Refining the Definition of an African American Community-defined Practice

A supplemental report to the African American Population Report for the California Reducing Disparities Project: *We Ain’t Crazy! Just Coping with a Crazy System: Pathways into the Black Population for Eliminating Mental Health Disparities*

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CiMH Team – Contributing Writers:

Lawford Goddard, Ph.D., Consultant
Institute for the Advanced Study of Black Family Life and Culture, Inc.

Kristee L. Haggins, Ph.D., Senior Associate
California Institute for Mental Health (CiMH)

Wade W. Nobles, Ph.D., Consultant
Institute for the Advanced Study of Black Family Life and Culture, Inc.

Will Rhett-Mariscal, Ph.D., Acting Associate Director
California Institute for Mental Health (CiMH)

Doretha Williams-Flournoy, M.S., Deputy Director
California Institute for Mental Health (CiMH)
EXECUTIVE SUMMARY

In response to the call for national action to reduce mental health disparities and seek solutions for unserved and underserved communities, California developed a statewide policy initiative intended to improve access, quality of care, and increase positive outcomes for racial, ethnic, sexual, and cultural communities (California Department of Mental Health, 2010). The California Reducing Disparities Project (CRDP) provided funding for five unserved and underserved populations to develop reports that assessed the status of services, including the following groups: (1) African Americans, (2) Asian/Pacific Islanders, (3) Latinos, (4) Native Americans, and (5) Lesbian, Gay, Bisexual, Transgender, Queer and Questioning (LGBTQ). Five Strategic Planning Workgroups (SPWs), corresponding to each population, were formed to provide the California State Department of Mental Health with community-defined evidence and practices, and population-specific strategies for reducing disparities in mental health.

This paper is a supplemental report to the African American Population Report for the California Reducing Disparities Project, entitled *We Ain’t Crazy! Just Coping with a Crazy System Pathways into the Black Population for Eliminating Mental Health Disparities*. It is designed to support the African American Strategic Planning Workgroup (SPW) efforts to refine the criteria for community-defined practice (CDP) and to present a model for identification, evaluation, and establishment of baseline fidelity for African American community-defined practices. The concept for this supplemental report originated from the final meeting of the SPW, as recommendations for next steps were explored. The following SPW members, Dr. Wade Nobles, Dr. Lawford Goddard, and Doretha Williams-Flourney, three of the five authors of this paper, indicated their interest in moving this agenda forward. We hope it stimulates further discussion and examination of CDPs for African Americans.

While CDPs hold the promise of improving access to, retention in, and quality of services for unserved, underserved and inappropriately served ethnic and cultural groups, they are not clearly defined in the current literature. There has been a lack of clarity due to the conflation of the type of evidence that validates a practice (scientific or community-defined) versus the practices that have been validated using these types of evidence (evidence based practices [EBPs] and CDPs), i.e., the term “community-defined evidence” has been used sometimes to describe the practice as well as the type of evidence validating the practice. Additional confusion arises from the term CDP, because it has been used to describe various strategies and practices, such as outreach strategies, cultural practices used for prevention, treatment strategies, and culturally adapted evidence-based practices, among others. The wide variability of the use of this term has caused confusion about what exactly a CDP is. Our goal is to help add to the discourse about the definition of and strategies used for CDPs and for African American CDPs in particular.

This paper provides a brief description of the experience of being Black in White America and its impact on one’s mental health; an overview of the issues relevant to African American CDPs in the broader context of CDPs, and describes the logic, rationale, terminology, conditions, and culture for understanding culturally congruent African American community-defined practice.
INTRODUCTION

Background – The California Reducing Disparities Project

The former California State Department of Mental Health has been a national leader in integrating cultural competence and population characteristics in the design and delivery of mental health services. Compared to other states around the county, California has made relatively successful efforts to study, implement, and evaluate cultural competence in mental health services at the county and city level.

In response to the call for national action to reduce mental health disparities and seek solutions for unserved and underserved communities, California developed a statewide policy initiative intended to improve access, quality of care, and increase positive outcomes for racial, ethnic, sexual, and cultural communities (California Department of Mental Health, 2010). The California Reducing Disparities Project (CRDP) provided funding for five unserved and underserved populations to develop reports that assessed the status of services, including the following groups: (1) African Americans, (2) Asian/Pacific Islander, (3) Latinos, (4) Native Americans, and (5) Lesbian, Gay, Bisexual, Transgender, Queer and Questioning (LGBTQ). Five Strategic Planning Workgroups (SPWs), corresponding to each population, were formed to provide the California State Department of Mental Health with community-defined evidence and practices, and population-specific strategies for reducing disparities in mental health. Each SPW conducted some form of community-based participatory research (CBPR) as a framework to guide their efforts to engage stakeholders. They surveyed their respective populations regarding mental health needs, experiences with the mental health system, and identified community-defined evidence or practices meant to decrease barriers, improve services and decrease disparities.

According to the California State Department of Mental Health (SDMH) Community-defined evidence (CDE) is a basis for validating practices that have effectiveness in achieving mental health outcomes for underserved communities. It also defines a process underway to nationally develop specific criteria by which practices’ effectiveness may be documented using community-defined evidence that eventually will allow the procedure to have an equal standing with evidence-based practices currently defined in the peer reviewed literature (County of Los Angeles Department of Mental Health Mental Health Services Act Prevention and Early Intervention Community-defined Evidence (CDE) Models Guidelines, 2011).

The Evolution and Limitations of Evidence-Based Programming

Intending to ensure that people receive the best services available, academicians, policymakers, researchers and funders have begun to promote, if not require, evidence-based practices (U.S. Department of Health and Human Services (2001) Mental Health: Culture, Race, and Ethnicity — A Supplement to Mental Health: A Report of the Surgeon General). Implicit in this standard is the requirement that evidence-based practices must be well-defined, manualized interventions and treatments that show “evidence” of positive impact in randomized controlled trials as judged by peer-reviewed publications. The
evidence-based designation has become a kind of “gold standard” for work being done and work likely to be supported.

There are, however, problems and limitations with evidence-based designations and/or requirements as so defined. In the area of behavioral health disparities for communities of color, the requisite of evidence-based does not take into account differential ways of knowing and being that has not been assessed through empirical evidence and/or may have different definitions of evidence. Evidence-based requirement as defined in the literature is limited to and grounded in a Western episteme and worldview and may not be compatible with the reality of culturally distinct groups of indigenous peoples (e.g., Native Americans); historically captive peoples (African American); marginalized peoples (Latino/Hispanic, Asian, etc.); as well as non-Western groups from around the world.

One example of the complexity of issues that can arise from applying evidence-based practices to culturally distinct groups can be found in attempts to adapt these practices to a particular group. The Latino/Hispanic community has experienced some empirically supported treatments that have been adapted or designed for that specific cultural community (McCabe et al., 2005; Griner & Smith, 2006; Isaacs et al., 2008; Jackson-Gilfort et al., 2001; Martínez & Eddy, 2005). Most of these “adaptations” rely on language translations that fall short of achieving full cultural authenticity because they do not fundamentally address the core values, beliefs, traditions, rituals, and historical contexts of the targeted populations. Although Martinez, et al (2010) report that recent evaluations of research on culturally adapted “evidence-based practice” suggest promising results with regard to efficacy and effectiveness of interventions (Griner & Smith, 2006; Miranda et al., 2005), they note that a number of questions still remain, including whether the adaptation of a practice compromises the fidelity of a particular intervention (Isaacs et al., 2008). The standard assumption is that if research shows that a particular model works, you must implement it in the same way it was implemented in the study (fidelity to the tested practice) if you want to have a high degree of confidence that you will get the same results. Cultural adaptation of an evidence-based practice involves altering a practice in such a way that it fits with the worldview of the target community, thus altering the practice to the extent that it might no longer reasonably be called evidence-based.

The systemic demand for evidence-based programming and practice, which typically has cultural limitations, has stymied the promotion and development of authentically distinct cultural programming and practices which have epistemologically defined both lived experience and evidence of effective practice. Cultural adaptations have been used to address this dilemma. However, adaptation alone is insufficient to correct the limitation of the narrowly defined (Western only) evidence-based programming and practice. Cultural congruency and not simply cultural adaptations, especially for the African American community, will be required to expand and clarify the discourse on evidence-based practice, community-defined evidence; and community-based practice.

Another key problem with evidence-based practice is that the criteria used (randomization, statistical significance, standardized instruments and publication in a refereed journal), are often beyond the capacity, reach, or interest of many of the community-based organizations that are providing critical services to its population. For example, randomization of participants is not just a scientific methodological choice; it creates a moral-ethical dilemma
for the organizations – should an agency withhold services, i.e., the practice, which the agency believes can transform the lives of the population, from a population that is in need of services, even if it is just for a temporary amount of time (wait list condition) in the name of science? Community-based agencies exist to meet the needs of the community. As such, service to the people takes precedence over scientific randomization. Conducting research on a practice can also be too costly and time-consuming for a community-based agency and requires expertise not typically contained within provider agencies. Given these challenges, then, it is unlikely that programs and practices known to the community to be effective will become evidence-based practices.

Attempts to define, in general terms, community-defined practices (CDP), Practice based Evidence (PBE), and evidence based practice (EBP) can be found in recent publications like the African American CRDP Report (2012), the County of Los Angeles Department of Mental Health Mental Health Services Act Prevention and Early Intervention Community-defined Evidence (CDE) Models Guidelines (2011) and the California Institute for Mental Health’s Adult Cultural Relevance Full Service Partnership Toolkit (2012), respectively. Yet Community-defined Practices are not clearly defined in the current literature. There has been a lack of clarity due to the conflation of the type of evidence that validates a practice (scientific or community-defined) versus the practices that have been validated using these types of evidence (EBPs and CDPs), i.e., the term “community-defined evidence” has been used sometimes to describe the practice as well as the type of evidence validating the practice. Additional confusion arises from the term CDP because it has been used to describe various strategies and practices, such as outreach strategies, cultural practices used for prevention, treatment strategies, and culturally adapted evidence-based practices, among others. The wide variability of the use of this term has caused confusion about what exactly a CDP is. Our goal is to help add to the discourse about the definition of and strategies used for CDPs and for African American CDPs in particular.

Community-defined practice is the preferred terminology for the scope of this discussion because it refers to strategies used as opposed to the validation process for determining efficacy. Community-defined practice gives credence to the perspectives of ethnic community. It reflects the values of the community and is seen as beneficial to the members of the group. In this sense community adoption, not an external agency, is the credentialing body for the practice. As such, community-based practices are more culturally congruent with the population receiving the services. A practice has been deemed community-defined if the community itself has vetted it. These community-defined practices are, in reality, best practices in the community.

The following discussion will provide more specificity relative to these concepts as they relate to the African American community.
AFRICAN AMERICAN COMMUNITY-DEFINED PRACTICES

Purpose of this paper

This paper is a supplemental report to the African American Population Report for the California Reducing Disparities Project, entitled We Ain’t Crazy! Just Coping with a Crazy System: Pathways into the Black Population for Eliminating Mental Health Disparities. It is designed to support the African American Strategic Planning Workgroup (SPW) efforts to refine the criteria for community-defined practice (CDP) and to present a model for identification, evaluation, and establishment of baseline fidelity for African American community-defined practices. The concept for this supplemental report originated from the final meeting of the SPW, as recommendations for next steps were explored. The following SPW members, Dr. Wade Nobles, Dr. Lawford Goddard, and Doretha Williams-Flournoy, three of the five authors of this paper, indicated their interest in moving this agenda forward. We hope it stimulates further discussion and examination of CDP’s for African Americans.

This paper provides a brief description of the experience of being Black in White America and its impact on one’s mental health; an overview of the issues relevant to African American CDPs in the broader context of CDPs, and describes the logic, rationale, terminology, conditions, and culture for understanding culturally congruent African American community-defined practice.

Dilemma of Being Black in White America

The psychological effect that the ideology of white supremacy and European imperialism, in the form of slavery and colonialism, has had on Africa and her people has never been fully addressed and understood. The complexity of geo-political and psycho-social damage for African people can best be captured in the notions of derailment and morphing. Derailment is an important metaphor because like a train derailment, the train continues to be in motion, just off its track. The cultural and psychological derailment of African people is hard to detect because African life and experience continues. The idea of morphing is a process of changing (or morphing) one image, idea or identity into another as if by seamless transition. In effect the process of first dehumanizing African people and then supposedly bringing the “savages” to civilization was in fact a morphing of the African human being.

The most profound lingering psychological effect of slavery and colonization for African people has been a sense of human alienation resulting from being infected with or assaulted by long-standing, ongoing ideas of African dehumanization, negation and nullification that required African American people to deny or morph their Africaness into images, ideas and identities more congruent with not being African. Hence, the striving for equality was morphed into the

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1 Refer to the full African American Population Report which can be found at [http://www.cdph.ca.gov/programs/Documents/African_Am_CRDP_Pop_Report_FINAL2012.pdf](http://www.cdph.ca.gov/programs/Documents/African_Am_CRDP_Pop_Report_FINAL2012.pdf) for an in-depth analysis of the findings. In general, the most challenging factor identified by the report that directly and indirectly impacts poor mental health and behavioral health outcomes African Americans is real and perceived racism. Race and culture must be addressed to realize healing and considered in the development and implementation of CDPs for African Americans.
desire for integration, acculturation and assimilation. Being equally and fairly treated and respected as African people was exchanged for acceptance contingent upon the degree to which African American people disassociated themselves from their intrinsic Africaness (Blackness) and embraced being like White people.

The greatest falsehood of American history is that African people were thrust into the New World empty of any intrinsic beliefs, ideas and culture worthy of human respect and recognition. The common belief was that Africans had no culture and were located slightly above the great Apes in the Great Chain of Being. The legacy of this thought is what makes it difficult to identify African American behaviors, programs and services as grounded in culture and not just reactions to poverty and racism. To the contrary, Africans were the first people to be conscious of being conscious. They were the first people to stand erect and to speak. As the creators of human civilization, Africans invented language, social organization, philosophy, architecture, medicine, music, dance and religion. Africans came into slavery with language in their mouths and grounded in beliefs that everything was interconnected and whole and that reality consisted of both visible and invisible realms with the invisible being far greater than the visible. Through this core cultural tapestry of vitalism, the African (Bantu-Kongo) core cultural worldview was spirit driven and defined with a meaning of being human as being a spirit housed in a human (physical) container that recognizes the humanity of other spirits and responds to them in humane ways. In contrast, the core beliefs of the master class privileged the ideas of materialism, individuality, class, sexism, mind, body and spirit differences; that anatomy was destiny and that knowing was limited to only that which one could physically perceive. Clearly there was, in addition to political domination and economic exploitation, a “clash of culture” between Africans and their captors. There remains a similar and more complex cultural clash between African Americans and the dominant society. In fact, the constant survival proposition for African Americans has been the choice between being Black or succeeding by assimilating in American society. The implicit rule of engagement was (is) to be an individual or openly a member of a cultural community; to use as a survival and advancement strategy the core African American cultural beliefs or to embrace mainstream beliefs, attitudes, and behaviors has been a constant dilemma. Again, the invention, implementation, and administration of African American services and programming have been shaped by this unrecognized cultural clash.

African American Culture

IT IS CULTURE NOT RACE. An unrecognized consequence of the “dehumanizing” experience of African enslavement in America was the intellectual and philosophical attempt to assert that African people had no culture (see, Hegel, 1966). Human beings are creators and maintainers of culture and if Africans were thought to be less than human, then by definition Africans could not have culture. This dehumanizing falsehood was coupled with the ideology of white supremacy that offered an explanation of human beings and human affairs along a linear spectrum of racial hierarchies of superior and inferior positioning with Black people being located at the most inferior position. Race was asserted to categorize both the value of human character and the meaning of all human relationships. This singular fact has confused both the lay and scholarly understanding and appreciation of African American reality. It is culture not race that allows one to know, understand and effectively work with African American people (Nobles, 2000).
In addressing the question of what is culture, McNair (2004) prefaces his exhaustive review noting that “The human spirit evolves through a variety of different groups and subgroups through the medium of culture. It therefore needs a variety of different cultural experiences to realize its full potential or to fulfill itself. Every human culture is a fairly unique expression of the human spirit.” In referencing the symbolic anthropologist Clifford Geertz (1973), McNair further acknowledges culture as a historically transmitted pattern of meanings embodied in symbols, a system of inherited conceptions expressed in symbolic forms by means of which men communicate, perpetuate, and develop their knowledge about and their attitudes toward life” (Geertz 1973:89). This "historically transmitted pattern of meaning" shapes the consciousness and the behavior of members of a culture and influences the creation of their artifacts as well. McNair further notes that Nobles (1985) along with Ani (1994) define culture in such a way that it includes the idea of spirit. Nobles defines culture as “a process that represents the vast structure of behaviors, ideas, attitudes, values, habits, beliefs, customs, language, rituals, ceremonies, and practices "peculiar" to a particular group of people, and that provides them with a general design for living and patterns for interpreting reality.” Nobles further asserts that culture is as essential to human life as water is to living fish. Culture is not simply the song and dance of a people. Nor is it merely the compilation of their holidays and rituals or the listing of their heroes and heroines. Culture gives meaning to reality. It is the total environmental reality. As such, culture has the power to compel behavior and the capacity to reinforce ideas and beliefs about human functioning, including mental health, educational achievement, motivation, and development. It is the invisible medium which encompasses all human existence. It is important to note that nothing human happens independent of culture.

Nobles further presents a model of culture consisting of three levels (1) cultural aspects; (2) cultural factors and (3) cultural manifestations. Additionally, he acknowledges that culture reflects the tone, character and quality of life of a people; its moral and aesthetic style and mode and the conception of the course and purpose of events in the world as well as guidelines for the creation of the ideas and concepts about human life and living. This spirit, which is most often seen as a force or ethos, is the active agent that causes the creation of cultural thought and behavior.

The idea of African American culture being spirit-defined and spirit-driven requires some brief explanation. African American people are unquestionably recognized as being highly religious or spiritual. This is seen as a cultural aspect of African American people. What is most often understood as culture are its manifestations (1985, p. 102). Being highly religious can be seen as a cultural manifestation. The overall phenomena of culture, however, is best understood as being grounded in a people’s ontological, cosmological and axiological beliefs which are informed and formed by their understanding of what it means to be human.

The major cultural and linguistic lineage for African American people are the BaNtu-Kongo (see, Fukiau, 1980; Holloway, 1991; Kuyk, 2003)). Traditionally, the BaNtu believe that being Human is to be spirit, energy or power. It is one who lives and moves within and is inseparable from the ocean of waves/radiations of spirit (energy or power). A Human being is a "knowing and knowable" spirit (energy or power) through which one has an enduring relationship with the total perceptible and ponderable universe. To be human is to be a spirit in motion (unfolding). It is to be one (spirit) who affirms one’s humanity by recognizing the
humanity of others and on that basis establishes humane relations with them. Humans are containers and instruments of Divine spirit and relationships.

Accordingly, in order to fully understand contemporary African American culture, one has to explore the traditional African meaning of being human that shapes and defines the general design for living and patterns for interpreting reality as well as informs the behaviors, ideas, attitudes, values, habits, beliefs, customs, language, rituals, ceremonies, and practices of African American people.

Contemporary African American culture should, in fact, be seen as a psycho-cultural geopolitical complex composite of African cultural retentions and American social inventions. This spirit-driven/defined culture combines an undifferentiated consciousness, a cultural coloring, a particular “tone” and certain "feel" that becomes the signature of members of a cultural group. African Americans, as a group, are, therefore, culturally complex. Despite the tremendous variety that exists among African American people, most African Americans continue to share elements of a common culture. African American life and living is grounded in both environmental conditions and a complex structure of cultural precepts, virtues, values, customs, themes and prerequisites. Traditional African American cultural values alone consist of respect for elders, race pride, collective responsibility, restraint, devotion, reciprocity, patience, cognitive flexibility, courage, resilience, defiance, integrity, self-mastery, persistence, and productivity. The complete set of cultural components results in over 54 distinct yet interrelated ideas and beliefs that serve as the crucial (more often than not disregarded and misunderstood) African American cultural template (see Appendix 1). These characteristics are grounded both in African culture and in the experiences that African Americans have had in North America.

Given this explanation of African American culture, cultural grounding should be a critical component for working with African American people. However, the cultural grounding of African American people is too often viewed as absent, invisible or of little value. To the contrary, all Mental Health services, i.e., intervention, prevention and treatment programming as well as education, professional development, and staff training targeted to African American people should be informed by an in-depth understanding of the culture of African American people.

Before discussing the implications of African American culture for community-based practices, a brief discussion of African American response to racial and cultural oppression may help to properly contextualize African American service programming and delivery.

**African American Response to Racial and Cultural Oppression**

The African American\(^2\) response to racial and cultural oppression began literally from the

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\(^2\) Oftentimes, the terms African, African American and Black are used interchangeably. However, the term African (for both continental and diasporan) is more accurate for every discussion. African is indicative of a cultural distinction that embraces our humanity. Black is a term that only captures a biological meaning of race in the context of racism and, in many instances, our history in reaction to and/or our contact with Whites. At best it refers to a qualification of our nationality, i.e., Black American.
moment of African invasion and capture. No major critique has been given that has been more insightful than that of Frederick Douglass. On July 5, 1852, Douglass gave a speech at an event commemorating the signing of the Declaration of Independence.

What, am I to argue that it is wrong to make men brutes, to rob them of their liberty, to work them without wages, to keep them ignorant of their relations to their fellow men, to beat them with sticks, to flay their flesh with the lash, to load their limbs with irons, to hunt them with dogs, to sell them at auction, to sunder their families, to knock out their teeth, to burn their flesh, to starve them into obedience and submission to their masters? Must I argue that a system thus marked with blood, and stained with pollution, is wrong? No! I will not…

What, then, remains to be argued? … That which is inhuman, cannot be divine!

Mr. Douglas concludes his remarks with the question,

What, to the American slave, is your 4th of July? I answer; a day that reveals to him, more than all other days in the year, the gross injustice and cruelty to which he is the constant victim. To him, your celebration is a sham; your boasted liberty, an unholy license; your national greatness, swelling vanity; your sound of rejoicing are empty and heartless;… shout of liberty and equality, hollow mockery; your prayers and hymns, your sermons and thanks-givings, with all your religious parade and solemnity, are to him, mere bombast, fraud, deception, impiety, and hypocrisy -- a thin veil to cover up crimes which would disgrace a nation of savages.

While the lingering effects of African American historical trauma due to slavery is seldom addressed and the African cultural retentions seldom acknowledged, both are essential to fully understanding both the historical and contemporary response to living, including how we access, create and respond to services. For the African American, the very fabric and cloth of American society was woven with savagery, slavery, segregation, discrimination, political domination, economic exploitation, cultural denigration, and psychic terrorism.

The African American response to these aberrant and toxic societal conditions has, however, never been passive or accepting. From the moment of the savage kidnapping in Africa, African captivity and enslavement has been met with constant and continuous resistance, revolt and rebellion. There were constant slave insurrections in the United States from 1526 to 1864. Enslaved Africans resisted capture and enslavement in Africa, and later on in slave ships that came to the New World. Africans resisted in the plantation fields and in the Big House and they organized unrelenting slave actions against their oppression. They fought for their freedom and liberation and were killed and died in the cause of freedom. This tradition of non-acceptance of dehumanization and exploitation and the African’s intrinsic sense of humanity, equality and fairness was, in actuality, the root and kernel of the African American radical protest movement known as the civil rights and Black nationalist movements. Hence, revolt, resistance, protest and even collaboration have all served as survival strategies in the African American struggle.

One strategy deserving particular attention is revealed in African American aesthetics. The ability to overcome and outsmart powerful adversaries and to achieve one’s goals in life is critical to those found at the bottom of the power continuum. The teaching of this strategy is found as a direct cultural expression in the Eshu mythology of the Yoruba and the Ananse folktales of the Asante. The continuation of this dramatic form is reflected, as cultural retention/invention, in African American aesthetics as, for example, the “Signifying Monkey” and “Brer Rabbit,” tricksters.
By definition, tricksters are animals or characters who, while ostensibly disadvantaged and weak in a contest of wills, power, and/or resources, succeed in getting the best of their larger, more powerful adversaries. The social situation of the Trickster is generally located as or pictured in the contest of wills and interest. Tricksters achieve their objectives through indirection, misdirection and mask wearing, by playing upon the gullibility of their opponents. Paul Lawrence Dunbar's poem, “We Wear the Mask” (see below) first professionally published in 1897 is representative of this tradition and not much has changed for African American people.

We Wear the Mask
WE wear the mask that grins and lies,
It hides our cheeks and shades our eyes,—
This debt we pay to human guile;
With torn and bleeding hearts we smile,
And mouth with myriad subtleties.
Why should the world be over-wise,
In counting all our tears and sighs?
Nay, let them only see us,
while We wear the mask.
We smile, but, O great Christ, our cries
To thee from tortured souls arise.
We sing, but oh the clay is vile
Beneath our feet, and long the mile;
But let the world dream otherwise,
We wear the mask!

Paul Laurence Dunbar (1872-1906)

The trickster achieves its life goals or challenges by misdirection, masking and outsmarting or outthinking their opponents. They use their own intelligence and wit (most often unrecognized or disrespected by their powerful adversary) to get out of trouble or to achieve their goals.

The lived experience of African American people and communities relative to dealing with White privilege and mainstream program services and policies, in many respects, satisfies the contest of differential wills, goals, interest and reality condition. Given that, in spite of having a Black President of the United States, and major achievements in education and business as well as the new political correctness of claiming the achievement of a post racial society, there remains a fundamentally different reality for Black people, especially those in need of services, in America. Consequently, we wear the mask of integration, assimilation, acculturation and “one size fits all” while utilizing the “trickster function” to get services, programs and activities supported and implemented. This conditional criterion makes the development of authentic African American community-based practice challenging. One has to go behind the mask and uncover the true native intelligence and cultural intent in order to fully know and be able to test the effectiveness of African American community-defined evidence and practice.

The depth of this conceptual incarceration and epistemological dilemma was (is) captured in the thoughts of two shining Black princes from the African world, Malcolm X and Steve Biko. Malcolm X noted that, “In hating Africa and in hating the Africans, we ended up hating ourselves, without even realizing it. Because you can’t hate the roots of a tree, and not hate the
tree. You can't hate your origin and not end up hating yourself. You can't hate Africa and not hate yourself.” In countering the pernicious thought that there was nothing of value in Africa, he further responded to that idea, by noting that we “left our mind in Africa.” In a similar and concise refrain, Steve Biko further reminded us that, “The most potent weapon in the hands of the oppressor is the mind of the oppressed.” Both these sons of Africa noted, in their own words and histories, that the problem of knowing for African people was created by colonization and enslavement wherein we were (and are) forced to deny and/or not recognize or value an African understanding of anything. In many unfortunate ways, scholarship, services development and implementation all reflect the unconscious hating of Africa and thereby become an unknowing weapon of the continued oppression of African American people.

**Implications for Understanding Community-Defined Practice (CDP)**

Not being able to openly identify with being Black clearly retards the establishment of Black community-defined practices. Having to mask the ideas, beliefs and identity of programs and/or programmatic services creates an additional and unaddressed challenge to create and define African American community-defined practices. Seldom do we see Black services identifying with Black “ways” as we see in other ethnic-specific communities, i.e., La Clinica de La Raza, Indian Health Services, Asian Pacific Health Care, etc.. The inability to openly identify as African American or Black and even more prohibitive as African, results in a strange dilemma where both service provider and service recipient must present themselves and their work as not being openly Black.

What, in fact, is rather clear, is that the lived experiences of African American people regardless of class, gender or status is one of being in relation to anti-Black (African) toxic and pathogenetic ideas and beliefs that serve as the passport to entry into mainstream society with all of its privileges and resources. African American (Black) programming is, accordingly, socially encouraged to morph or mutate their Blackness in order to be supported. Consequently the African American community doesn’t have the same ability to track African American culturally grounded practices with an unapologetic lens or foundation. As such, the African American community has difficulty in even identifying or coming to agreement on what are Black/African American “ways.”

The fact that the African American community has little opportunity to openly “test” Black defined and determined practices does not, however, mean that there are no Black community-defined practices. The African American experience, like every human community, is always in relation to the societal context in which we live. To understand a people’s cultural life in context it helps to review the Culturecology Model developed by King and Nobles (1997).

Culturecology represents a unique and radically innovative model for the delivery and development of public health services and strategies targeting health disparities, particularly in the African American community (Nobles, et al, 2009). Emerging from the importance given to “cultural congruency” associated with African centered thought, the question and role of culture in human understanding and functioning is believed central to the work of social-behavioral science (Nobles, 1972, King, et al, 1976, Akbar, 1984.).
Culture is the defining substance of all human action. It is fundamental to human life and living. It enwraps all of human reality and nothing happens outside of it. To make this point, Nobles (1986) has suggested that “Culture is to humans as water is to fish”. It encompasses everything. In arguing that culture is the defining substance of all human action, King and Nobles (1997) coined the concept of “culturecology,” as a contraction of “culture”, (i.e., the process that provides people with a general design for living and patterns for interpreting reality) and “ecology”, (i.e., the relations/interactions of organisms, including people to one another and to their physical environment), to capture the totality of cultural framing and the significance of cultural congruency.

“Culturecology” recognizes that both people and the environment are cultural organisms. In a monograph commissioned by the Center for Disease Control (CDC, 1996) King and Nobles argued that incomplete, flawed and ahistorical conceptions of African American human relations undermine the good intentions of clinical interventions and that a radically new approach was needed in which a culturally constructed self in a web of relations replaces individualism. As such, the model posits that what people do and how they behave is largely determined by their culture and social condition and that the person, as cultural agent, has a sense of efficacy and wellness resulting from the sense of being human which is culturally defined.

Accordingly, the inviolate assumption of the culturecology model is that human well-being is a “relational event” resulting from and defined by situationally bound units of relationships between the person as cultural agent and the environment as having cultural agency. The culturecology model recognizes that the “relationship” between persons and environments must also be understood and that the “relationship” between person and environment cannot be understood in absence of their cultural meaning. The culturecology model recognizes that (1) “the nature of the person” and “the nature of the environment” are inextricably connected, (2) both the environment and human beings are cultural phenomena, and (3) the “cultural grounding” and meaning of each (person and environment) must be culturally understood in order to fully understand the interactive relationship between persons and health and disease. In effect, it requires the simultaneous examination of the forces that promote and prevent disease in the African American community.

Utilization and Application of African American Culture

Many African American critical thinkers have come to realize how miraculous it is for Black/African behavioral health and social services practitioners to be able to discern and understand anything about African reality (historical and contemporary, as well as continental and diaspora) with an African mind. Not only are we limited by the use of European languages to discuss African phenomena, we are also limited in more ways than we can imagine by the fact that we address African phenomena with European and American theories, concepts, ideas, mindsets and world-views. Even the perception of what is actually problematic or intellectually intriguing is shaped by westernization. Equally true is the need to deny, omit, mask, morph or mutate the significance of African American culture in order to provide, access and/or support African American Mental Health services. Seldom do African American services openly and unapologetically define their services, until very recently, as Black or African Centered treatment or interventions. Never are African American services allowed or encouraged to
develop and explore, other than as faith-based, the spirit-driven nature of their programming. Nor are their conscious attempts to specifically apply the healing beliefs, customs and traditions found in the African American community.
WHAT SHOULD AN AFRICAN AMERICAN COMMUNITY-DEFINED PRACTICE LOOK LIKE?

Given the elevation of culture to the question of African American Community-defined Practice, the formation, implementation and evaluation of a CDP should show direct evidence of African vitalism and humanism and African American traditional communal and relational sensibility and inclination. African American community based practices should, at a minimum, demonstrate in their philosophy, structure, function and relational outcomes a recognizable linkage between the meaning of being human and the contours of its cultural manifestations as represented in the behaviors, beliefs, values, attitudes, customs and traditions it engenders. In effect, African American community-defined practices must be culturally congruent with the best of African American cultural reality. They should reflect and represent the reinforcement and/or restoration of an African American general design for living and patterns for interpreting reality (worldview) as grounded in African American behaviors, ideas, attitudes, values, habits, beliefs, customs, language, rituals, ceremonies, metaphors and practices so as to have the “culturecological” potential and ability to move the mental health status or condition of African American clients/consumers and their families from the least healthy to the most healthy reality.

Just as the practice must be culturally congruent, what is considered problematic, dysfunctioning, or mental disorder should also be vetted against the requisites of culture. In this regard, the classification of disease, i.e., nosology, must also be addressed. Jane Gilbert notes that what is considered as “mental disorder” is found and recognized in all societies. However, she rightfully further notes that how it is shown in individual behavior, what people think causes the disorder, and what treatment is considered appropriate, vary tremendously between cultures. Accordingly, the question of what is mental illness and the different classifications of it, i.e. nosology, must also be privileged by different cultures. Guided by the informative character of African cultural retentions and African American cultural inventions, the defining and development of an African centered nosology should at minimum reflect the utilization and exploration of African language and terminology; and the vetting of the classificatory system’s application and relevance to African American cultural ideas, beliefs and notions. An African American nosology should allow for the illumination, clarification, study and understanding of African American community-defined practice.

As we address this question of culturally congruent African American evidence-based and community-defined practice, it is essential that we consider the following critical terms from an African American context. These terms have relevance for African American ways of knowing and being and inform the criteria for the formation of an African American community-based practice:

Community

The concept of community in contemporary society has eroded to mean mostly housing complexes where people live in close proximity having little or nothing to do with each other. Community is, however, more than just living close by each other. Technically, the term
community is comprised of the prefix “com” meaning with, together, or all together. The root word “unity” means the state, quality or condition of being one or having an intent to secure a single effect or result. In its applied sense, community is an identifiable area that has recognizable boundaries (both geographical and psychological), shares a common set of experiences and conditions (events, world-view, values, beliefs, etc.) and has a sense of its own being, belonging and desire to secure a particular effect. Community (see Nobles, 1993), therefore, represents simultaneously a place (identifiable area and/or mind-set), a history (set of shared experiences and conditions) and a people (sense of being and belonging). Simply put, community is simultaneously an identifiable place, and a collection of connected people with a shared common world-view, experiences, values and beliefs.

Shared collective memory in the form of values, beliefs, etc., is a special determiner of community in the African American experience. Specific group affiliation, i.e., religion (Muslim, Christian, Traditional), migratory origin (southern, eastern), new diasporan continental (e.g., Hausa, Yoruba, Ethiopian, Somali, etc.), and Caribbean immigrants (e.g., Jamaican, Haitian, etc.), also create particular distinctions within the African American community. In some African American communities, gang affiliation and turf boundaries would also be definers of community.

**Identity**

Given the complexity of African American culture and history, an African American community-defined practice should encourage and reflect the exploration of both “retentions” of traditional African practices, beliefs and attitudes and the new “inventions” of African American practices, beliefs and attitudes. A critical feature of African American community-defined practices needs to include the license to openly acknowledge its identification and image as African/Black. Just as Asian, Hispanic and Native American services openly represent themselves as ethnic-specific, African American community-defined practices should be rewarded for not hiding or morphing its cultural identity.

Consistent with the liberation of ethnic-specific identity for African American community-defined practices, the essential nature for the recognition and respect of these community-defined practices is the vetting of its cultural fabric as key to the restoration of the mental health, wellness and wholeness of the African American community.

**Evidence**

In addition to evidence measurement using standardized forms of instrumentation that have the psychometric properties of reliability and validity based on the empirical validation obtained from a population sample, the nature of the evidence should also allow for the development of new and non-traditional forms of measurement, including qualitative measures. Given the complexity of African American culture and history, evidence for an African American CDP should be defined as: any observable and measurable indicators of behavior, attitude and/or belief that support the restoration of wellness, wholeness and mental health, and reflect the exploration of either retentions of traditional African practices, attitudes and beliefs, and/or the
invention of new African American practices, attitudes and beliefs. The purpose of “evidence” is to be able to document and/or discern “change” which is usually defined as a statistical difference. However, given the African American cultural feel or “tone”, would suggest that “evidence” be defined and/or captured as a “new tone” in the community being served. Note for instance, statistical difference requires a mathematical shift wherein in music, tone is determined by two or more different notes occupying the same space at the same time. Evidence of a new (healing) tone may be evidenced by more African American cultural beliefs or ideas occupying the consciousness (space) of African American people than toxic demeaning ideas and/or beliefs, thus creating an African American mentally healthy “tonal vibration.”

Community-defined Evidence

Community-defined evidence refers to the knowledge gained from a “community-placed” program or practice. Such knowledge is in the form of “evidence” that is obtained and gleaned through the analysis of the experience in community. Such data are often obtained from observations by program staff, participants, and members of the community who are relevant to the experiences of the participants in the program (e.g., teachers, parents in a school-based program focusing on students), the notes kept by the program staff, and records from other parts of the agency implementing the practice. Community-defined evidence should be a correlate of community-defined practice. As such, and given the requisites of African American cultural congruency, a critical feature of both community-defined practice and community-defined evidence is the open acknowledgement of its African/Black cultural identity and image and the creation and adoption of what constitutes evidence of the experience from that cultural grounding.

Community-defined Practice

African American community-defined practice should be defined as any practice, action and/or activity located in community-based organizations and/or initiatives whose implicit intent and explicit consequence is to restore and/or reinforce the African American meaning of being a whole person whose humanity recognizes the humanity of other people and in so doing relates to them in humane ways. Community-defined practices (CDP) should reflect, respect and represent African American ways of knowing and being as well as inform and shape the mentally healthy behaviors, ideas, attitudes, values, habits, beliefs, customs, language, rituals, ceremonies, and practices of African American people. CDPs must be able to provide evidence of their ability and/or potential to reinforce and/or restore mental health, wellbeing and wholeness as recognized and defined by African American people (community-defined evidence).

Intervention

An intervention for an African American CDP should include any practice and/or process that simultaneously interrupts the alignment and/or connection to toxic and pathogenic ideas, beliefs and behaviors while internalizing culturally congruent ideas, beliefs and behaviors supportive of collective wellness, wholeness and mental health for African Americans. Simply
put, there is an integration of an African centered worldview into the practice.

**Prevention**

Given the African American history and collective memory of being prevented and denied due to enslavement, segregation and discrimination, the emphasis should not be on “prevention” but “promotion”, the promotion of health and wellness for African Americans. In this regard, promotion is defined as any activity, action, program or process that provides cultural inoculation against the damaging and diminishing ideas and beliefs about Black people and Blackness while simultaneously encouraging and supporting culturally congruent ideas, beliefs and behaviors that lead to and/or reflect the sense of confidence, competence and the sense of full possibility and unlimited potential.

**Treatment**

As a therapeutic process, in an African American CDP, treatment would be any seamless practice and/or process tapping both the visible and invisible realms of reality and simultaneously engaging the client and the therapist in a mutually binding process designed to activate the energy of self-healing potential.

It is important that African American Community Based Practices challenge and purge from African American time and space those repugnant and vulgar ideas and beliefs that distort and lie about African American being, and embrace those that reinforce and restore who and what we really are, the human manifestation of the Divine. An African American Community Based Practice should ultimately reflect and respect the African American meaning of being and give “voice” to the African American community’s ability to activate its own self-healing potential.
IMPLICATIONS

Defining and Assessing African American Community-defined Practice

The variety and diversity of community-based practices dictate the need for a process of recording and documenting these practices so as to allow the African American community the ability to implement and evaluate its culturally grounded best practices’ effectiveness and benefit. The defining and/or refinement of African American community-defined practice will need to be as complex as African American phenomena. Clearly there is a need to establish standards for African American community-defined practice and criteria that will allow and/or guide the review of many programs offered to address disparities reduction. Like culture, the criteria should be fluid and ever evolving like a river and not stagnant like a standing pool. Consistent with this idea and given the exigencies of applying and utilizing African American culture and the ever-present context of real contextual constraints of a less than open, free and just society relative to African American life and living, there is, nevertheless, a real need for precise criteria and/or standards to shape and assess African American community-defined practices.

Accordingly, African American community-defined practice must, at minimum, be aligned with components of African American cultural orientation (see Appendix 1: Key Components of African American Cultural Orientation Chart) and provide demonstrable evidence of being effective relative to simultaneously encouraging and supporting African American culturally congruent ideas, beliefs and behaviors and the resistance and resilience toward the toxic and destructive elements of American life and living. The reinforcement and/or restoration of traditional and widely accepted ways of behaving or doing something that is specific to African American life and living in a particular place, or time, i.e., customs, as well as, the typical standards or patterns of socio-cultural behavior that is typical of and expected by African American people, i.e., norms, should also be included in the platform or scaffolding of African American community-based practice.

The issue of access, funding application, governing policy, implementation procedures as well as assessment and evaluation, including the actual instruments, i.e. forms, tone, etc. to record and document the experience should all be equally held to the requirement of African American cultural congruency. African American community-defined practice should be vetted against a set of criteria for determining and assessing the cultural congruency of the practice and the requisites for assessing what constitutes community-defined evidence as identified below.

Criteria for Determining African American Community-defined Practice

a. Identify openly as an African American community-defined practice
b. Show evidence of emerging and being predictable from the African American cultural orientation
c. Have a demonstrable strategy that allows the target client to transition from the least to the most mentally health reality
d. Be able to specify a rationale and justification for its guiding classification of the problematic and/or disease, i.e., nosology

e. Must utilize (what information/experience is provided to participants) the cultural precepts, values, principles, of the African American community, i.e., grounding

f. Intent - should be centered (the underlying logic and theory behind the practice) in the restoration of the African sense of being and the development of feelings of wholeness and wellness in the community

g. Content - should utilize a wholistic perspective that addresses the self-healing potential of community as reflected in the spiritual, physical, social aspects/domains of life and living

h. Process - must reflect an interactive strategy (the way it is done) that allows for an interdependent relationship between the provider and the participants as well as individuals and community

i. Outcome - should be demonstrably capable of reinforcing and/or restoring “clients/consumers” who have developed a sense of confidence, competence, and consciousness, as well as a commitment to the welfare and wellbeing of the family, community and society

Assessment for African American Community-defined Evidence

As part of the recording and documentation of community-defined culturally grounded best practices, there is also a need to assess systematically what is considered community-defined “evidence.” In assessing the evidence, there is the broader task of generalizing to a higher level of abstraction these indicators of evidence. For example, several different examples of “evidence” can be grouped into a broader conceptual category of evidence. That is, the different types of evidence can be considered concrete indicators of a more abstract concept. For example evidence of “behavioral change” can be measured by indicators related to the prevention of toxic, demeaning and denigrating ideas, beliefs and behaviors stimulating human dysfunction while promoting ideas, beliefs and behaviors supportive of the sense of confidence, competence and the sense of full possibility and unlimited potential.

Where Do We Go From Here?

The discourse presented in this document is the beginning of a series of discussions that refines the definitions and criteria for community-defined practices applicable to African Americans. Experts in the field of African and African American culture are invited to critique and build on the aforementioned discussion. Psychologists, social workers, healthcare providers, social service agencies, local and federal governments, community members, and community based services providers all have a stake in improving the health and wellness of African Americans. Investing in strategies that empower self-management, family resiliency, and community development will result in a thriving society. Community-defined Practices have the potential of contributing to a beleaguered system of care that has demonstrated minimum progress in meeting the needs of African Americans. CDPs can enhance the existing system of care and support efforts toward a thriving, more resilient community.

The next step in the refinement of the AA CDP criteria outlined in this document is a process
of adoption by professionals, researchers, and services providers. The AA SPW funded by the Department of Mental Health was unable to complete this process due to the lack of necessary resources and time. The development of this document met similar challenges but was able to focus its discussion on the refinement of the definitions and conditions needed to establish an AA CDP. The convening of experts in African American culture and consumer experts familiar with engagement, implementation, and outcomes will require additional time and efforts. This next step involves the development of practical examples or elements of each characteristic. Each of the characteristics described in Appendix 1 should be clearly defined and assigned a series of practice examples, then validated by services providers, researchers and professionals in the field. Time and resources were not available to take this process to that level of scrutiny. Adoption of the criteria will lead to the establishment of standards for an AA CDP.

Once a standard has been established it is then possible to identify practices / strategies aligned with the criteria currently in use within the community and to develop new practices. Identification and ongoing evaluation of these practices will then help researchers and providers understand the efficacy and conditions of use for these practices. This type of information will help to inform the certification and cataloging of practices for use and the credentialing of practices as evidence based.

The identification and certification of AA CDP is necessary to ensure that practices are in alignment with authentic characteristics inherent within African culture and adapted to the African American experience. Consumers, providers, and funders will be assured that a certified AA CDP has met the standard, has some strategy for evaluation, and can demonstrate predictable outcomes. Certification will also establish a standard for maintaining fidelity and form the basis for determining the practice as evidence based.

The credentialing of a practice will have implications for the training of future behavioral health professionals as well. At the onset, individuals who have knowledge of the cultural ethos of African Americans and the cultural underpinning in the development and implementation of the practice must train those individuals responsible for delivering the practices to the public. Individuals providing the training and delivering the services must embrace and promote the values inherent in the practice. The certification of practices will inform the public about the nature of the practice and allow individuals to choose services that are the right fit for them. The credentialing of a practice will result in increased efficacy of the practice, individual adoption of the goals and outcomes intended, and greater community support for its implementation.

Another outgrowth of certification and cataloging is the development of toolkits, which may be used to maintain fidelity to the practice, educate the public, and establish longevity for future outcome evaluation and innovation. Toolkits as a vehicle for training and service delivery may be used to describe the populations and conditions in which particular practices may be most effective as well as their limitations. Unlike traditional mental health training typically provided within university settings and graduate programs, tool kits may be an effective vehicle for training lay professionals and educating consumers in the implementation and evaluation of outcomes for a specific practice. Tool kits are usually distributed via professional meetings, online, and in community provider settings making them more accessible to the general public and transparent for evaluation purposes.
As the criteria for AA CDPs are developed and adopted in community settings, opportunities for engaging nontraditional mental health service providers emerge. There are many contexts in which African community-defined practices exist but are not defined as such and have not been incorporated into publicly funded services. For example, providers who are skilled in indigenous African healing practices, Pentecostal religious worship, and grandmothers who train new mothers, have soothed, healed, empowered, and rejuvenated Africans and African Americans using practices that have been passed down across generations. The adoption of community-defined practices opens the door to those individuals, making it possible for the field of mental health to be expanded to include non-university trained individuals, reducing the cost for service delivery, empowering the community to care for itself, and system transformation inspired by the lessons learned from these gifted healers who currently operate outside the public mental health system.

The transformation of the public behavioral health system may also include adapted models for service delivery such as the development of critical care units that incorporate peers skilled in the implementation of AA CDP and offer them as part of the inpatient hospitalization experience. Full service partnerships may also be expanded to include indigenous service providers or fully adapted to reflect a series of AA CDPs. This type of adaption has the potential of creating full service partnerships that are designed to specifically meet the needs of African American consumers and supported by African American community or faith-based organizations, indigenous healers, as well as family members and friends.

Clearly, the public behavioral healthcare system has a lot to gain by adopting African American Community-defined Practices. What is outlined here in this document is just the beginning of many possibilities. Support for adapting treatment to include strategies deemed compatible with the individuals receiving the care and the engaging of a broader audience of providers can only help strengthen a beleaguered public behavioral health system. The continued development of AA CDPs will ultimately assist California in achieving The Triple Aim of the Affordable Care Act mandate: to reduce costs, to improve care, and to improve health outcomes.
APPENDIX 1

Chart I

*Key Components of African American Cultural Orientation*

<table>
<thead>
<tr>
<th>CULTURAL LAWS</th>
<th>CULTURAL VIRTUES</th>
<th>CULTURAL PREREQUISITES</th>
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<tbody>
<tr>
<td>Consubstantiation</td>
<td>(Ma’at)</td>
<td>Sense of Family</td>
</tr>
<tr>
<td>Interdependence</td>
<td>Truth</td>
<td>Sense of History</td>
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<tr>
<td>Egalitarianism</td>
<td>Justice</td>
<td>Language Orientation</td>
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<tr>
<td>Collectivism</td>
<td>Righteousness</td>
<td>Significance of Names/naming</td>
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<tr>
<td>Transformation</td>
<td>Harmony</td>
<td>Importance of Songs &amp; Symbols</td>
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<tr>
<td>Cooperation</td>
<td>Balance</td>
<td>Sound (music) &amp; Rhythm (dance)</td>
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<td>Humanness</td>
<td>Propriety</td>
<td>Dietary Habits</td>
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<tr>
<td>Synergy</td>
<td>Order</td>
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<tr>
<td>CULTURAL CUSTOMS</td>
<td>CULTURAL VALUES</td>
<td>CULTURAL THEMES</td>
</tr>
<tr>
<td>Belief in God (Moral Character)</td>
<td>Respect (Elders)</td>
<td>Spirituality</td>
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<tr>
<td>Sanctity of Family &amp; Children (relationships)</td>
<td>Self Mastery (thought/behavior)</td>
<td>Resilience</td>
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<tr>
<td>Sense of Excellence</td>
<td>Patience</td>
<td>Humanism</td>
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<td>Sense of Appropriateness</td>
<td>Race Pride</td>
<td>Communalism</td>
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<tr>
<td>Importance of History</td>
<td>Collective Responsibility</td>
<td>Orality &amp; Verbal</td>
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<td></td>
<td>Restraint</td>
<td>Expressiveness</td>
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<td>Devotion</td>
<td>Personal Style &amp; Uniqueness</td>
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<td>Cognitive Flexibility</td>
<td>Realness</td>
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<td>Persistence</td>
<td>Emotional Vitality</td>
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<td>Reciprocity</td>
<td>Musicality/Rhythm</td>
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