emergency call-in option for those experiencing mental health emergencies or crises.[199]

To decrease arrest rates and increase the opportunity for appropriate mental health services being provided to individuals who are experiencing behavioral health emergencies, the Task Force recommends that the Legislature enact legislation to require and fund the establishment of Police-Mental Health Collaboration (PMHC) programs at law enforcement agencies throughout California. PMHCs are collaborative partnerships among law enforcement, mental health providers, and often CBOs.[200] PMHCs are designed to allow law enforcement to safely respond to behavioral health emergencies and have been shown to be effective in diverting individuals to appropriate mental health settings instead of jails without a concomitant

increase in other harms.[201] Key features of effective PMHC programs include training for law enforcement officers on recognizing signs and symptoms of mental illness, education to increase officer awareness of mental health resources within their community and collaboration with those resources, and training for officers in de-escalation techniques.[202] The Task Force recommends that the Legislature require training for law enforcement officers that includes these elements and also require local law enforcement agencies to engage in routine evaluation and reporting of findings to determine effectiveness and to make program improvements.[203]

The Task Force additionally recommends that the Legislature increase funding to courts to expand diversion and mental health collaborative court programs in each city and county. The Task Force further recommends that the Legislature enact legislation requiring the appropriate entity or agency, whether that is the district attorney or the court, to assess all individuals who have been diagnosed with or have a demonstrable mental illness that can be connected to their illegal behavior for entry into a diversion and mental health collaborative court program.[204] The Task Force also recommends that the Legislature enact legislation and provide funding to require cities and counties to collect and retain screening and referral data for diversion and collaborative court programs, disaggregated by race, gender, and age.[205]

The Task Force recommends that the Legislature enact legislation to increase funding to expand county pretrial support services with Public Defender offices, county partnerships that provide mental health services and treatment planning services within jails and other detention facilities, and programs that assess individuals before they are released to connect them with appropriate services within their community.[206] Where possible, the county should identify and augment opportunities for recently released individuals to be linked to culturally congruent CBOs that have a successful history of providing services in African American communities, including programs that incorporate a peer support component in the reentry process.[207]

The Task Force also recommends that the Legislature enact legislation to provide funding to expand existing Offices of Diversion and Reentry (ODR) programs in each county and to establish and fund ODR programs in counties throughout the state where those programs do not exist. At a minimum, the ODR programs should provide mental health programming and services to individuals held in county facilities and help individuals released from county facilities transition to community-based programs that provide mental health treatment planning services, mental health services, medications, and permanent housing.[208] The Task Force recommends that the Legislature provide additional funding to each ODR program to collect demographic data for the populations served, disaggregated by age, race, and gender.

The Task Force recommends that the Legislature enact legislation to increase funding for CBOs that provide mental health services, permanent housing, and mental health treatment planning to people recently released from county facilities, and provide those services in African American communities. The Task Force further recommends that the Legislature provide additional funding to CBOs to collect demographic data for the populations served, disaggregated by age, race, and gender.

The Task Force recommends that the Legislature enact legislation to establish and fund 24/7 receiving centers in each city and county that will provide the following services for recently released individuals:

- Serve as a welcoming station for recently released individuals who are waiting for assignment to a treatment center, after-treatment living facility, home, or other safe destination;
- Connect recently released individuals with wrap-around services provided by CBOs;
- Provide transportation services to safe destinations for recently released individuals.[209]

The Task Force further recommends that the Legislature fund and require each locality to collect demographic data, disaggregated by race, gender, and age, for the population served by the receiving centers to assess the need for additional resources.

The Task Force recommends that the Legislature enact legislation to increase funding for CBOs that provide wrap-around services, including, but not limited to, mental health services, housing, and treatment services, to individuals with mental health needs who have been recently released from county jail or prison.[210] This proposal further recommends that the Legislature ensure funding is provided to CBOs operated by staff that is culturally congruent with the African American community and CBOs that have a demonstrated history of providing satisfactory services to African Americans and in African American communities.[211] The Task Force further recommends that the Legislature include within the legislation additional funding to require each county

to collect and maintain demographic data on the CBOs that receive funding under this legislation, including the racial makeup of each CBO's staff.[212]

Finally, the Task Force recommends that the Legislature enact legislation to increase funding for culturally appropriate mental health treatment and services options for African Americans released from county facilities regardless of their mental health diagnosis.

Eliminate Legal Protections for Peace Officers Who Violate Civil or Constitutional Rights

Under existing law, police officers who violate a person's civil or constitutional rights— such as through excessive force, unjustified shootings, or race-based policing—may be sued under state law (via the Tom Bane Civil Rights Act, Civ. Code § 52.1 et seq. or "Bane Act") and federal law (via 42 U.S.C. § 1983). Under federal law, however, officers are protected by "qualified immunity," which places an often-insurmountable burden on plaintiffs in such cases.[213] Qualified immunity is not applicable under California state law, but the Bane Act (and related judicial precedent) does pose at least one major obstacle to relief: the requirement that a plaintiff prove not only that an officer violated a civil or constitutional right, but also that the officer "specifically intended" to violate the person's civil or constitutional rights.[214] For example, in *Reese v. County of Sacramento* (9th Cir. 2018) 888 F.3d 1030, 1035, a police officer knocked on Mr. Reese's door and shot him after a brief confrontation. The jury ruled in favor of Mr. Reese on his Bane Act claim, having determined that the shooting was unjustified and that Mr. Reese had not posed an immediate threat to the officer.[215] However, the Ninth Circuit Court of Appeals overturned the jury verdict because Mr. Reese had not proven that the officer specifically intended to violate his rights.[216] This artificial legal hurdle is anathema to efforts to redress the history of police violence against African Americans.

Qualified immunity is not applicable under California state law, but the Bane Act (and related judicial precedent) does pose at least one major obstacle to relief: the requirement that a plaintiff prove not only that an officer violated a civil or constitutional right, but also that the officer "specifically intended" to violate the person's civil or constitutional rights.

The Task Force accordingly recommends strengthening the Bane Act by eliminating the requirement that a victim of police violence show that the officer "specifically intended" to commit misconduct. At least two bills have been advanced that would have enacted this proposal (Senate Bill 2 (Bradford, 2021-2022 Reg. Sess.) and Assembly Bill 731 (Bradford, 2019-2020 Reg. Sess.)), but neither were enacted with this specific provision included.[217] The Act should also be amended to provide that unwanted touching or verbal assault can constitute a violation of its provisions.

Recommend Abolition of the Qualified Immunity Doctrine to Allow Access to Justice for Victims of Police Violence

As discussed in Chapter 3, Racial Terror, and Chapter 11, An Unjust Legal System, African Americans, especially descendants of persons enslaved in the United States have faced centuries of violent, oppressive, and discriminatory policing by law enforcement that persists today. Yet the qualified immunity doctrine often shields law enforcement from liability for violating a person's constitutional rights. Under this doctrine, a civil rights plaintiff must show that the officer violated "clearly established law" in order to state a viable claim for relief.[218] Thus, courts often hold that "government agents did violate someone's rights, but that the victim has no legal remedy simply because that precise sort of misconduct had not occurred in past cases."[219] As one analysis has concluded, "[q]ualified immunity is one of the most obviously unjustified legal doctrines in our nation's history."[220] Additionally, legal scholarship has indicated that the doctrine is rooted in an error made between the 1871 enactment of 42 U.S.C. § 1983 and the first compilation of federal law in 1874, leading one federal appeals judge to issue an opinion expressing concern that "Congress's literal language [may have] unequivocally negated the original interpretive premise for qualified immunity[.]"[221]

Recent legislative efforts to reform or end qualified immunity at the federal level have failed, in part due to the threat and availability of a filibuster to block proposed legislation.[222] The Task Force accordingly recommends that California's Senate and Congressional Delegations urge Congress to end both the filibuster and the qualified immunity doctrine. The Task Force also recommends the creation of a state-funded compensation scheme for victims of police misconduct whose claims would otherwise be – or have already been – barred by qualified immunity.

Endnotes

[1] See, e.g., Hankerson et al., *The Intergenerational Impact of Structural Racism and Cumulative Trauma on Depression* (2022) 179 Am. J. Psychiatry 395 (as of May 16, 2023); Comas-Diaz et al., *Racial Trauma: Theory, Research, and Healing: Introduction to the Special Issue* (2019) 74 Am. Psychologist 1 (as of May 16, 2023).

[2] Trent et al., *The Impact of Racism on Child and Adolescent Health* (2019) 144 Pediatrics 2 (as of May 16, 2023).

[3] Lugo-Candelas et al., *Intergenerational Effects of Racism: Can Psychiatry and Psychology Make a Difference for Future Generations?* (2021) 78 JAMA Psychiatry 1065 (as of May 16, 2023).

[4] *Ibid.*

[5] Trent et al., *Racism on Child and Adolescent Health*, *supra*, at p. 7.

[6] See Chapter 3, Racial Terror.

[7] *Id.* at pp. 94, 102-105.

[8] *Id.* at p. 119.

[9] See Chapter 3, Racial Terror.

[10] *Id.* at p. 118.

[11] *Ibid.*

[12] Valle, *Existing Disparities in California's System of Specialty Mental Health Care* (2019) Cal. Pan-Ethnic Health Network (as of May 16, 2023).

[13] *"We Ain't Crazy, Just Coping With a Crazy System": Pathways into the Black Population for Eliminating Mental Health Disparities*, Cal. Reducing Disparities Project, African American Population Report (Woods et al. edits. 2012) p. 28. (as of May 16, 2023) (hereafter African American Population Report).

[14] *Ibid.*

[15] *Id.* at p. 91.

[16] African American Population Report, *supra*, at pp. 50, 75.

[17] A culturally congruent health care practice involves the application of evidence-based medical treatment that is congruent with the preferred cultural values, beliefs, worldview, and practices of the patient. (See Marion et al., *Implementing the New ANA Standard 8: Culturally Congruent Practice* (2016) Online J. of Issues in Nursing (as of May 17, 2023) (discussing cultural congruence in nursing practice).)

[18] Barriers to mental health care in African American communities include lack of providers from diverse racial/ethnic backgrounds, lack of culturally competent providers, and general distrust of the health care system. Am. Psychiatric Assn., Mental Health Disparities: African Americans (2017) p. 3 (as of May 17, 2023); see also Boris Lawrence Henson Foundation, African American Cultural Competency Training (as of May 17, 2023).

[19] African American Population Report, *supra*, at p. 31 (noting that about 10 percent of African Americans who develop behavioral disorders access services through churches).

[20] CDEPs are a "set of practices found to yield positive results as determined by community consensus over time. These practices may or may not have been measured empirically (by a scientific process) but, have reached a level of acceptance by the community. CDE[Ps] take[] a number of factors into consideration, including a population's worldview and historical and social contexts that are culturally rooted. [They are] not limited to clinical treatments or interventions. CDE[Ps are] a complement to Evidence Based Practices and Treatments, which emphasize empirical testing of practices and do not often[]consider cultural appropriateness in their development or application." (*Id.* at Forward.)

[21] The Community Healing Network, an organization focused exclusively on the emotional emancipation of Black people across the African Diaspora, developed a specific version of a racial healing circle called Emotional Emancipation Circles (EECs) in collaboration with The Association of Black Psychologists (ABPsi). (Community Healing Network (as of May 17, 2023).) EECs are "liberatory spaces" in which African American people share stories, learn emotional wellness skills, and deepen their understanding of the impact of historical forces on their sense of self-worth, their relationships, and their communities. (*Ibid.*)

[22] See, e.g., African American Population Report, *supra*, at p. 178.

[23] See White and Young, *Positive Racial Identity Development in Early Education: Understanding PRIDE in Pittsburgh* (2016) U. of Pittsburgh School of Education, p. 5 (noting that "[s]ocial biases in children begin to form as early as 3-5 years, with 3-year-olds attributing more positive traits to the dominant societal race and 5 year olds attributing negative traits to non-dominant races") (as of May 17, 2023).

[24] Carlo et al., *Culture-Related Adaptive Mechanisms to Race-Related Trauma Among African American and US Latinx Youth* (2022) J. Adversity and Resilience Science (as of May 17, 2023).

[25] White and Young, *Positive Racial Identity Development in Early Education*, *supra*, at p. 4.

[26] English et al., *Daily Multidimensional Racial Discrimination Among Black U.S. American Adolescents* (2020) 66 J. Applied Developmental Psych. p. 12 (as of May 17, 2023).

[27] *Id.* at pp. 13-14.

[28] White and Young, *Positive Racial Identity Development in Early Education*, *supra*, at p. 4; see also Carlo et al., *Culture-Related Adaptive Mechanisms to Race-Related Trauma*, *supra*.

[29] See Meza et al., *Black Youth Suicide Crisis: Prevalence Rates, Review of Risk and Protective Factors, and Current Evidence-Based Practices* (2022) 20 Am. Psych. Assn.: Focus 197, 197-198 (as of May 25, 2023).

[30] Cummings, *Listening to Black Californians: How the Health Care System Undermines Their Pursuit of Good Health—Executive Summary*, Cal. Health Care Foundation (Oct. 2022) pp. 1-2 (as of May

17, 2023); see also van Ryn and Burke, *The Effect of Patient Race and Socio-Economic Status on Physicians' Perceptions of Patients* (Mar. 2000) 50 Soc. Sci. & Med. 813, 828 (describing a study that determined physicians tended to perceive African Americans and members of low and middle socioeconomic status groups more negatively on a number of dimensions than they did white patients and patients of upper socioeconomic status; study also found that physicians assessed a patient's likelihood of adhering to medical advice based on the patient's race) (as of May 17, 2023).

[31] Cummings, *Listening to Black Californians*, *supra,* at p. 2.

[32] *Ibid.*

[33] Some medical illnesses and their associated medications have side effects that can "masquerade" as psychological disorders. See Magnani, Psychological Masquerade: Physical Illness and Mental Health (2010) (as of May 18, 2023).

[34] Existing provisions in California law direct resources toward reducing disparities in healthcare services. See, e.g., Welf. & Inst. Code, § 5830, subd. (c)(2) (authorizing funding for programs that promote advocacy for underserved populations including advocacy to improve access to mental health services); Health and Saf. Code, § 131019.5, subd. (c)(2).

[35] Office of Health Equity (as of May 18, 2023).

[36] Kamleiter, *Helping African American Kids and Teens with Mental Health* (Sept. 23, 2020) Children's Minnesota (as of May 18, 2023).

[37] *Ibid.*; Abdi and Sanders, *Bridging the Mental Health Care Gap for Black Children Requires a Focus on Racial Equity and Access* (May 30, 2022) Child Trends.

[38] The Children's Partnership, *A Child is a Child, Snapshot: California Children's Health, Black Children's Health* (Feb. 2023) (as of May 18, 2023).

[39] Grills et al., *Black Child Suicide: A Report* (Oct. 15, 2019) National CARES Mentoring Movement, p. 5 (as of May 18, 2023).

[40] *Ibid.*

[41] The Children's Partnership, *Black Children's Health*, *supra*.

[42] *Ibid.*

[43] Gordon, *Addressing the Crisis of Black Youth Suicide* (Sept. 22, 2020) Nat. Inst. of Mental Health (as of May, 31, 2023).

[44] Grills et al., *Black Child Suicide*, *supra*, at p. 7.

[45] Meza et al., *Black Youth Suicide Crisis*, *supra*, at p. 199.

[46] Congressional Black Caucus Emergency Taskforce on Black Youth Suicide and Mental Health, *Ring the Alarm: The Crisis of Black Youth Suicide in America* (2019) pp. 14-15.

[47] Grills et al., *Black Child Suicide*, *supra,* at p. 10.

[48] Assari et al., *Discrimination Increases Suicidal Ideation in Black Adolescents Regardless of Ethnicity and Gender* (Nov. 6, 2017) Behav. Sci., p. 6 (as of May 18, 2023); see also Brooks et al., *Capability for Suicide: Discrimination as a Painful and Provocative Event* (2020) 50 Suicide and Life-Threatening Behav. 1173 (research study determined that discrimination increased risk of suicide in Black adults).

[49] Congressional Black Caucus Emergency Taskforce on Black Youth Suicide and Mental Health, *Ring the Alarm*, *supra,* at p. 15 (citing Tynes et al., *Race-Related Traumatic Events Online and Mental Health Among Adolescents of Color* (2019) 65 J. of Adolescent Health 371, 376).)

[50] Gordon, *Addressing the Crisis of Black Youth Suicide*, *supra*.

[51] *Ibid.*

[52] The Children's Partnership, *Black Children's Health*, *supra*.

[53] Quirk, *Mental Health Support for Students of Color During and After the Coronavirus Pandemic* (July 28, 2020) Center for American Progress (as of May 18, 2023).

[54] Grills et al., *Black Child Suicide*, *supra,* at pp. 27-28.

[55] National Institutes of Health, Notice of Special Interest (NOSI) in Research on Risk and Prevention of Black Youth Suicide, No. NOT-MH-20-055 (2020) (as of May 18, 2023).

[56] In 2018, the American Academy of Pediatrics endorsed the Guidelines for Adolescent Depression in Primary Care recommendation that adolescents 12 years and older be screened annually for depressive disorders using a self-report screening tool. (Selph and McDonagh, *Depression in Children and Adolescents: Evaluation and Treatment* (Nov. 15, 2019) 100 American Family Physician 609, 610.)

[57] Lebrun-Harris et al., *Five-Year Trends in US Children's Health and Well-being, 2016-2020*, (Mar. 14, 2022) JAMA Pediatrics 176(7):e220056.

[58] An example of a self-report tool is The Short Mood and Feelings Questionnaire (SMFQ), a 13-item self-report questionnaire designed to measure core depressive symptoms in children and adolescents aged 6-17 years old. One study found that children self-report tools were valid and reliable in screening children for depression. Reynolds et al., *Measuring Depression In Children: A Multimethod Assessment Investigation* (1985) 13 J. Abnormal Child Psych. 513, 513–526. In the same study, parent assessment tools to screen children for depression were not found to be reliable. (*Ibid.*)

[59] See Rutgers University, *Depression in Black Adolescents Requires Different Treatment*, Science Daily (Jan. 18, 2018) (as of Jan. 23, 2023).

[60] Cultural congruence in the educational context is "the idea that learning is best accomplished in classrooms compatible with the cultural context of the communities they are supposed to serve." (Singer, *What Is Cultural Congruence, and Why Are They Saying Such Terrible Things about It?* Occasional Paper No. 120. (1988).)

[61] This proposal directly incorporates certain recommendations made by the Center for American Progress. (See Quirk, *Mental Health Support for Students of Color*, *supra*.)

[62] McKinney et al., *Youth-Centered Strategies for Hope, Healing and Health* (May 2022) National Black Women's Justice

Institute and The Children's Partnership, p. 18 (as of May 18, 2023).

[63] Nardi et al., *Effectiveness Of Group CBT In Treating Adolescents With Depression Symptoms: A Critical Review* (Jan. 2016) Internat. J. Adolescent Med. Health (as of May 18, 2023) (meta-analysis finding both Group Cognitive Behavioral Therapy (G-CBT) and group interpersonal psychotherapy effective in reducing depressive symptoms in adolescents.) "Successful G-CBT outcomes were related to the presence of peers, who were an important source of feedback and support to observe, learn, and practice new skills to manage depressive symptoms and improve social-relational skills." (*Ibid.*). See also Walker, *Peer Programs Helping Schools Tackle Student Depression, Anxiety*, National Education Association News (Nov. 14, 2019) (as of May 31, 2023).

[64] "Peer mentoring helps schools create safer and more nurturing school environments to help support students' social and emotional needs and general well-being." (Walker, *Peer Programs Helping Schools Tackle Student Depression, Anxiety*, *supra.*); see also Congressional Black Caucus Emergency Taskforce on Black Youth Suicide and Mental Health, *Ring the Alarm, supra,* at p. 24 (describing a successful peer-to-peer program at the University of Virginia, Project Rise, which is focused on helping Black students on campus with a myriad of issues).

[65] Mizock and Harkins, *Diagnostic Bias and Conduct Disorder: Improving Culturally Sensitive Diagnosis* (2011) 32 Child & Youth Services 243, 248 (summarizing research finding discrimination at school predicts conduct problems and low academic performance in African American adolescents).

[66] As explained *supra,* CDEPs are "practices that a (historically marginalized) community has mutually agreed to be healing, though not typically empirically validated by Western standards." McKinney et al., *Youth-Centered Strategies for Hope, Healing and Health*, *supra*, at p. 21.

[67] Quirk, *Mental Health Support for Students of Color*, *supra.*

[68] See Ferren, *Social and Emotional Supports for Educators During and After the Pandemic* (July 20, 2021) Center for American Progress (as of May 23, 2023).

[69] One such example of a trauma-informed school program is the University of California San Francisco (UCSF) HEARTS program. (UCSF, *Program Overview* (as of May 18, 2023) (hereafter HEARTS Overview).) The stated goals of HEARTS include: "(1) increasing student wellness, engagement, and success in school; (2) building staff and school system capacities to support trauma-impacted students by increasing knowledge and practice of trauma-informed classroom and school-wide strategies; (3) promoting staff wellness through addressing burnout and secondary traumatic stress; and (4) interrupting the school to prison pipeline through the reduction of racial disparities in disciplinary office referrals, suspensions, and expulsions." (*Ibid.*) To achieve these goals, HEARTS services include: "(1) professional development training and consultation for school personnel and community partners; (2) workshops for parents/caregivers; and (3) individual psychotherapy for trauma-impacted students." (*Ibid.*)

[70] Specifically, the MHSOAC oversees the Adult and Older Adult Mental Health System of Care Act and the Children's Mental Health Services Act. The MHSOAC also oversees Prevention and Early Intervention Programs, Education and Training Programs, Innovative Programs, and Human Resources. (Welf. & Inst. Code, § 5845, subd. (a).)

[71] *Ibid.*

[72] Welf. & Inst. Code, §§ 5830, 5845, subd. (d)(8).

[73] Assem. Bill No. 850, vetoed by Governor, Oct. 2, 2017 (2017-2018 Reg. Sess.).

[74] MHSOAC, Elevating the Commission's Voice on Racial Equity: Racial Equity Plan (2022), pp. 1-2, in Meeting Materials Packet, Commission Teleconference Meeting (as of May 19, 2023).

[75] *Id.* at p. 5; see also MHSOAC, Agenda Item 8, in Meeting Materials Packet (2022) (as of May 19, 2023.

[76] MHSOAC, Racial Equity Plan, *supra,* at p. 5.

[77] See Welf. & Inst. Code, §§ 5830, 5845.

[78] MHSOAC, Agenda Item 8, *supra*.

[79] See Chapter 3, Racial Terror.

[80] Office of Policy Development and Research, *Neighborhoods and Violent Crime* (2016) Evidence Matters (as of May 19, 2022).

[81] *Ibid.*

[82] *Ibid.*

[83] Carpiano et al., *Concentrated Affluence, Concentrated Disadvantage, and Children's Readiness for School: A Population-Based, Multi-Level Investigation* (2009) 69 Soc. Sci. & Med. 420 (as of May 19, 2023).

[84] Office of Policy Development and Research, *Neighborhoods and Violent Crime*, *supra.*

[85] African American Population Report, *supra*, at p. 191.

[86] For an example, see the UCSF HEARTS program, an intervention program that is "largely aimed at school climate and culture change through building capacity of school personnel around implementing trauma-informed practices, procedures, and policies." UCSF, *HEARTS Overview*, *supra.*

[87] Unaddressed exposure to violence, racism, and other ACEs can lead to toxic stress, which can impede learning and lead to a host of other negative outcomes. (See, e.g., Center on the Developing Child, Harvard University, *ACEs and Toxic Stress: Frequently Asked Questions* (as of May 19, 2023).) "[Y]outh with [post-traumatic stress symptoms] have deficits in key areas of the [prefrontal cortex] responsible for cognitive control[,] attention, memory, response inhibition, and emotional reasoning—cognitive tools that may be necessary for learning[.]" (Carrion and Wong, *Can Traumatic Stress Alter the Brain? Understanding the Implications of Early Trauma on Brain Development and Learning* (2012) 51

J. Adolescent Health S23, S26 (as of May 19, 2023).) Trauma also affects areas of the brain responsible for organization, goal-setting, planning, understanding and following instructions, and classroom behaviors. (Wolpow et al., *The Heart of Learning and Teaching: Compassion, Resiliency, and Academic Success* (2016) p. 12 (as of May 19, 2023).)

[88] Bartone et al., *Peer Support Services for Bereaved Survivors: A Systematic Review* (2019) 80 Omega – J. Death and Dying ("Of the 32 studies meeting all inclusion criteria, most showed evidence that peer support was helpful to bereaved survivors, reducing grief symptoms and increasing well-being and personal growth. Studies also showed benefits to providers of peer support, including increased personal growth and positive meaning in life.").

[89] See, for example, the Community Healing Network's Emotional Emancipation Circles (EECs), one form of healing circles developed in collaboration with The Association of Black Psychologists (ABPsi).

[90] Bartone et al., *Peer Support Services for Bereaved Survivors*, *supra*.

[91] Research suggests that "violent crime occurs in a small number of 'hot spots,'" either particular street intersections or blocks. (See Office of Policy Development and Research, *Neighborhoods and Violent Crime*, *supra*.)

[92] See Sharkey, *Uneasy Peace: The Great Crime Decline, The Renewal Of City Life, And The Next War On Violence* (2018) p. 144. Patrick Sharkey posits that the most fundamental change that took place in U.S. cities that led to a decline in violent crime was the reclaiming, and subsequent transformation, of public spaces, by local community organizations that provided social services and safe spaces for young people, created stronger neighborhoods, and confronted violence.

[93] See Anderson et al., *Reducing Crime by Shaping The Built Environment With Zoning: An Empirical Study of Los Angeles* (2013) 161 U. Pa. L.Rev. 699, 723-724 (as of May 19, 2023).

[94] Traditionally, LGBTQ stood for Lesbian, Gay, Bisexual, Transgender, and Queer community. Some sectors of the LGBTQ community use Q to refer to "Questioning" and others use it to refer to "Queer." (Mikalson et al., *First, Do No Harm: Reducing Disparities for Lesbian, Gay, Bisexual, Transgender, Queer and Questioning Populations in California*, The California LGBTQ Reducing Mental Health Disparities Population Report (2012) p. 20 (as of May 19, 2023).) The plus symbol "is used to signify all of the gender identities and sexual orientations that are not specifically covered by the other five initials." (Cherry, *What Does LGBTQ+ Mean?* (Nov. 7, 2022) Verywell Mind (as of May 19, 2023).)

[95] Same-Gender Loving (SGL) is an alternative term used by some African Americans to describe their sexual orientation because they view the terms "gay" and "lesbian" as primarily white terms. (GLAAD, GLAAD Media Reference Guide, LGBTQ Communities of Color (2022) (as of May 19, 2023)); see also Douglas and Turner, *How Black Boys Turn Blue: The Effects of Masculine Ideology on Same-Gender Loving Men* (April 20, 2017) Psychology Benefits Society (as of May 19, 2023).

[96] GLSEN and the National Black Justice Coalition, *Erasure and Resilience: The Experiences of LGBTQ Students of Color, Black LGBTQ Youth in U.S. Schools* (2020) p. xvii (as of May 19, 2023); Mahowald, *Black LGBTQ Individuals Experience Heightened Levels of Discrimination* (July 13, 2021) Center for American Progress (as of May 19 2023).

[97] Ramirez, *A 'Crisis': 1 in 4 Black Transgender, Nonbinary Youths Attempted Suicide in Previous Year, Study Finds* (Feb. 28, 2023) USA Today (as of May 19, 2023).

[98] *Ibid*.

[99] *Ibid*.

[100] Black LGBTQ students experienced verbal harassment, physical harassment, and physical assault at school. (GLSEN and the National Black Justice Coalition, *Black LGBTQ Youth in U.S. Schools*, *supra*, at p. 14.)

[101] *Id*. at pp. xvi, 13.

[102] *Id*. at p. 15.

[103] *Id*. at pp. 13-14.

[104] *Id*. at p. 15.

[105] *Id*. at p. 23.

[106] *Id*. at p. 24.

[107] *Id*. at p. 25.

[108] *Ibid*.

[109] *Id*. at p. 18.

[110] *Id*. at p. 30.

[111] Centers for Disease Control and Prevention, *Protective Factors for LGBTQ Youth* (2019); GLSEN and the National Black Justice Coalition, *Black LGBTQ Youth in U.S. Schools*, *supra*, at p. 26.

[112] *Id*. at p. 38.

[113] *Id*. at pp. 20, 37.

[114] *Id*. at p. xviii.

[115] See *id*. at p. xvii.

[116] Green et al., *All Black Lives Matter: Mental Health of Black LGBTQ Youth* (2020) Trevor Project, p. 8.

[117] *Ibid*.

[118] People who identify as nonbinary do not identify their gender as man or woman. Gender nonconforming means that an individual's physical appearance or behaviors do not align with a specific gender. (Centers for Disease Control and Prevention, Adolescent and School Health: Terminology (as of May 19, 2023).)

[119] Green et al., *All Black Lives Matter*, *supra*, at p. 8.

[120] The Trevor Project, *Research Brief: Mental Health of Black Transgender and Nonbinary Young People* (Feb. 2023) p. 1 (as of May 19, 2023); Ramirez, *A 'Crisis,' supra*.

[121] Ramirez, *A 'Crisis,' supra*.

[122] Gordon, *Addressing the Crisis of Black Youth Suicide*, *supra*.

[123] Green et al., *All Black Lives Matter*, *supra*, at p. 10.

[124] *Ibid*.

[125] *Ibid*.

[126] *Ibid.*

[127] *Ibid.*

[128] Cultural humility is defined as having an interpersonal stance that is other-oriented rather than self-focused. It is "characterized by respect and lack of superiority toward an individual's cultural background and experience." (Hook et al., *Cultural Humility: Measuring Openness to Culturally Diverse Clients* (2013) 60 J. Counseling Psychol. 353, 353 (as of May 19, 2023).) "Cultural humility is a lifelong process of self-reflection and self-critique whereby the individual not only learns about another's culture, but one starts with an examination of her/his own beliefs and cultural identities." (Yeager and Wu, *Cultural Humility: Essential Foundation for Clinical Researchers* (2013) 26 Applied Nursing Research, p. 2 (as of May 19, 2023).)

[129] Mikalson et al., *First, Do No Harm*, *supra*, at p. 177.

[130] The Centers for Disease Control identified GSAs as a protective factor for LGBTQ youth. (Centers for Disease Control and Prevention, *Protective Factors for LGBTQ Youth*, *supra*.)

[131] Green et al., *All Black Lives Matter*, *supra*, at p. 17.

[132] See, e.g., *id.* at p. 4 (listing presence of supportive family or other support person and in-person access to LGBTQ+-affirming spaces as protective factors); Centers for Disease Control and Prevention, *Protective Factors for LGBTQ Youth*, *supra*.

[133] See Green et al., *Breaking Barriers to Quality Mental Health Care for LGBTQ Youth* (2020) The Trevor Project, pp. 21-22 (as of May 19, 2023).

[134] *Id.* at p. 20.

[135] *Id.* at pp. 20-21; see also Green et al., *All Black Lives Matter*, *supra*, at p. 10.

[136] Green et al., *Breaking Barriers*, *supra*, at p. 21.

[137] Mikalson et al., *First, Do No Harm*, *supra*, at p. 176.

[138] Mahowald, *Black LGBTQ Individuals Experience Heightened Levels of Discrimination*, *supra*.

[139] *Ibid.*

[140] *Ibid.*

[141] *Ibid.*

[142] *Ibid.*

[143] Choi et al., *Black LGBT Adults in the US: LGBT Well-Being at the Intersection Of Race* (2021) U.C.L.A. School of Law Williams Inst., p. 16 (as of May 19, 2023).

[144] *Ibid.*

[145] *Ibid.*

[146] *Ibid.* Low income is defined as reporting an income household size ratio at or below the 200 percent federal poverty level (FPL).

[147] Mahowald, *Black LGBTQ Individuals Experience Heightened Levels of Discrimination*, *supra*.

[148] Choi et al., *Black LGBT Adults in the US*, *supra*, at p. 18.

[149] Mikalson et al., *First, Do No Harm*, *supra*, at p. 54.

[150] *Id.* at p. 90.

[151] *Id.* at pp. 159-160.

[152] *Id.* at p. 55.

[153] *Id.* at p. 161-162.

[154] *Id.* at pp. 160-161.

[155] *Id.* at p. 161.

[156] *Id.* at p. 159.

[157] Kates et al., *Health and Access to Care and Coverage for Lesbian, Gay, Bisexual, and Transgender (LGBT) Individuals in the U.S.* (May 3, 2018) Kaiser Family Foundation (as of May 19, 2023).

[158] Mahowald, *Black LGBTQ Individuals Experience Heightened Levels of Discrimination*, *supra*.

[159] *Ibid.*

[160] *Ibid.*

[161] Green et al., *Breaking Barriers*, *supra*, at p. 21.

[162] Mikalson et al., *First, Do No Harm*, *supra*, at p. 176.

[163] The Gay Affirmative Practice Model requires practitioners to reflect on the following issues when treating LGBTQ+ clients: (1) the attitude of the provider toward LGBTQ+ identity, that is, whether the provider views same-gender sexual desires and behaviors as a normal variation in human sexuality; (2) The provider's knowledge about the patient/client that is, whether the provider automatically assumes heterosexuality and understands the coming out process; and (3) the provider's skills in being able to assess and deal with their own heterosexual bias and homophobia. (*Id.* at p. 63.)

[164] See Sen. Bill No. 973 (2019-2020 Reg. Sess.) § 3.

[165] Garwood and Carrero, *Lifting the Voices of Black Students Labeled with Emotional Disturbance: Calling All Special Education Researchers*, 48 Behav. Disorders 121, 121-122. "Emotional Disturbance" is a category of special education eligibility criteria under federal and state law that includes some recognized psychiatric diagnostic conditions, such as schizophrenia, but is not itself a mental health diagnosis, and can be applied to a child who meets the legal criteria even if that child has not received a clinical mental health diagnosis. (34 C.F.R. § 300.8, subd. (c)(4)(i); 5 Code Regs. § 3030, subd. (b)(4); Disability Rights California, *What Are the Eligibility Criteria for Emotional Disturbance?* (as of May 22, 2023).)

[166] Mizock and Harkins, *Diagnostic Bias and Conduct Disorder*, *supra*, at p. 245. Conduct Disorder is a psychiatric diagnosis in which a person exhibits a "repetitive and persistent pattern of behavior in which the basic rights of others or major age-appropriate societal norms or rules are violated." (Am. Psychiatric Assn., Diagnostic and Statistical Manual of Mental Disorders (5th Ed., Text Revision, 2022) (DSM-5-TR).) Youth diagnosed with Conduct Disorder experience significant stigma and more adverse outcomes in their physical and mental health and when they encounter the criminal legal system. (Mizock and Harkins, *Diagnostic Bias and Conduct Disorder*, *supra*, at pp. 246-247.)

[167] *Id.* at p. 244.

[168] *Id.* at p. 245.

[169] Clark, *Conduct Disorders in African American Adolescent Males: The Perceptions That Lead to Overdiagnosis and Placement in Special Programs* (2007) 33 Ala. Counseling Assn. J. 1, 2 (as of May 19, 2023); Garwood and Carrero, *Lifting the Voices of Black Students Labeled with Emotional Disturbance*, *supra*, at p. 122.

[170] Garwood and Carrero, *Lifting the Voices of Black Students Labeled with Emotional Disturbance*, *supra*, at p. 122.

[171] *Ibid.*

[172] Mizock and Harkins, *Diagnostic Bias and Conduct Disorder*, *supra*, at p. 245.

[173] *Ibid.*

[174] Rentz, *Black and Latino Children Are Often Overlooked when It Comes to Autism* (2018) NPR (as of May 19, 2023).

[175] *Ibid.*

[176] Mizock and Harkins, *Diagnostic Bias and Conduct Disorder*, *supra*, at pp. 247-248.

[177] *Id.* at p. 248.

[178] *Ibid.*

[179] Wakefield et al., *Should the DSM-IV Diagnostic Criteria for Conduct Disorder Consider Social Context?* (2002) 159 Am. J. Psychiatry 380 (as of May 19, 2023).

[180] The DSM-5-TR is the text revision of the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders, the leading treatise for the classification, diagnosis, and treatment of mental disorders in the field of psychiatry. (DSM-5-TR, *supra*; see Am. Psychiatric Assn., *DSM History* (as of May 19, 2023).) The DSM-5-TR was published following significant backlash over the DSM-5's "diagnostic expansiveness" many in the field believed would lead to a "tidal wave of false positive diagnoses [by] transforming normal conditions into . . . disorders." (Wakefield, *Diagnostic Issues and Controversies in DSM-5: Return of the False Positives Problem* (2016) 12 Annu. Rev. Clin. Psychol. 107, 107.)

[181] Am. Psychiatric Assn., Diagnostic and Statistical Manual of Mental Disorders (5th Ed., Text Revision, 2022) p. 535; Mizock and Harkins, *Diagnostic Bias and Conduct Disorder*, *supra*, at p. 247.

[182] California Education Code sections 56320 through 56330 and Title 5 California Code of Regulations sections 3021 through 3023 govern assessments in conformity with the federal Individuals with Disabilities Educational Act (IDEA) and its implementing regulations.

[183] The IDEA is codified at 20 U.S.C. § 1400 et seq. Its implementing regulations are codified at 34 C.F.R. § 300.1 et seq.

[184] See Ed. Code, §§ 56320-56330; see also Cal. Code Regs., tit. 5, §§ 3021-3023.

[185] Mizock and Harkins, *Diagnostic Bias and Conduct Disorder*, *supra*, at p. 247-248.

[186] See Cal. Board of Psychology, *Continuing Professional Development Information* (as of May 20, 2023).

[187] Mizock and Harkins, *Diagnostic Bias and Conduct Disorder*, *supra*, at pp. 248-249.

[188] See, e.g., Lukowiak, *Academic Interventions Implemented to Teach Students with Emotional Disturbance* (2009) J. Am. Academy of Special Ed. Professionals 63, 69-71 (as of May 20, 2023).

[189] *Ibid.*

[190] Vera Institute of Justice, *Incarceration Trends in California* (Dec. 2019) (as of May 20, 2023); see also NAACP *Criminal Justice Fact Sheet* (2023) (noting that African Americans nationally are incarcerated at five times the rate of white people) (as of May 31, 2023).

[191] Franco, *The Prevalence of Mental Illness in California Jails is Rising: An Analysis of Mental Health Cases & Psychotropic Medication Prescriptions*, 2009-2019 (Feb. 2020) Cal. Health Policy Strategies L.L.C., p. 3 (as of May 20, 2023); see also Collier, *Incarceration Nation* (Oct. 2014) Monitor on Psychology (as of May 20, 2023).

[192] Bronson and Berzovsky, *DOJ Indicators of Mental Health Problems Reported by Prisoners and Jail Inmates, 2011-12* (June 2017) U.S. Dept. of Justice Bureau of Justice Statistics, pp. 4-5 (as of May 20, 2023).

[193] Scully, *Criminal Justice Reform Means Reforming the Mental Health System* (March 5, 2021) Nat. Alliance on Mental Illness Blog (as of May 20, 2023); see also Collier, *Incarceration Nation*, *supra*.

[194] Watson et al., *Police Reform From the Perspective of Mental Health Services and Professionals: Our Role in Social Change* (2021) 72 Psychiatric Services 1085 (as of May 20, 2023); see Rafla-Yuan et al., *Decoupling Crisis Response from Policing—A Step Toward Equitable Psychiatric Emergency Services* (2021) N. Engl. J. Med. 1769, 1769-1771 (describing incidents where people suffering mental health emergencies were seriously injured or killed by law enforcement) (as of May 20, 2023).

[195] Thompson, *Gender, Race, and Mental Illness in the Criminal Justice System* (2020) Corrections & Mental Health, An Update of the Nat. Inst. Of Corrections, pp. 4-5 (as of May 20, 2023); see Schlesinger, *Racial Disparities in Pretrial Diversion: an Analysis of Outcomes Among Men Charged with Felonies and Processed in State Court* (2013) 3 Race and Justice 210, 223, 228 (as of May 20, 2023).

[196] See Prins et al., *Exploring Racial Disparities in The Brief Jail Mental Health Screen* (2012) 39 Crim. Justice Behav. 635 (as of May 21, 2023).

[197] Couloute, *Nowhere to Go: Homelessness Among Formerly Incarcerated People* (Aug. 2018) Prison Policy Initiative (as of May 21, 2023).

[198] Behavioral health emergencies include emergencies based on mental health and/or substance abuse issues. (Emergency Nurses Association, *Behavioral Health* (as of May 22, 2023).)

[199] The number 988 became operational in July 2022 as the new three-digit number for suicide prevention and mental health crises. (Substance Abuse and Mental Health Services Administration, *988 Appropriations Report* (Dec. 2021) p. 2 (as of May 22, 2023); Silva, *988 Suicide Prevention Hotline Launches Nationwide* (July 14, 2022) NBC News (as of May 22, 2023).)

[200] The U.S. Department of Justice PMHC Toolkit includes the following types of PMHC programs: The Crisis Intervention Teams model (CIT), which involves trained officers and trained call dispatchers collaborating with mental health providers to transport individuals to mental health treatment centers with a "no refusal policy" instead of county jail; the Mobile Crisis Team model, which involves a group of mental health professionals who respond to calls for service at the request of law enforcement officers; a Co-Responder Team model, which partners a specially trained officer with a mental health crisis worker to respond to mental health calls; a Case Management Team model, which involves behavioral health professionals and officers proactively providing outreach and follow-up to individuals who call frequently and often use emergency services; and a "Tailored Approach" where the agency selects elements of the above options for a particular community's needs to build an individualized, robust, end effective program. (Bureau of Justice Assistance, *Police-Mental Health Collaboration (PMHC) Toolkit*, Types of PMHC Programs (as of May 22, 2023); Watson and Fulambarker, *The Crisis Intervention Team Model of Police Response to Mental Health Crises: A Primer for Mental Health Practitioners* (2012) 8 Best Pract. Mental Health 71 (as of May 22, 2023).)

[201] See e.g., Rogers et al., *Effectiveness of Police Crisis Intervention Training Programs* (2019) 47 J. Am. Academy Psychiatry & Law, 414, 418 (as of May 22, 2023); Watson and Fulambarker, *The Crisis Intervention Team Model of Police Response to Mental Health Crises: A Primer for Mental Health Practitioners*, *supra* (stating that research studies indicate that the CIT Model is effective in diverting people with mental health emergencies from jails to treatment settings) (as of May 21, 2023); see also International Association of Chiefs of Police and UC Center for Police Research and Policy, *Assessing the Impact of Co-Responder Team Programs: A Review of Research*, pp. 6-8 (stating that research indicates that co-responder teams are effective in connecting individuals to mental health treatment resources and may result in fewer arrests than regular police intervention) (as of May 22, 2023). Research also indicates that diversion, whether at the initial contact with police or later in the legal process, may be one option for increasing access to and utilization of mental health services: "increasing time in the community, and reducing jail days, without a concomitant increase in arrests, substance use, or psychiatric symptoms." (Broner et al., *Effects of Diversion on Adults with Co-Occurring Mental Illness and Substance Use: Outcomes from a National Multi-Site Study* (2004) 22 Behav. Sci. Law 519, 537 (as of May 22, 2023).)

[202] See, e.g., Bureau of Justice Assistance, *Police-Mental Health Collaboration (PMHC) Toolkit, The Essential Elements of PMHC Programs* (as of May 31, 2023).

[203] See, e.g., Meehan et al., *Do Police–Mental Health Co-Responder Programmes Reduce Emergency Department Presentations or Simply Delay The Inevitable?* (2019) 27 Australasian Psychiatry 18 (assessing co-responder model and concluding that the co-responder model was effective in resolving immediate mental health crises and in diverting individuals away from emergency departments and inpatient facilities) (as of May 22, 2023); see also Waters, *Enlisting Mental Health Workers, Not Cops, In Mobile Crisis Response* (Jun. 2021) Health Affairs (describing successes of programs in several localities that dispatch health crisis workers and emergency medical technicians, instead of police, to people experiencing serious mental health distress).

[204] A study of four mental health courts, two of which were in California, found that participants had lower rearrest rates and fewer incarceration days than the "treatment as usual" group. (California Administrative Office of the Courts, *Mental Health Courts: An Overview* (2012) p. 7 (as of May 22, 2023.) Research also showed that mental health courts effectively link "mentally ill offenders with necessary treatment services," which leads to participants having a "greater likelihood of treatment success and access to housing and critical supports than mentally offenders in traditional court." (*Id.* at p. 5.) Mental health courts helped participants avoid "hospitalizations, rearrests, violence against others, and homelessness." (*Id.* at p. 6.)

[205] See *Connerly v. State Personnel Bd.* (2001) 92 Cal.App.4th 16, 53, 61-63 (holding data collection regarding minority business participation does not violate Proposition 209).

[206] See, e.g., OnTrack Program Resources, *Community Health & Justice Project: Blueprint* (Dec. 2022) p. 12 (discussing recommendations of Sacramento agency-community working group focusing on outcomes for African Americans with mental health issues involved with criminal legal system) (as of May 22, 2023); c.f. Salas and Fiorentini, *Looking Back at the Brad H. Settlement: Has the City Met Its Obligation to Provide Mental Health & Discharge Services in the Jails?* (May 2015) New York City Independent Budget Office, pp. 5-6 (discussing New York City's obligations to provide direct mental health services and discharge planning and case management services to persons in custody at its jails before they are released) (as of May 22, 2023).

[207] OnTrack Program Resources, *Community Health & Justice Project*, *supra*, at pp. 10-11; see Annie E. Casey Foundation, *Reentry: Helping Former Prisoners Return to Communities* (2005) p. 30 (noting successful transition for individuals with mental health needs into the community requires collaboration between community mental health services and correctional facilities before release) (as of May 22, 2023).

[208] Several programs stress the importance of providing a variety of wraparound services to individuals reentering their communities after incarceration. (See, e.g., OnTrack Program Resources, *Community Health & Justice Project*, *supra* at p. 12; see also Pettus-Davis and Kennedy, *Researching and Responding to Barriers to Prisoner Reentry: Early Findings From A Multi-State Trial* (2018) Florida State U. Inst. for Justice Research and Development, p. 5

(describing ongoing process and early lessons of a study of the 5-Key Model, a prisoner reentry model designed by formerly incarcerated individuals, practitioners, and researchers).) The 5-Key Model identifies five considerations necessary for successful reentry programs: healthy thinking patterns; meaningful work trajectories; effective coping strategies; positive social engagement; and positive interpersonal relationships. (*Id*. at p. 6.) Programs based on the 5-Key Model begin reentry preparation "as early as possible during an individual's incarceration and continue the supports in the community after an individuals' release from incarceration." (Florida State U. Inst. for Justice Research and Development, *The 5-Key Model for Reentry* (as of May 22, 2023); see also Bianco, *Op-Ed: An L.A. Program Helps People Get Mental Health Care Instead Of Jail Time. Why Not Expand It?* L.A. Times (July 18, 2022) (noting that ODR programs are effective in "moving people with mental health issues out of jail and onto a path to permanent supportive housing, keeping them off the streets and out of hospitals and incarceration long term") (as of May 22, 2023).)

[209] OnTrack Program Resources, *Community Health & Justice Project*, *supra*, at p. 12.

[210] *Id*. at pp. 11-12.

[211] OnTrack Program Resources, *Community Health & Justice Project*, *supra*, Attachment 8: Agency Stakeholder Key Informant Interview Summary, at pp. 1, 2-3, 7.

[212] See *Connerly, supra,* 92 Cal.App. at 16, 53, 61-63 (holding data collection regarding minority business participation does not violate Proposition 209).

[213] For a more detailed discussion of qualified immunity, see Chapter 20, Policies Addressing Racial Terror, section J, *infra*.

[214] See, e.g, *Cornell v. City and County of San Francisco* (2017) 17 Cal. App.5th 766, 801-04.

[215] *Reese*, *supra*, 888 F.3d at 1036.

[216] *Id*. at 1044-1045.

[217] SB 2 was signed into law, but the elimination of "specific intent" had been amended out of a prior version. (See Cal. Leg. Information, *SB-2 Peace Officers: Certification: Civil Rights* (as of May 22, 2023) (March 11, 2021 version, Civil Code § 52.1(b)(2)).) AB 731 was shelved. (See Cal. Leg. Information, *SB-731 Peace Officers: Certification: Civil Rights* (as of May 22, 2023) (August 25, 2020 version, Civil Code § 52.1(b)(2)).)

[218] See *Harlow v. Fitzgerald* (1982) 457 U.S. 800, 818.

[219] Schweikert, *Qualified Immunity: A Legal, Practical, and Moral Failure* (Sept. 14, 2020) Cato Institute Policy Analysis, at p. 2 (as of May 22, 2023).

[220] *Id*. at p. 1.

[221] *Rogers v. Jarrett* (5th Cir. 2023) 63 F.4th 971, 979 (conc. opn. of Willett, J.); Reinert, *Qualified Immunity's Flawed Foundation* (2023) 111 Cal. L.Rev. 201.

[222] See, e.g., Levine and Wu, *Lawmakers Scrap Qualified Immunity Deal in Police Reform Talks*, Politico (Aug. 17, 2021) (as of May 22, 2023).