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Full service partnership (FSP) programs were designed under the leadership of the California Department of Mental Health in collaboration with the California Mental Health Directors Association, the California Mental Health Planning Council, the Mental Health Services Oversight and Accountability Commission, mental health clients and their family members, mental health service providers, and other key stakeholders of the mental health system. Although in existence since 2005, full service partnership programs are continuing to develop the distinguishing characteristics that lead to good outcomes for mental health clients and their families.

The FSP Tool Kit is intended to provide FSP supervisors and team members with written guidance to support ongoing development of programs and integration of practices. This publication series encompasses a Tool Kit for each age group — children, transition-age youth, adults, and older adults — in recognition of programmatic differences that exist across the four age groups.
Preface (cont’d)

The Tool Kit has numerous unique characteristics that include:

- Development with close involvement of diverse, statewide advisory committees that represent all of California’s public mental health constituents, including clients, family members, counties, and mental health service providers.

- Identification not only of service delivery models for age-specific full service partnerships, but also an overview of practices that can be integrated into full service partnerships.

- Reference and access to website links that offer additional in-depth information on the majority of practices included in the Tool Kit.

- Recommended resources to assist in the ongoing development of full service partnership programs that support clients in their recovery.
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This Tool Kit is dedicated to all the people with lived experience, children and their families, transition-age youth, adults, or older adults, who continually demonstrate their belief in possibilities. This project was funded through California’s Department of Mental Health (DMH). Creation of this Tool Kit resulted from the ideas, experience, and suggestions from many groups and people throughout California. Advocates committed to the improvement of services for ethnic and cultural minority communities, and participants from the statewide advisory committee, age-specific committees, and the performance measurement subcommittee demonstrated tireless dedication to ensure a practical outcome. Representatives from all 58 counties — through county departments, regional networks, partner agencies, and community-based agencies — participated via meetings, conference calls, and interviews.

Additional appreciation is extended to the staff and consultants at the California Institute for Mental Health (CiMH) for their excellent leadership and compassionate guidance in this visionary endeavor.
ADULT FSP TOOL KIT
SUBCOMMITTEE MEMBERS
(LISTED IN ORDER OF FIRST NAME)

Anthony Delgado, LCSW, Program Manager II, Orange County Health Care Agency, Adult and Older Adult MHSA Programs

Arden Carr, LMFT, Clinical Site Supervisor, Siskiyou County Human Services Agency, Behavioral Health Division

Autumn Valerio, formerly of the California Department of Mental Health, presently with CiMH

Betty Dahlquist, MSW, CPRP, Executive Director, California Association of Social Rehabilitation Agencies (CASRA)

Dave Pilon, PhD, Executive Director, Mental Health America, Los Angeles

Delphine Brody, Client Advocate

Gary Cristofani, Team Leader, Rubicon Programs Inc., MHSA Bridges to Home

Gladys Lee, District Chief, Planning Division and Ethnic Services Manager, Los Angeles County Department of Mental Health

Ilda Aharonian, Psychologist, Los Angeles County Department of Mental Health

Jaclyn Culleton, Program Manager, MHSA Coordinator, Humboldt County Department of Health and Human Services, Mental Health Branch

Jim Isherwood, MHSA Coordinator, Lake County Department of Mental Health

Jo Ann Johnson, LCSW, Cultural Competence and Ethnic Services Manager; Research, Evaluation and Program Outcomes Manager; and Workforce, Education and Training Manager, Sacramento County Department of Health and Human Services, Division of Behavioral Health Services

Joseph Robinson, LCSW, CADC II, Associate Director, California Association of Social Rehabilitation Agencies (CASRA)

Kalene Gilbert, Program Head, Adult Systems of Care, Los Angeles County Department of Mental Health

Karen Stockton, PhD, MSW, BSN, Director, Modoc County Health Services and Mental Health Department

Karolyn Rim Stein, Director, Department of Health and Human Services, Mental Health Branch, Humboldt County

Kyle Titus, PhD, LCSW, Deputy Director of Adult Services, Monterey County Health Department, Behavioral Health Division

Lisa McGinnis, LMFT, Program Manager II, Central Valley Region, and Department of Behavioral Health FSP Coordinator, San Bernardino County
Lynn Slotky, Family Member

Marcelo Cavalheiro, Older Adult ATLAS Administrator, Older Adults and Adults Telecare Corporation, Los Angeles Services

Maria Funk, PhD, Mental Health Clinical District Chief, Adult Justice, Housing, Employment, and Education Services, Los Angeles County

Maria Ostheimer, Client Advocate

Mark Shotwell, CATC/CAADE, BA, Supported Employment Specialist, Bonita House, Inc. HOST, Alameda County

Pamlyn Milsap, Program Coordinator, Homeless Coordinator, Humboldt County Department of Health and Human Services

Richard Van Horn, MDiv. (Master of Divinity), President Emeritus, Mental Health America of Los Angeles

Stacie Hiramoto, Racial and Ethnic Mental Health Disparities Coalition

Stacy Starr, LCSW, Mental Health Program Coordinator, Sacramento County Adult Mental Health Services

Steve Leoni, Client Advocate

Tara Yaralian, Mental Health Clinical Program Head, Underrepresented Ethnic Populations, Planning Division, Los Angeles County Department of Mental Health

COMMUNITY DEFINED PRACTICES
COMMITTEE MEMBERS
(LISTED IN ORDER OF FIRST NAME)

Arden Carr, LMFT, Clinical Site Supervisor, Siskiyou County Human Services Agency, Behavioral Health Division

Autumn Valerio, formerly Staff Mental Health Specialist, Office of Multicultural Services, California Department of Mental Health; presently Program Coordinator, Center for Multicultural Development, CiMH

Clayton Chau, Associate Medical Director, Center of Excellence in Education, Training, Research, and Advocacy for Reducing Health Disparities, Orange County Health Care Agency, Behavioral Health Services

Debbie Innes-Gomberg, PhD, Licensed Psychologist; District Chief, MHSA Implementation and Outcomes Division, Los Angeles County Department of Mental Health

Delphine Brody, Client Advocate

Doretha Williams-Flournoy, MS, Deputy Director of CiMH; Center for Community Capacity Improvement, Center for Multicultural Development
Gigi Crowder, Ethnic Services Manager, Behavioral Health Care Services, Oakland

Gladys Lee, District Chief, Planning Division and Ethnic Services Manager, Los Angeles County Department of Mental Health

Jennifer Clancy, MSW, Senior Associate, CiMH

JoAnn Johnson, LCSW, Cultural Competence and Ethnic Services Manager; Research, Evaluation and Program Outcomes Manager; and Workforce, Education and Training Manager, Sacramento County Department of Health and Human Services, Division of Behavioral Health Services

Katherine Elliott, PhD, MHP, CiMH consultant

Kimberly Knifong, MBA, Department of Mental Health, Office of Multicultural Services, Sacramento

Poshi Mikalson, MSW, LGBTQ Mental Health Project Manager, Mental Health America of Northern California

Rocco Cheng, PhD, Corporate Director of Prevention and Early Intervention Services, Pacific Clinics, Irwindale

Stacie Hiramoto, Racial and Ethnic Mental Health Disparities Coalition

Steve Leone, Client Advocate

Veronica Kelley, LCSW, Deputy Director of Regional Operations and AOD Services and Cultural Competency Officer, Santa Barbara County

Vicki Smith, MSW, CPRP, Deputy Director, Systems of Care, Workforce and Infrastructure, CiMH, retired.

Community Defined Programs: Contributors

Albert G. Titman Sr. CADC II, Behavioral Health Program Manager, Sacramento Native American Health Center Inc.

Angie Denisse Otiniano, Mental Health Program, Latino Health Access

Audrey Rozeboom, MA, CT, Sr Mental Health Counselor/Supervisor, Asian Pacific Community Counseling, Transcultural Wellness Center

Britta Guerrero, Chief Executive Officer, Sacramento Native American Health Center, Inc.

Francisca Leal, Mental Health/Peso Saludable, Program Director, Latino Health Access

Hendry Ton, MD, MS, Medical Director, Transcultural Wellness Center, Associate Clinical Professor, UC Davis Health System

Simon Wai, M.Div. Program Director, Asian Pacific Family Center - East

T. Tomas Alvarez III, M.S.W., Founder & Executive Director, Beats, Rhymes and Life, Inc.
Acknowledgements (cont’d)

PROJECT LEAD

Cathy Bankson, MS, Senior Associate, CiMH

PRINCIPAL TOOL KIT WRITER

Debbie Innes-Gomberg, PhD, Clinical PsychologistDistrict Chief, MHSA Implementation Unit, Los Angeles County Department of Mental Health and CiMH Consultant

CULTURAL RELEVANCE WRITER

Katherine Elliott, PhD, MPH, CiMH Consultant

TECHNICAL WRITER

Cathy Bankson, MS, Senior Associate, CiMH

COVER DESIGN

Mary Ushana Williams, MBA

COVER ARTWORK

Art has always been wonderfully creative and therapeutic according to James M. Chapman III. All his life, as he has drawn and painted, it would take him away from his trials and tribulations. His soul has been filled with joy as his mental health has been blessed.

California Institute for Mental Health
2125 19th Street, 2nd Floor
Sacramento, CA 95818
Terminology

We appreciate that no one term may fit the same situation. The writers also realize that one term does not convey the same meaning across all age groups. However, to facilitate the writing of this project, selection of only one expression for certain concepts became necessary. We thank the committee members who, for the sake of clarity, helped guide us through this process.

For example, we designated the term “client” as the universal identifier for an individual with lived experience, even though we acknowledge that the term “consumer” or “person” may be more common in some areas or in some groups. Exceptions to this selected term may be found throughout the text if written within a direct quotation.

Configuration of health and mental health services with sensitivity to the needs of multicultural communities has been variously termed “cultural competence,” “cultural responsiveness,” and “cultural relevance.” This portion of the FSP Tool Kit series is titled “Cultural Relevance” to reflect the intent and spirit of our approach. Specifically, we hope that the tools in this document will assist county programs and providers in offering the best possible care to minority
Terminology (cont’d)

clients – care that reflects the values and beliefs of the culturally rich and diverse communities that form the fabric of the state of California, care that is culturally relevant. Although the term “cultural relevance” is used most frequently in this document, it is used interchangeably with “cultural competence” and “cultural responsiveness.”
Introduction

This Full Service Partnership Cultural Relevance Tool Kit was created as part of a series of documents designed to provide training and technical assistance to counties implementing full service partnership programs. The first component in the series, the FSP Philosophies and Practices Tool Kit, offers practical guidelines for implementation of FSP programs with particular attention to promoting practices that embody the guiding principles of the Mental Health Services Act (MHSA). The current Tool Kit expands on that foundation by focusing on the principle of cultural relevance espoused in the MHSA essential elements. This Tool Kit presents guidelines and practical tools to assist counties and providers in improving the quality of and access to care for unserved, underserved, and inappropriately served ethnic and cultural groups.

The Cultural Relevance Tool Kit is meant to be used in conjunction with the Philosophy and Practices Tool Kit for a particular age group.
Background
California continues to lead the nation in ethnic and cultural diversity, with approximately 57% of the population identifying as ethnic minorities. Of the minority population, 37% are Hispanic or Latino (any race); 13% Asian; 6.2% African American; 1% Native American; 4.9% multiracial; and 0.4% Native Hawaiian or Pacific Islander.\(^1\) Given the demographics of this state, mental health providers and mental health organizations must be prepared to meet the needs of dynamic, culturally rich, and diverse client communities.

Disparities in Mental Health and Mental Health Services

Ethnic minorities constitute a significant portion of the population in need of services, yet receive fewer mental health services and poorer quality care\(^2\) than other population segments. California estimates for 2007–2008 indicate that the widest disparity in access to care existed for Hispanics and Latinos; the prevalence of severe mental illness for the Hispanic and Latino population was estimated at 560,000 individuals, but only 150,000 received mental health services (a discrepancy of approximately -73%). Discrepancies also existed for Native Americans (-59%), Asians (-51%), non-Latino Whites (-26%), and African Americans (-13%).

Disparities in quality of care are more difficult to document; however, research suggests that ethnic minorities are less likely to receive evidence-based treatments;\(^3\) more likely to receive services in restrictive and punitive settings (such as inpatient psychiatric institutions, child welfare departments, and criminal

justice settings;⁴ and are exposed to institutional and provider racism and discrimination.⁵

These disparities in type of care provided explain to some degree the disproportionate use of mental health services by African Americans; although penetration rates indicate that this group is served more than others, African Americans obtain much of their care through involuntary services (as inpatients) or involvement in child welfare services and criminal justice.⁶ This research on quality of care does not take into account grassroots efforts to counteract these disparities through culturally relevant approaches to mental health care for communities of color. However, with minimal financial and infrastructure support, these grassroots activities are hampered in their ability to counteract deficits in the mainstream mental health system and, consequently, disparities persist. The emergence of interest in community-defined practices represents an effort to recognize and empower local, community-driven programs that respond to disparities in access and quality of care.

**Organization of the Tool Kit**

This Tool Kit presents guidelines, practical suggestions, and approaches to improving quality of care and access to care for multicultural communities.

Cultural competence is defined as the “ability of systems to provide care to patients with diverse values, beliefs, and behaviors, including tailoring delivery to meet patients’ social, cultural, and linguistic needs”⁷ and involves competence or abilities in three areas: 1) multicultural knowledge, 2) awareness, and 3) skills. The first, multicultural knowledge, suggests that providers should have specific knowledge about the demographic makeup, history, traditions, customs, values and beliefs, and language of the cultures of the groups they serve. Second,

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providers should be aware of their own cultural heritage; the ways in which their cultural values, practices, beliefs, and worldview differ from those of others; their biases and assumptions; and the ways in which their worldview affects the clinical encounter. Finally, providers must possess a range of therapeutic and communication skills to be flexible and to be able to alter the therapeutic approach based on cultural differences.

The California Brief Multicultural Competence Scale (CBMCS) is based on cultural competence theory and expands the tripartite model of cultural competence to include the following domains: 1) multicultural knowledge, 2) awareness of cultural barriers, 3) sensitivity and responsiveness to consumers, and 4) sociocultural diversities. These categories are linked to specific training topics in the CBMCS curriculum. The first three categories resemble and expand upon the original tripartite model. The fourth category focuses on the interaction of membership in various marginalized groups, including lesbian, gay, bisexual, transgender, queer and questioning (LGBTQ), veterans, and persons with physical disabilities.

The FSP Cultural Relevance Tool Kit emphasizes an applied approach to a specific area of service provision: full service partnerships. This emphasis on the application of theory is evident in the inclusion of a wide variety of “implementation strategies” for each tool. Because of this functional emphasis, an organizing framework based on both cultural competence theory and the CBMCS structure culminated in five categories, including one focusing on specific mental health programs and practices for ethnic and cultural minorities.

Accordingly, borrowing from both the cultural competence literature and the CBMCS, the organizing framework for the FSP Cultural Relevance Tool Kit includes the following domains:

- Domain #1: Multicultural Knowledge
- Domain #2: Cultural Barriers to Care
- Domain #3: Cultural Self-Awareness
- Domain #4: Sociocultural Diversities
- Domain #5: Specific Practices
The CBMCS domains that focus on four major ethnic groups – African American, Asian/Pacific Islander, Latino, and Native American – form the structural basis for this Tool Kit. Because this Tool Kit was written with inclusiveness in mind, many of its components are applicable to ethnic and cultural populations in addition to these four groups.

This Tool Kit is based upon three major resources:

1. FSP Advisory Committee recommendations in conjunction with subcommittees associated with each age group and community-defined practices.
2. Cultural competence theory, scholarly studies, and research literature.
Domain #1

Multicultural Knowledge

The Multicultural Knowledge domain contains tools to build understanding of the culture of groups and individuals served. It encourages knowledge of: (1) specific ethnic and cultural groups, their worldview, language, cultural norms, values, attitudes, beliefs, and behaviors; (2) clients’ ethnic and cultural identification, the extent to which clients share the views of their community, and how individuals within a community may differ; and (3) social, historical, and political forces that influence a specific ethnic or cultural group, such as racism, discrimination, exposure to war, immigration trauma, and historical oppression.
Developing Knowledge of Populations Served: History and Culture

Purpose

To assist FSP teams in developing an awareness of the various communities served and an understanding of the culture of these communities.

Definition

County mental health departments typically serve a culturally diverse population. Providers can improve the effectiveness of their services by developing knowledge about populations served, history, and culture. Understanding of the cultural values, traditions, beliefs, behaviors, religion, and worldviews of clients, as well as historical events that are relevant to them, can help optimize interactions with them.
Implementation Strategies

Identifying groups served

- Collect and disseminate detailed information identifying the groups served and the languages spoken. Census data and threshold language data can be a starting point for identifying and gaining understanding of each of the ethnic groups served in a particular county.

- Gather additional important data from cultural brokers, community-based agencies, and faith-based organizations that serve clients. Knowledge of the size and distribution of Hmong, Russian, Palestinian, Somalian, and other populations that are not reflected in U.S. Census categorization may be crucially important in some counties. By interviewing key cultural leaders and representatives of community-based organizations (CBOs), county service agencies may develop a more comprehensive awareness and understanding of such cultural and ethnic groups.

Developing Knowledge

- Work to gain a basic understanding of the history of the ethnic groups served and the obstacles they face.

- Ask each client for a history of important events in his or her life. Include questions about experiences of racism and discrimination, immigration history and trauma, and stories about relationships between the client’s culture and other relevant cultures.

- Train the staff to research each client’s country of origin. Discuss with the client the tentative understandings gained from Staff’s research, and seek clarification, corrections of misinterpretations, and elaboration.

- Study major events and experiences to which members of the agency’s cultural clientele may have been subjected. Clients and conditions to consider may include:
Implementation Strategies (cont’d)

- African Americans – history of slavery and ongoing racism and discrimination.

- American Indians – loss of land, genocide, elimination of spiritual beliefs supplanted by missionaries' beliefs, and coerced integration.


- Hispanics and Latino Americans – wars independence, American occupation, immigration and corresponding policies, and fear of deportation.

Examine the history of racism in the United States and the different types of racism that clients of different age groups experience. For example, older adults may have been exposed to more overt forms of racism, such as violence, harassment, and hate crimes, while younger clients may experience more subtle and covert racism sometimes described as “racial microaggressions”.

Recognize that individuals from some cultures are more likely than others to suffer from post-traumatic stress disorder due to exposure to war-related violence. Affected cultures include those originating in Southeast Asian countries, Central America, and some African countries. Clients also may undergo immigration trauma resulting from rape, other forms of violence, or exposure to harsh environmental conditions during the immigration journey.
Creating a Cultural Formulation

Purpose

To assist FSP teams in developing a framework for assessing and serving clients and families from different cultural and ethnic backgrounds. This framework will enable a more effective partnership to be established between the team and the client, and will permit application of more effective interventions and supports.

Definition

The DSM-IV-TR provides a comprehensive outline for creating a cultural formulation that consists of the following elements:

Cultural identity of the individual. Understand the perspective of the client and his or her family regarding ethnic and cultural affiliations, and the degree of involvement or affiliation with the client’s culture of origin and the host culture.
Definition (cont’d)

**Cultural explanations of the individual’s illness.** Understand from the perspective of the client and his or her family what they consider the source of the mental illness and how they characterize it.

**Cultural factors related to the psychosocial environment and levels of functioning.** Understand from the perspectives of the client and family members how they view psychosocial stressors and what they regard as support, including social and familial support, and the role of religion or spirituality, if any, in the client’s life.

**Cultural elements of the relationship between the FSP team member(s) and the individual.** Identify differences among the client, family, and FSP team member in culture, ethnicity, language, social status, age, gender, or sexual identity, and assess the impact those differences may have on engagement, relationship development, and treatment.

**Overall cultural assessment for diagnosis and services.** Conduct an overall assessment of how the preceding cultural considerations may affect diagnosis and service delivery.
Implementation Strategies

- Adopt a respectfully curious approach in obtaining the information to create the cultural formulation. Providers should avoid making assumptions and instead should focus on asking questions to elicit information and begin building a relationship.

- Consider consulting with a cultural broker when a significant difference in the culture of the provider and the client exists.

- Acknowledge where cultural differences exist, and discuss the ways in which these differences affect the client’s ability to form a strong working relationship with the provider.

- Create a template or form outlining the elements of the cultural formulation.

- Apply the cultural formulation as the basis for understanding the client from his or her perspective.

- Utilize the cultural formulation in understanding how clients express and explain physical and emotional symptoms of concern.

In conjunction with the completion of the Cultural Formulation as part of the assessment and treatment planning process, consider using Client- or Person-Centered Treatment Planning in which the treatment plan is developed in alignment with client values and goals. Developing an understanding of the client based on how the client views themselves and not based on stereotypes or cultural assumptions about a client’s treatment preferences will enhance the success of treatment. Certain individuals may wish the inclusion of their family or may defer to the expertise of the treatment team to be more prescriptive in treatment planning and goal identification. This is entirely consistent with a Person-Centered Treatment Planning process.
Purpose
To provide information for FSP teams about individual differences within ethnicities and cultures. FSP providers should have an understanding of the wide variation of cultural perspectives within a cultural group and should explore the ways in which clients perceive and relate to both their culture of origin and the dominant culture. Acculturation models and racial and ethnic identity models provide a framework for understanding a client’s relationship to and sense of membership in both the culture of origin and in the dominant culture.

Definition
For many minority individuals, the process of developing a healthy racial or ethnic identity is difficult in a society in which a dominant white culture clearly exists. Understanding diversity within racial and ethnic groups, along with the culture and worldview...
of clients, requires a sense of the ways in which they have developed a racial or ethnic identity and the ways in which they relate to the dominant culture. Racial and ethnic identity models help to elucidate the experiences that individuals have in developing their racial or ethnic identity.

The racial/cultural identity development (R/CID) model indicates that members of minority groups, in the process of establishing their cultural and racial identity relative to the dominant culture, may experience (in no particular order) the following five stages:

**Stage 1** – Initial conformity to the prevailing culture.

**Stage 2** – The beginning of questioning initial conformity through awareness of racism and stigma thus taking pride in one’s own culture and race.

**Stage 3** – Embracing one’s own ethnic and cultural activities and norms while no longer conforming to the dominant culture.

**Stage 4** – Becoming independent of one’s own ethnic and culture by developing one’s own cultural and ethnic identity.

**Stage 5** – Combining one’s ethnicity/culture with that of the prevailing culture while maintaining a separate interest such as advocating on behalf of one’s culture/ethnicity.
Implementation Strategies

- Review the resources throughout the Tool Kit.
- Discuss examples of each stage that staff may have experienced and/or encountered.
- Provide additional resources and/or models as needed.
Acculturation

Purpose

To understand the impact that adjustment to a new culture exerts on clients and families.

Definition

Acculturation refers to the process of cultural change that takes place when an individual from one culture comes into contact with a new culture. Acculturation may involve changes in language spoken, behaviors, customs, and values. It often entails changes in the person’s affiliation to his or her culture of origin, as well as adoption or rejection of elements of the new culture. Research has suggested that people who are able to retain a sense of connection to their culture of origin while adopting elements of the new culture (a bicultural orientation) tend to have better outcomes.
Implementation Strategies

- Assess the level of acculturation of the client, child, and family. While the level of English language acquisition often is used as a proxy measure for acculturation, a more accurate picture of a person’s acculturation status may be obtained by using an acculturation questionnaire.

- Be aware that the level of acculturation of the client and family members may affect their understanding of mental illness and its causes, their willingness to seek services and disclose information about emotional problems, their interest in seeking alternative and complementary treatments, and their understanding and acceptance of psychotherapy and psychiatric interventions. Be respectful of differences in acculturation as well as alternative views of mental illness and treatment.

- Gather information about the client’s culture of origin and the ways in which the client’s family and community traditionally respond to mental illness. Explore the current views of the client and family regarding mental illness.

- Assess the social environment of the client and family. Do they engage with other people who have similar cultural views and experiences?

- Support development of positive ethnic identity. This may entail helping clients explore their sense of self, their family history, their relationships with their parents and/or their children and grandchildren, and their values and beliefs.

- Recognize that the process of acculturation may be a significant source of stress. Stressors related to acculturation may include loss of one’s community and social network; changes in socioeconomic status and resulting financial stress; loss of structure and activity in daily life; and loss of meaningful social roles (Miller, 1999). Support clients and/or families in managing this stress by assisting them in identifying coping strategies.
These strategies may be as simple as learning to ride the bus or using an automated teller machine, or as complicated as understanding the changes in cultural values that create conflict within families as family members acculturate differently.

- Assess for acculturation conflicts within families. For example, in many families children adopt a new language as well as new cultural values, beliefs, and behaviors more quickly than their parents do. The resulting cultural differences between parents and children can be a source of stress and conflict. Similarly, in many families – particularly immigrant and refugee families – older adults who live with extended family members may have different levels of acculturation, which may cause conflict. Working with these clients entails being sensitive to these cultural conflicts and assisting family members in communicating and accepting each other’s values and beliefs.

- Recognize that differences in family members’ acculturation levels may result in disagreement regarding treatment strategies and goals. Be prepared to manage this conflict in a respectful and collaborative manner that takes into account cultural roles and expectations.
Purpose

To help FSP teams recognize the impact of social conditions on clients and/or families, and to integrate strategies to address social concerns in treatment planning.

Definition

The conditions in which people live and work, including poverty, unemployment, neighborhood violence, racism, and discrimination, are among the social determinants of mental health. These indicators of socioeconomic status have an immense impact on mental health. Ethnic minority communities in the U.S. have greater exposure than mainstream populations to adverse social conditions; they are more likely to be poor, to experience inequities in employment opportunities, to be exposed to violence, to experience poor health and health-care access, and to be the victims of racism and discrimination.
For many mental health clients, these conditions play a critical role in the development and course of psychiatric illness as well as responsiveness to treatment. Mental health providers can deliver effective treatment for such clients only after becoming aware of the extent to which these factors contribute to clients’ mental illness, and take appropriately responsive actions. Fortunately, the “whatever it takes” philosophy central to FSP programs provides mechanisms for responding to these conditions.
Implementation Strategies

- Assess the social and economic environment of the client and/or family, and explore the implications of these social conditions for the family and for the client’s recovery.
  - What is the level of financial stability of the client and the family?
  - Is the client or caregiver unemployed and if so, is this a source of stress?
  - Are the client and family exposed to adverse neighborhood conditions such as violence, prostitution, delinquency, or drug use and selling, and if so, what is the impact of this exposure?
  - Do the client and family have access to parks, grocery stores, playgrounds, libraries, medical treatment, transportation and other resources?

- Explore the impact of poverty, if present, on the client and/or family. In addition to the stress of financial instability, poverty may cause isolation, exclusion, stigma, and shame.
  - Do the client and family have sources of social support – friends and extended family?
  - Do the client and family feel involved in and part of the community?
  - How do the client and family cope with poverty?

- Scrutinize the impact of racism and discrimination on the client’s mental health and well-being, and incorporate strategies in the treatment plan to confront their effects. Experiences of racism and discrimination may influence the client’s mental health directly (e.g., through direct acts of violence and by causing fear, anxiety, stress, feelings of isolation, and anger) as well as indirectly (e.g., by limiting the client’s ability to access resources).
Implementation Strategies (cont’d)

- Establish a safe environment in which care providers, clients, and families can discuss social conditions. Acknowledge the influence of these social conditions in mental illness, and recognize that clients and family members may be uncomfortable talking about matters that pertain to social inequities and racism. Some clients may respond most favorably to care providers of the same ethnic and/or cultural background.

- Broaden discussions of interventions to include strategies to deal with poverty, violence, and racism. Discuss ways in which the client could feel safer and more connected to the community.

- Recognize the role of providers as advocates and partners, and engage in activities to promote improved social conditions for clients. Doing so may include assisting in local activities to improve neighborhood conditions, and educating the staff about inequities in social conditions that affect local communities.

- Initiate emergency and temporary financial resources when possible and appropriate. FSP programs allow flexible expenditure of funds in a broad array of service activities, including those that can respond to inadequacies in housing, employment, access to health care, or other unfavorable social conditions.

- Connect clients with employment assistance agencies, legal aid, refugee services, and other community agencies that can help resolve social and economic problems. Ensure follow-through by assisting clients in navigating other systems.

- Ensure that the staff has easily accessible up-to-date information regarding local resources and social service agencies. Schedule monthly “field trips” to local service agencies as a means of encouraging staff members to establish connections with them.
Implementation Strategies (cont’d)

- Co-locate mental health programs, whenever possible, with health or social service agencies, and coordinate care across social service sectors.

- Develop scattered site housing options in safe, yet affordable areas to avoid creating highly concentrated housing in unsafe areas where illegal activities may be prominent.

- Consider how the experiences of clients with serious mental illness – including psychiatric hospitalization, incarceration, and homelessness – affect the team’s engagement strategies, cultural formulation, and service planning.

- Recognize that field-based services and subsidized transportation are essential for clients at or below the poverty level.
Using Complementary and Alternative Treatments

Purpose

To understand the role of complementary and alternative healing practices in response to mental health problems in ethnic and cultural minority communities. To assist FSP teams in working effectively with clients who rely on or are interested in alternative healing practices.

Definition

*Use of complementary and alternative treatments* encompasses practices, interventions, and services that are not part of the conventional health or mental health system. While some of these treatments such as nutritional supplements, meditation, and prayer are common across groups, some are tied to specific spiritual beliefs. For example, Native American sweat lodge ceremonies, Hmong shaman practices, and Mexican curanderismo incorporate spiritual practices. Complementary and alternative practices may be performed by shamans, sobadores, curanderos, and spiritual leaders of various faiths.
Implementation Strategies

- Build staff capacity to work effectively with clients who utilize alternative treatment practices by:
  - Working with cultural brokers and community leaders to identify and connect with local providers of alternative treatments.
  - Building relationships with alternative treatment providers based on mutual respect and collaboration.
  - Increasing staff awareness and understanding of complementary and alternative practices by sponsoring workshops and by offering other opportunities to learn about practices and connect with local providers.

- Work with clients in:
  - Exploring the role of alternative and complementary practices with them and with families.
  - Ensuring that the treatment team is well informed regarding the rationale, process, and potential outcomes of the particular treatment in order to integrate a treatment plan with a specific complementary or alternative practice that a client and family requests.
  - Collaborating with alternative treatment providers to ensure coordination of care, and avoid conflicting approaches to treatment by sensitively and respectfully exploring the possibility of merging traditional Western medical treatments with alternative treatments that the client practices.

- Build capacity within communities to enable complementary and alternative treatment providers to become part of provider networks utilized by FSP programs. The process may include fostering relationships between community providers and organizations with supportive...
Implementation Strategies (cont’d)

infrastructure, and conducting workshops to teach community providers how to build relationships with county agencies, facilitate knowledge exchange, and assist alternative care practitioners in navigating county system requirements.
The Role of Biological or Client-Identified Immediate and Extended Family

Purpose
To understand the diverse roles of family members and the different types of family structures across cultural groups, and to integrate this understanding into treatment implementation and planning.

Definition
*The role of biological or client-identified immediate and extended family* is pivotal in providing services to the client and/or family. Diversity in cultural norms and values often is most evident in the way family members relate to one another. Families across cultures differ in their ways of communicating, in family hierarchies and power structures, gender and parent/child roles, and collective versus individualistic orientation. Furthermore, cultural differences may arise within families as children often adjust to new cultures faster than their parents. To conduct services effectively, providers should gain knowledge and understanding about the normative family patterns in communities served, as well as the cultural norms within the client’s family.
Implementation Strategies

- Be aware that people outside the nuclear family may be considered extended family members and given influence in the decisions. These may include extended relatives, members of a faith community, fictive kin, or others.

- Consult with a cultural broker or expert to gain an understanding of different expectations across cultures. Cultural brokers may offer insight into the traditional ways in which family members communicate, how parents discipline their children, how families divide work responsibilities, and the expectations for men, women, and children within the family.

- Involve specific family members in the initial assessment, service planning, and ongoing services if the client signs a release of information to communicate with them. Family can be an excellent source of information for completion of a Partnership Assessment Form (PAF).

- Remember that assessment of the client without the presence of family members often is important. However, doing so may feel uncomfortable or inappropriate among some cultures. Work with the family and client to develop a plan for assessment that ensures that clinical goals are achieved while respecting the family’s cultural expectations.

- Gain better understanding of the relationships within the client’s family by asking the following questions:
  - Whom does the client consider family members?
  - With what level of family participation, if any, is the client comfortable?
  - Does the client live with family? If so, is that the client’s preference?
  - Who acts as a source of support for the client?
  - Does the client wish for a different relationship with his or her family?
Implementation Strategies (cont’d)

■ Develop an understanding of the client’s and family’s expectations for service, including how family members view mental illness and what they consider acceptable treatment goals.

■ Be aware that in some cultures, stigma may play a significant role in family members’ response to mental illness. Some families may seek to hide the problem, or isolate the individual with mental illness. Through psychoeducation, supports, and validation, assist families in coping with feelings and stigma regarding the mental illness.

■ Consider involving multiple family groups as resources, particularly for families from similar ethnic or cultural backgrounds. These groups can serve to educate and support family members, and families can act as supporters for each other.
Recognizing Cultural Strengths and Protective Factors

**Purpose**

To assist providers in identifying, recognizing, and incorporating cultural strengths and assets into assessment and treatment planning.

**Definition**

*Recognizing cultural strengths and protective factors* within specific ethnic and cultural populations includes cultural values, behaviors, practices, and beliefs that buffer individuals from stress and foster resiliency. These factors include positive ethnic identity, strong and positive relationships with family, and cultural traditions and ceremonies.
Implementation Strategies

■ Conduct an assessment of the client’s protective factors as part of the cultural formulation and overall assessment. Explore community, family, and individual factors that contribute to resilience.

■ Remember cultural protective factors may include:
  - Values such as filial piety and collectivism (common in Asian communities) or a strong sense of family support and family obligations (common in Latino communities).
  - Traditional ceremonies and rituals such as the spiritual healing practices used in the Hmong community or the traditional sweat lodge used in Native American communities.
  - Positive ethnic and cultural identity.
  - Community assets such as ethnic pride programs, community cultural centers, media resources, LGBTQ organizations, and cultural fairs and events — e.g., Hmong radio or Univision TV. (Refer to the Domain #2 tool titled “Building on Community Assets.”)

■ Choose interventions, in partnership with the client, that promote specific protective factors such as enhancing family connection and support, and engaging in activities that strengthen the client’s connection to his or her cultural heritage. (Refer to the Domain #1 tool titled “The Role of Biological or Client-Identified Immediate and Extended Family.”)

■ Assist clients who wish to increase their religious affiliation; offer to help them access local spiritual or religious organizations or support groups. (Refer to the Domain #4 tool titled “Spirituality and Religion.”)

■ Explore the client’s cultural worldview.
Implementation Strategies (cont’d)

- In what ways does the client affiliate with his or her culture of origin?
- In what ways does the client affiliate with the dominant culture?
- Support the client in examining his or her cultural identity and resolving cultural conflicts.

- Explore sexual identities with LGBTQ clients, and the intersection of ethnic, racial, and sexual identities.
Organizational Elements of Cultural Competence

Purpose

To assist FSP programs in improving cultural competence by addressing organizational elements critical to providing effective cross-cultural care.

Definition

Consideration of the organizational elements of cultural competence encompasses valuing diversity; engaging in a cultural self-assessment; paying close attention to and managing the dynamics of cultural differences; creating an institutional cultural knowledge; and creating alignment between diversity policies, organizational structure, organizational values, and services.\(^8\)

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Implementation Strategies

For Counties

- Use the cultural competency plan as a roadmap for implementing culturally competent and relevant services, recruiting a diverse workforce, and creating a countywide plan for reducing ethnic and cultural disparities.

For Provider Organizations

- Use the county’s cultural competency plan as a foundation for an agency-specific plan to create culturally competent and relevant services; to recruit a diverse workforce; and to enact a plan, in conjunction with the county, to reduce ethnic and cultural disparities in the regions served by the agency.
Purpose

To understand the cultural expression of emotional reactions that are specific to certain cultures and ethnicities, and to avoid misdiagnosing a set of behaviors that may have an alternative cultural explanation.

Definition

*Understanding and treating culture-bound syndromes* requires recognition of “recurrent, locality-specific patterns of aberrant behavior and troubling experience that may or may not be linked to a particular DSM-IV diagnostic category.”

Examples of such syndromes include:

*“Amok* – a dissociative episode, occurring with males, characterized by a period of depressed affect followed

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by an outburst of violent or aggressive behavior. These episodes tend to be precipitated by perceived insults or slights and are accompanied by feelings of persecution, amnesia, and exhaustion. Incidents have been reported in Malaysia, Laos, the Philippines, Polynesia, Papua New Guinea, and Puerto Rico, and among the Navajo population.

**Ataque de nervios** – a feeling of being out of control, manifested by shouting, periods of crying and trembling, heat in the chest that rises to the head, and verbal or physical aggression. Such feelings may be accompanied by dissociative experiences, episodes of fainting or feeling as though one is having a seizure, and suicidal gestures. Incidents have been reported among Latinos from the Caribbean, Latin American, and Latin Mediterranean groups.

**Billis and colera** – extreme anger manifesting itself in Latinos as acute nervous tension, headache, trembling, screaming, and stomach disturbance, and in severe cases, loss of consciousness. Chronic fatigue may result.

**Bouffee delirante** – resembling a brief psychotic disorder, a sudden outburst of agitation, aggression, confusion, and psychomotor excitement, sometimes accompanied by visual or auditory hallucinations or paranoid ideation. Incidents have been reported in West Africa and Haiti.”

Implementation Strategies

- Consider or rule out culture-bound syndromes as a possible explanation for behaviors noted from clients of indigenous cultures and where symptoms remit in the manner consistent with specific syndromes.
- Consult with people who have expertise in these syndromes when a client may be experiencing a culture-bound syndrome.
- Ask the client how his or her culture or ethnicity explains the symptoms that are being experienced.
Each of the tools listed below has specific resources that you can locate in the general resource section on pages 52-54. This guide enables you to focus on the pertinent resources linked directly to each tool.

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✔ Articles


✔ Assessment

5. Multicultural test titles (acculturation and ethnic identity measures) on the Antioch University Multicultural Center website: http://www.multiculturalcenter.org/test/

✔ Books


✔ Curriculum

Report


Websites

Cultural Barriers to Care

According to the President’s New Freedom Commission report on Mental Health, “in a transformed mental health system, all Americans will share equally in the best available services and outcomes, regardless of race, gender, ethnicity, or geographic location.” However, minority communities continue to experience disparities in access to and quality of care. Mental health providers across the state must continue in efforts to engage communities of color. The purpose of this domain is to identify and resolve barriers that impede services for clients from diverse cultural and ethnic backgrounds.
Establishing Successful Outreach and Engagement for Specific Unserved and Underserved Cultural and Ethnic Populations Within a Community

Purpose
To address ethnic and cultural disparities, FSP programs should implement outreach and engagement strategies that are culturally relevant and target underserved communities.

Definition
The concept of outreach and engagement, as codified by the California Department of Mental Health, and defined by MHSA Regulations in the California Code of Regulations (CCR), Section 3640, means to “reach, identify and engage unserved individuals and communities in the mental health system and reduce disparities identified by the county.”

Using the State’s definition as a starting point, FSP programs must engage in establishing successful outreach and engagement for specific underserved and underserved cultural and ethnic populations.
within a community. Operationally, engagement involves establishing a trusting relationship and is a critical component of the outreach process.

Further, Erickson and Page describe outreach and engagement as a dance, in the sense that each step in the outreach and engagement process is contingent upon the client’s response to the previous set of actions.

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Implementation Strategies

- Identify ethnic and cultural groups that are historically underserved within specific communities. Work with community leaders from these groups to develop strategies for rectifying barriers to access.

- Select staff members who have constructive relationships with specific ethnic and cultural communities and have bilingual capabilities that enable them to work with groups with limited English proficiency.

- Remember that mentally ill individuals who are homeless require a specialized type of outreach and engagement that requires sensitivity to the culture of living on the street. Staff who have lived experience of homelessness often are very effective at homeless outreach and engagement.

- Use an approach that is responsive to cultural differences. Understand the ways in which culture may affect an individual’s willingness to seek help, attitudes about his or her illness, and attitudes toward treatment.

- Be aware that some individuals may decline to access services due either to fear of disclosing their identities or to lack of trust in government services. For example, many undocumented clients may fear risk of deportation if they access services. LGBTQ clients may face violence and harassment if their sexual identity is discovered. Individuals from rural communities may fear the stigma associated with seeking services. Take steps to maximize client safety and confidentiality.

- Identify and build relationships with existing community resources such as faith-based organizations, community based agencies that have established relationships with target communities, and traditional or spiritual healers.

- Use motivational interviewing strategies, including adopting an informal demeanor, to build rapport and elicit behavior change by helping clients to explore and resolve ambivalence.  

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Implementation Strategies (cont’d)

■ Understand the cultural and belief system of each client. For example, homeless people often feel much safer and in control on the streets than they do in a shelter or in housing.

■ Be aware of local activities of U.S. Citizenship and Immigration Services and the ways in which these activities influence Latino service utilization. Clients who are undocumented may be reluctant to seek services for fear of being detected by Immigration Services. Dedicate time in FSP team meetings to explore failed engagements.

■ Actively create opportunities for staff and team self-reflection.
Incorporating Key Cultural Elements in Service

Purpose

Clients will be more likely to seek services and to stay in treatment if the environment in which services are provided is culturally congruent and incorporates cultural elements into interventions.

Definition

By *incorporating key cultural elements into services*, providers may enhance the client’s engagement in treatment, the therapeutic alliance with the provider, and ultimately the outcome of their treatment. Effectiveness is enhanced by identifying and incorporating activities that are relevant to specific ethnic and cultural groups.
Implementation Strategies

■ Integrate ethnic-specific foods into engagement processes, services, and activities, such as client picnics and outings, when appropriate and preferred by clients.

■ Incorporate culturally relevant activities. Ensure that culture-specific activities reflect the preferences of the communities served. To avoid making inaccurate assumptions about the community’s preferences in cultural activities, consider choosing a provider from within the community to take the lead or to contract with experts in these types of activities. The selection of activities should be governed by community, family, or client preferences. Culturally relevant activities may include:
  ➢ Tai chi.
  ➢ Placticas or informal conversations.
  ➢ Weaving, beading, or common cultural crafts.
  ➢ Cooking traditional foods.
  ➢ Gardening.
  ➢ Cultural celebrations such as Día de Los Muertos (Latino) or Chinese New Year.
  ➢ Drumming.
  ➢ Talking circles.
  ➢ Traditional or popular dance (e.g., Mexican ballet folklorico, hip-hop, African dance, Chinese folk dance, or Indian classical dance).

■ Consider using cultural stories or folk tales, images, or symbols in psychotherapy. For example, folk tales have been used effectively in cuento therapy, a culture-specific treatment modality. (These techniques must
Implementation Strategies (cont’d)

be used with caution because an inadequate knowledge of these cultural elements may result in misuse. The provider may consider consulting with a cultural expert or broker regarding the appropriateness of the intervention. In addition, he or she should confer with the client to ascertain the meaning of the story, symbolism or imagery for the client.)

- Furnish ethnic and culturally relevant magazines and videos or audiovisual displays in waiting areas.
Building on Community Assets

Purpose

Improve effectiveness of services by engaging and utilizing existing community assets in treatment.

Definition

Many minority communities have organizations, agencies, and individuals that are known and trusted community resources. By partnering with these entities, leaders, providers, and organizations that have been working successfully in communities and have built trust through years of dedicated service. By building on community assets, providers may enhance client engagement, coordination of care, collaboration with other service providers, and effectiveness of services. Community assets may include schools, clinics, businesses (hair salons, ethnic grocery stores), media (TV, radio, Internet), parks, wellness programs, cultural centers, festivals, community leaders (e.g., mothers or caregivers who are active in the community), faith-based healers, teachers or administrators who come from the community, and elders.
Implementation Strategies

- Conduct an “asset mapping” exercise in which teams identify existing community assets. Asset mapping may involve brainstorming with the team, interviewing cultural brokers or community leaders and community members, or touring geographical areas to identify places where people congregate.

- Build partnerships with churches, temples, and spiritual healers within the communities served by the FSP program. Partnerships should include reciprocal support, education, and outreach.

- Establish a positive presence by becoming partners with the community. Providers should strive to build constructive relationships with their communities by attending community events and cultural celebrations. In addition, providers may consider serving on local committees and governing boards. Mental health providers should strive to receive as much support from the community as is given to the community.

- Build partnerships with primary-care and other local health clinics that are often the point of entry for ethnic community members who are experiencing serious mental illness. Individuals from ethnic communities often are more willing to identify health concerns than to reveal mental health explanations.

- Conduct outreach and education in community organizations where ethnic minority families are likely to congregate.

- Support local mental health organizations and other family support groups that regularly offer education on the signs and symptoms of mental illness and local resources available within specific ethnic and cultural communities.

- Be aware of and responsive to differing cultural attitudes regarding the disclosure of mental illness in public settings.

- Incorporate influential community members in service planning, based on client preferences and with documented authorizations from clients, including client-identified spiritual leaders and non-traditional healers.
Field-Based Services

Purpose
To provide services in a client’s natural community environment rather than in an agency’s office in order to improve the likelihood of engagement and reduce stigma.

Definition
Field-based services are performed in a client’s natural environment — in their home, at a park, in a coffee shop, or some other community location or facility that the client prefers.
Implementation Strategies

- Provide services in the location of the client’s preference.
- Respond to any safety concerns related to specific locations, utilize the daily team meeting to assess potential safety threats, and dispatch one or more team members to perform services in a secure location.
- Consider involving one or more individuals from the client’s support system in services, where appropriate and when the client consents.
- Avoid driving in vehicles bearing county logos when visiting clients and/or family members who may be uncomfortable about the visibility of an FSP team that signals county intervention.
- Consider co-locating services in primary-care clinics and other facilities that individuals from specific ethnic and/or cultural groups are likely to visit.
Establishing Funding for FSP Clients Who Are Unable to Obtain Payor Source

Purpose

To fund services for clients from specific ethnic communities who may never procure a payor source on their own and would otherwise remain unserved.

Definition

As part of the budget allocation process, agencies should establish funding for FSP clients who are unable to obtain a payor source. Funds dedicated to serve clients who lack a payor source should not be used to match to Medi-Cal, or nor for any purposes other than to serve clients without a payor source. Allocation of such funding can enhance the FSP’s ability to engage and serve clients.
Implementation Strategies

- Dedicate a certain percentage of FSP programmatic funding that cannot be matched to Medi-Cal and that can be used only for services for clients who lack a payor source.

- Pursue grants to obtain funds to serve clients who are unable to obtain funding for their services.

- Identify any funds that family members can contribute to assist in funding services for clients who have given their consent allowing FSP representatives to speak with family members.
Reducing Stigma Associated With Seeking Mental Health Service

Purpose

To understand and address the role that stigma plays in mental illness among ethnic and cultural minority groups.

Definition

Stigma in mental health refers to unfavorable perceptions about people who have mental health problems. Stigma may include perceptions that people with mental illnesses are undesirable, dangerous, or should be avoided or feared. *Reducing stigma associated with seeking mental health service* can encourage potential clients who might be reluctant to obtain help they need. Stigma manifests differently across cultural groups. Understanding the nature and degree of stigma common within ethnic and cultural minority communities enables providers to engage clients more effectively and to help clients and families cope with their own feelings regarding the mental illness, as well as the response of others in their community.
Implementation Strategies

At the Community Level

■ Consult with cultural brokers and community leaders to gain an understanding of community perspectives on mental illness and culture-specific manifestations of stigma.

■ Address stigma for specific cultural groups using targeted programming in minority-language media — radio, TV, Internet, and through community-based organizations.

■ Be aware that many ethnic and cultural minority groups have a history of oppression by government agencies and mental health organizations, which may affect clients’ and families’ willingness to trust these entities.

■ Make use of culture-specific resources for addressing stigma, including:
  - the National Institute of Mental Health’s (NIMH’s) “Real Men. Real Depression” campaign, which provides information and resources for Latino men with depression.
  - the National Alliance on Mental Illness’s (NAMI’s) Multicultural Action Center, which provides fact sheets, manuals, and other resources for Latino, African American, Asian/Pacific Islander, Native American/American Indian, and lesbian, gay, bisexual, transgender, queer, and questioning communities.
  - the Substance Abuse and Mental Health Services Administration’s (SAMHSA’s) “Campaign for Social Inclusion,” which contains resources on mental health for African American, Latino, Chinese American, and Native American communities.

■ Foster an understanding that mental health services contribute to a community’s collective well-being. This can be done through mass media cam-
Implementation Strategies (cont’d)

- Campaigns, community exposure to those who have recovered from mental illness, and publicizing the positive outcomes achieved through mental health intervention and community programs.

- Use targeted programming to address stigma in specific ethnic and cultural communities.

- Consider utilizing MHSA Outreach and Engagement funds to create opportunities for community education and anti-stigma campaigns.

- Explore opportunities through prevention and early intervention and MHSA statewide projects focusing on stigma and discrimination to create additional educational opportunities for communities.

- Create opportunities for shared learning and acceptance among clients, family members, and local communities.

At the Provider Level

- Establish peer employment positions and peer-run services to enhance the belief of staff members and clients in recovery from mental illness.

- Ensure that discussions within team meetings as well as in general are characterized by respect for clients and their experiences.

- Eliminate “staff only” common areas such as bathrooms.

At the Client Level

- Be aware that stigma manifests differently across cultures. Disclosures regarding mental illness may have a variety of detrimental consequences for clients, depending on the views of their family, friends, and community members regarding mental illness. Explore the potential consequences of disclosure when assisting the clients in accessing social support and working with family members.
Implementation Strategies (cont’d)

■ Address stigma in a way that validates the cultural perspectives of clients and families and their desire for confidentiality, while encouraging clients and families to accept and understand mental illness.

■ Recognize that in some cultures mental illness may be so stigmatized that families will prefer to remain isolated rather than seek support from family or friends.

■ Develop an understanding of the client’s self-perceptions regarding his or her illness and the perceptions of close family members, friends, and community members. Explore how these perceptions affect the client’s self-esteem, willingness to remain in treatment and collaborate with care providers, the degree to which the client is able or willing to access social support, and the recovery process.

■ Be aware that interplay between these sources of oppression — including experiences of discrimination based on race or ethnicity, disability, sexual identity, entry into the foster care system, and other stigmatizing experiences — can exacerbate stigma associated with mental illness. Help clients identify and develop strategies for coping with experiences of discrimination.

■ Utilize a strengths-based approach to assessment, service planning, and interventions.
The Role of the Client’s Social Support System

Purpose
To assist clients, particularly those who are socially isolated, in accessing support outside of the mental health system.

Definition
Social supports are ongoing social, nonprofessionally oriented interactions not involving mental health staff that offer encouragement for clients. Many ethnic and cultural minority clients experience social isolation when they leave behind the supportive networks of family, friends, and business relationships they had in their country of origin. Some minority individuals are marginalized because of racism and discrimination. Many LGBTQ clients have experienced rejection by family members, schoolmates, peers or other significant persons in their lives. The role of the client’s social support system is significant; members of some groups may experience difficulty in accessing social support if disconnected from their community due to geographic displacement or the type of historical erosion that has affected members of some Native American communities.
Implementation Strategies

■ Create non-professionally led groups that are coordinated by individuals from the community served, in the primary language of the clients served.

■ Help each client understand the importance of social support and identify social supports in his or her community. At times, that goal may require consulting with cultural brokers to generate ideas about available resources.

■ Consider assisting immigrant clients in contacting family or friends in the country of origin periodically. The use of the Internet, phone, and webcams may help clients feel more connected with social supports in other countries.

■ Recognize that accessing LGBTQ resources may pose a risk to safety for LG-BTQ clients in communities in which they may be subject to violent attacks. Discuss safety threats, and identify strategies for accessing resources while protecting client confidentiality.

■ Help clients explore ways in which they can become involved in cultural programs, events, and groups if they feel disconnected from their own community. When appropriate, consult with elders or community leaders about strategies to strengthen clients’ connections with their culture and heritage.

■ Identify and link clients to community resources and activities such as support groups, recreational programs, cultural activities, spiritual celebrations, and musical festivals that have relevance for their identified ethnicity or culture.
The Role of Religious and Cultural Leaders and Faith Centers

Purpose

To collaborate with faith-based organizations, cultural organizations and cultural leaders that often are central to communities and have a great deal of influence. The assistance of these organizations is critically important in engaging ethnic and cultural minority communities.

Definition

FSPs should recognize the role of religious and cultural leaders and faith centers in identifying and engaging community members who may be affected either directly or indirectly by mental illness. Prospective clients may have affiliations with local clergy, faith leaders, or faith organizations, and those relationships can be constructive in collaborations with mental health services agencies.
Implementation Strategies

- Partner with religious, cultural, and faith leaders within the community to disseminate information to community members about mental illness and mental health resources available.

- Explore the utilization of space for community groups or already existing groups and activities at local faith, religious, and cultural centers, as potential facilities for integration of client services within the community.

- Involve any community members who the client believes may assist him or her in the recovery process and goal attainment. Be sure to obtain documented authorization from the client before initiating any such contact. Involved community participants may include members of the clergy, spiritual leaders, or shamans.
Purpose

To develop trusting relationships between the provider organization and the community(ies) served.

Definition

Social capital refers to the sense that community members have that they are safe and happy within their communities, and to the people and institutions that clients trust within their communities. FSPs should take steps building the social capital and the community trust of the provider organization within the community or communities served, because neighborhoods with higher levels of social capital tend to have lower crime rates and better overall health and mental health.
Implementation Strategies

- Establish a positive presence by becoming partners with the community. Providers should strive to build constructive relationships through attendance and participation in community events and cultural celebrations. In addition, providers may consider serving on local committees and governing boards. A mental health provider should strive to receive as much support from the community as it gives to the community.

- Assist in establishing community “safety nets” for residents and clients.

- Assist in establishing, developing, and supporting community or neighborhood coalitions that are empowered to solve community-level challenges.

- Identify existing official and non-official resources in communities, and make that information widely available and easily accessible.

- Create networking opportunities for existing resource providers to encourage warm hand-off referrals among resources.

- Conduct educational activities for the community about mental illness, including offering resource information and sponsoring a speakers bureau composed of clients, family members, and non-consumers to illustrate inclusion and recovery.

- Collaborate with mental health prevention and early intervention (PEI) programs, as well as analogous programs that non-mental health community-based agencies, faith-based groups, and other organizations conduct.

- Reduce the stigma of mental illness by debunking myths that persons diagnosed with mental illness are violent or unpredictable.

- Establish partnerships between mental health programs and community organizations such as the YMCA, local parks, recreational establishments, gyms, health-care organizations, businesses, community-based organizations, traditional or spiritual healers, and advocacy groups.
Providing Appropriate Language Services

Purpose

To provide guidelines for working with clients who have limited English proficiency.

Definition

*Provision of appropriate language services* entails ensuring that interactions and treatment are conducted whenever possible in the primary language of the client. When providers who speak the client’s primary language are not available, language translators should be engaged to ensure effective communication.
Implementation Strategies

- Recruit and hire staff members who speak languages prevalent in the program’s service area.
- Develop relationships with graduate schools that train ethnically and linguistically diverse students; develop a training program and career ladder that encourages trained students to remain as staff members.
- Create and translate written forms in a level of language that is accessible for persons with little or no formal education. Consider making photo novellas for certain uses, especially health education.
- Train the staff to pay close attention to the vocabulary they use and to match their diction to the client’s educational level. Teach the staff how to assess for level of verbal and written literacy.
- Evaluate the client’s literacy level carefully. When working with members of cultures in which written language is limited, be certain to review written material carefully and at a pace that the client finds comfortable and sufficient for good comprehension.

Working with Language Translators

- Develop a network of trained language translators. Ensure that translators are trained in cultural sensitivity, and discourage them from applying their own interpretations of the content.
- Specify, when possible, use of translators who share the client’s ethnic background and who have mental health training.
- Maintain eye contact with the client and/or family members.
- Speak clearly, in a regular voice, one to two sentences at a time. Allow extra time for translation and for the family to ask questions.
Implementation Strategies (cont’d)

- Use simple language and avoid jargon.
- Set up the room so that the client and family are facing the provider and the linguistic translator.
- Confer with the translator in advance, if possible, to discuss the content of the session and to develop strategy for communication. Some concepts may not have a direct translation. Work with the translator to develop a phrase or explanation that adequately reflects the constructs being conveyed.
- Check in with the client and family to ensure that they feel comfortable with their understanding of the information.
- Avoid the use of family members or friends as translators, and never use children in that role because of the delicacy and complexity of the subject matter.
Purpose

To create alignment and trust between the mental health system and distinct cultural and ethnic communities for purposes of reaching, engaging, and serving clients from those communities. These communities are typically unserved by the mental health community due to stigma, fear, or lack of knowledge on the part of communities.

Definition

Cultural brokering is “the act of bridging, linking or mediating between groups or persons of different cultural backgrounds for the purpose of reducing conflict or producing change.” Using cultural brokers can help in various ways. They may serve as liaisons, cultural guides, mediators or catalysts for change.

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Implementation Strategies

- Build relationships with cultural leaders and community members who have the trust and respect of the community served. When possible, allocate resources for consultation with cultural brokers.

- Consider the role of MHSA Community Services and Support Outreach and Engagement funds to enable county agencies to compensate cultural brokers.

- Consider asking culture brokers to assist in identifying the needs of the underserved or underserved community; to work with the mental health system or provider to create services that meet those needs; and to participate in developing culturally relevant approaches to evaluation.

- Enlist cultural brokers to function in multiple simultaneous roles — as translators, advocates, conflict mediators and liaisons between mental health and members of unserved or underserved communities.
Each of the tools listed below has specific resources that you can locate in the general resource section on pages 85-87. This guide enables you to focus on the pertinent resources linked directly to each tool.

<table>
<thead>
<tr>
<th>Name of Tool</th>
<th>Resource Number(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Establishing Successful Outreach and Engagement for Specific Unserved and</td>
<td>3,5,10,16</td>
</tr>
<tr>
<td>Underserved Cultural and Ethnic Populations Within a Community</td>
<td></td>
</tr>
<tr>
<td>Incorporating Key Cultural Elements Into Services</td>
<td>6,8,13,17,23</td>
</tr>
<tr>
<td>Building on Community Assets</td>
<td>20,24</td>
</tr>
<tr>
<td>Field-Based Services</td>
<td>-</td>
</tr>
<tr>
<td>Establishing Funding for FSP Clients Who Are Unable to Obtain a Payor</td>
<td>-</td>
</tr>
<tr>
<td>Source</td>
<td></td>
</tr>
<tr>
<td>Reducing Stigma Associated With Seeking Mental Health Service</td>
<td>2,12,18,19</td>
</tr>
<tr>
<td>The Role of the Client’s Social Support System</td>
<td>21</td>
</tr>
<tr>
<td>The Role of Religious and Cultural Leaders and Faith Centers</td>
<td>-</td>
</tr>
<tr>
<td>Building the Social Capital and the Community Trust of the Provider</td>
<td>14,22</td>
</tr>
<tr>
<td>Organization Within the Community(ies) Served</td>
<td></td>
</tr>
<tr>
<td>Providing Appropriate Language Services</td>
<td>1,4,7,9,11,20</td>
</tr>
<tr>
<td>Using Cultural Brokers</td>
<td>15</td>
</tr>
</tbody>
</table>
✔ Articles


✔ Books


✔ Report & Research Paper


✔ Strategic Plan


✔ Websites


17. NAMI’s Multicultural Action Center: [http://www.nami.org/Content/NavigationMenu/Find_Support/Multicultural_Support/Resources/MAC_Resources.html](http://www.nami.org/Content/NavigationMenu/Find_Support/Multicultural_Support/Resources/MAC_Resources.html)


20. Relationship Model for Accessing and Assessing Underserved Communities [www.naccho.org/topics/modelpracticesz](http://www.naccho.org/topics/modelpracticesz)


Domain #3

Cultural Self-Awareness

To deliver adequate care in a cross-cultural context, providers must develop an awareness of their own worldviews, culture, beliefs, values, and biases. In addition, providers should consider the ways in which their cultural values and worldviews differ from those of their clients, the ways in which they are similar, and the ways similarities and differences affect the therapeutic relationship. In this domain, important areas for self-awareness are identified with tools and strategies for fostering self-awareness in providers and in FSP team members.
Developing Cultural Self-Awareness or Cultural Humility

Purpose

To help providers understand and address personal biases or ethnic and/or cultural barriers that arise within themselves and that may have an impact on therapeutic effectiveness.

Definition

*Developing cultural self-awareness or cultural humility* is part of becoming a culturally competent provider. Awareness of one’s own cultural values and beliefs and recognition of personal biases and prejudices can help providers to work more effectively with a range of different cultural perspectives and to forge stronger therapeutic alliances with clients.
Implementation Strategies

■ Promote self-awareness in FSP team members through periodic exercises that examine personal cultural identity, cultural assumptions, beliefs, biases, attitudes, and values. Hays\textsuperscript{14} has developed a framework for self-awareness that includes examining one’s identity through recognition of differences across age or generation, disability, spirituality, ethnicity, national origin, indigenous heritage, socioeconomic status, sexual orientation, and gender. (Refer to “Resources” for commonly used self-awareness exercises — e.g., the CBMCS participant handbook by Der-Karabetian et al.)

■ Develop an understanding of White privilege — the unearned advantages that non-Latino Whites enjoy by virtue of the color of their skin. Discuss the ways in which white privilege manifests itself in power dynamics among FSP team members and clients. Consider asking team members to read material such as Peggy McIntosh’s seminal work, White Privilege: Unpacking the Invisible Knapsack,\textsuperscript{15} and discuss it in the context of FSP service provision.

■ Promote awareness of oppression, discrimination, and racism. Develop understanding of the ways in which these social conditions affect clients: their day-to-day experiences, the barriers they face in accessing care, and inequities in access to resources.

■ Explore the ways in which the personal worldviews of staff members interact with those of clients and the ways in which differences in worldview affect the clinical encounter, the therapeutic relationship, diagnosis, goal-setting, treatment, treatment implementation, and adherence.

■ Develop skills of “dynamic sizing” and “scientific-mindedness.”\textsuperscript{16}

Implementation Strategies (cont’d)

- Dynamic sizing allows application of a person’s knowledge of cultural norms within a community in a flexible way — avoiding the pitfall of stereotyping. It involves integrating knowledge about the client’s culture with an awareness of the diversity within this culture. Thus, awareness of cultural differences must be combined with an understanding that not all clients of a particular cultural background will share the values, beliefs, and behaviors common in that culture.

- Scientific-mindedness involves approaching cultural information with curiosity, generating hypotheses, and then testing these hypotheses by questioning clients and/or families and cultural brokers. For example, a practitioner may hypothesize that a Latino client is more likely to want to stay home with extended family than to move out of the home, because that is a common value in Latino culture. Scientific mindedness suggests that the practitioner should test this hypothesis by exploring this idea with the client.

- Use cultural competence tools to allow staff members to examine their own level of cultural knowledge, awareness, and skills, and to facilitate discussions about cultural competence. Two frequently used measures are the Multicultural Counseling Inventory and the California Brief Multicultural Competence Scale (CBMCS), along with the Multicultural Awareness-Knowledge-Skills-Survey (MAKSS). Antioch University’s Multicultural Center also provides a list of multicultural measures. (Refer to “Resources” section for websites and other retrieval information.)

- Incorporate regular discussion of team and individual staff members’ cultural competency strengths and weaknesses into team meetings to promote open and honest analysis of areas of improvement.
Implementation Strategies (cont’d)

- Consider that clients and providers may differ in the way they conceptualize time and the extent to which they are future-oriented vs. present-focused. For clients with predominant orientations to the present, focus on short-term goals that progressively take on a longer-term focus.
Exploring Power Dynamics

Purpose

To understand and address the power dynamics that are inherent in the therapeutic relationship and in the provision of mental health services.

Definition

Inherent in the FSP concept is the idea that a partnership is established between the client and the FSP team. Treatment relationships are characterized, however, by a hierarchy in which the team possesses positional and legitimate authority in relation to the client. Clients and families react accordingly and, at times, may defer to the FSP team. Exploring power dynamics of FSP relationships is important because they may be accentuated when the ethnicities and cultures of FSP team members differ from those of the client, or when the client’s primary contact with the mental health system has been through the child welfare system, criminal justice system, Institutes for Mental Disease (IMD), state hospitals or inpatient psychiatric facilities, or other institutional settings.
Implementation Strategies

■ Discuss, as part of the service planning process, the roles of the FSP team, the client, and the client’s family or support system in developing and achieving goals with the client.

■ Recognize and acknowledge that power differentials are inherent in treatment relationships. When appropriate, discuss the ways in which differences in access to resources and decision making affect the collaborative relationship with the client.

■ Be explicit about the kinds of decisions that the client can make, the decisions that the provider can make, and the decisions that will be shared.

■ Specify the resources that the provider brings to the table and those that the client can access independently.

■ Identify strategies for clients to feel safe within the context of a hierarchical treatment relationship.

■ Explore the client’s view regarding the mental health system as well as previous experiences with social services. That’s important because the overrepresentation of ethnic minorities in child welfare and justice systems induces many minority clients to fear that involvement in mental health services may result in the loss of custody of their children or other undesirable consequences. These fears may heighten the power differential in the therapeutic relationship.
Experiences of Racism and Discrimination

Purpose

To increase FSP team awareness of the impact of racism, discrimination, and oppression on the client’s worldview, and to understand and address provider biases that may affect the treatment relationship and treatment effectiveness.

Definition

*Experiences of racism and discrimination* can exert a profound, enduring effect on physical as well as mental health. Oppression is defined as an act (or acts) of violence that by its nature interferes with a person’s ability to evolve as a complete human being.\(^\text{17}\) Oppression may manifest itself in feelings of being exploited, marginalized, and without power.\(^\text{18}\)


and may result in depression, post-traumatic stress disorder, suicidal ideation, or substance abuse, as well as physical illness.\textsuperscript{19}

Racism is defined as “a complex aggregate of prejudice and discrimination based on an ideology of racial domination and oppression.”\textsuperscript{20} Racism acts as a major stressor and can result in hypertension, cardiovascular reactivity, and physiological arousal, and can weaken an individual’s immune system.\textsuperscript{21}


Implementation Strategies

- Educate staff members and providers regarding racism and discrimination. Staff members and providers should become acutely aware of the history of discrimination in social service systems and in the criminal justice system. Research indicates that increasing awareness of discrimination may reduce biased decision-making.

- Advocate for changes in systems when discriminatory practices occur.

- Assess the roles of racism, stigma, and oppression in each client’s clinical presentation and worldview, including how they affect trust, belief in recovery, and interest in resuming integration into a community.

- Discuss clients’ thoughts and feelings about engagement with a therapist or provider whose race or ethnicity differs from theirs.

- Establish a relationship that is egalitarian, to the degree possible. While counselor self-disclosure is often discouraged in traditional psychotherapy, personal revelations often can help FSP personnel build constructive and trusting relationships with clients.

- Acknowledge cultural differences including, where applicable, the impact of not having lived experience with mental illness.

- Explore the ways in which the client has responded to racism in the past, and discuss the effectiveness of these strategies. Assist the client in identifying effective strategies for coping with and responding to racism.

- Be prepared to advocate with or on behalf of the client when he or she experiences racism.
Each of the tools listed below has specific resources that you can locate in the general resource section on pages 99-101. This guide enables you to focus on the pertinent resources linked directly to each tool.

<table>
<thead>
<tr>
<th>Name of Tool</th>
<th>Resource Number(s)</th>
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<tbody>
<tr>
<td>Developing Cultural Self-Awareness or Cultural Humility</td>
<td>2,3,4,5,6,8,9,11,12</td>
</tr>
<tr>
<td>Exploring Power Dynamics</td>
<td>7,10,13,14</td>
</tr>
<tr>
<td>Experiences of Racism and Discrimination</td>
<td>1,9,15</td>
</tr>
</tbody>
</table>
Resources

✔ Articles


✔ Assessments

3. Antioch University Multicultural Center: Access to multicultural measures. [Page includes link to Multicultural Counseling Inventory.] Retrieved from [http://www.multiculturalcenter.org/access.cfm](http://www.multiculturalcenter.org/access.cfm)

4. CBMCS (California Brief Multicultural Competency Scale) Multicultural Training Program: [http://www.sagepub.com/cbmcs/](http://www.sagepub.com/cbmcs/)


Books


Domain #4

Sociocultural Diversities

Members of racial, ethnic and other sociocultural minority groups may be subject to social and economic adversity, bias, discrimination, and inequities in access to and quality of mental health care. Further, some communities experience multiple forms of minority status. For example, ethnic minority individuals who identify as lesbian, gay, bisexual, transgender, queer, or questioning often experience various forms of oppression. The Sociocultural Diversities domain focuses on general strategies for engaging and working with numerous groups, and on the intersection of multiple forms of minority status.
Sexual Orientation: Lesbian, Gay, Bisexual, Transgender, and Questioning Populations

Purpose

To recognize that sexual orientation and identity are often central to an individual’s sense of self, and that they should be understood from the client’s perspective and considered within the context of treatment.

Definition

The concept of sexual orientation: lesbian, gay, bisexual, transgender, and questioning populations refers to a client’s sexual identity, behaviors, and attraction to people of either the same sex, opposite sex, or both sexes.
Implementation Strategies

- Understand how clients view their sexual orientation and how that identification has evolved. Ask whether they refer to themselves as “he” or “she.”

- Ask clients who identify as either bisexual or homosexual how willing they are to discuss their sexual orientation. Does the client experience shame or embarrassment regarding coming out as bisexual, gay, or lesbian? What are the daily experiences of the client?

- Determine to what degree the client perceives conflict between his or her sexual orientation, religion, and residential community.

- Ask religious or spiritual clients if they perceive a conflict between their sexual orientation, their religious or spiritual belief system, and their ethnicity or culture.

- Discuss how the client copes with stigma associated with being lesbian, gay, or bisexual.

- Help clients identify healthy and comfortable sources of social support in the community, including self-help groups and organizations. Recognize the anxiety or other discomfort that someone may experience when entering a gay and lesbian community center for the first time. Outreach and education by the FSP program is essential before clients with mental illnesses will be able to comfortably access services.

- Encourage FSP team members to examine and address any internalized heterosexism or biases they may have against lesbian, gay, or bisexual individuals.
Purpose

Men and women who have served in combat-related positions in the military have distinct symptom profiles and needs, because many of them experienced traumatic stress unfamiliar to most of the population. Consequently, military veterans often are reluctant to seek treatment due to potential stigma, and are at extreme risk for substance-related disorders.

Definition

Veterans are men or women who have performed military service, in combat-related or other positions.
Implementation Strategies

At the System Level

- Create an operational agreement among local Veterans Affairs (VA) hospitals and outpatient service centers and local mental health programs. These agreements should outline the mental health services that the VA offers, services available through the mental health system, procedures for outreach – particularly for veterans who are homeless – and referral processes. The agreement also should specify the VA's role in ruling out physical conditions such as traumatic brain injury and frontal lobe injuries that may result in behaviors resembling symptoms of mental health conditions.

- Establish ongoing education on veterans’ issues needed to enable public mental health programs to successfully engage and treat veterans. Such educational programs may take the form of monthly grand rounds or seminars focused on understanding traumatic brain injury, post-traumatic stress disorder, the culture of the military, and the experiences of combat veterans.

At the Service Level

- Remember that coping styles that were successful within the context of combat are often detrimental once the tour of duty has completed. Explore healthy coping strategies, within the context of treatment, to respond to the shame, disillusionment, fear, and isolation that many combat veterans’ experience. Consider identifying a military mental health professional to lead or oversee treatment programs and support groups. Only military personnel who have lived experience of combat can empathize with veterans who have been dispatched to war zones. Consequently, support groups led by VA or military-affiliated mental health professionals are essential.
Implementation Strategies (cont’d)

■ Explore cognitive behaviorally based treatments for post-traumatic stress disorder in combination with a medical consultation. Such treatments may include prolonged exposure (PE) and concepts from *Seeking Safety*[^22]

■ Assess the needs of the veteran’s family and the need for family interventions.

■ Evaluate the client’s familial and non-familial support system.

■ Assess for substance abuse and domestic violence and, if present, incorporate appropriate treatment.

Deaf or Hearing-Impaired and Blind or Visually Impaired Clients

Purpose

To serve the needs of people who are deaf, blind, or both, and who have a mental illness. They constitute a distinct and severely underserved population. Only 1 in 50 hearing-impaired individuals who need mental health services receives appropriate therapy.23

Definition

Deaf or hearing-impaired and blind or visually impaired clients require understanding of their particular needs. Hearing-impaired people view themselves as a cultural minority group rather than disabled. This cultural group also makes distinctions between hearing loss as an adult in comparison to a lifelong hearing loss condition.24

Implementation Strategies

- Develop an operational agreement or collaborative arrangement with local universities, schools, and social service agencies that provide specialized services to deaf and blind people, in order to create reciprocal referral and service approaches.

- Ensure representation from these cultural communities in stakeholder forums and community planning processes at the county level. Such representation is critically important for identifying and responding to unmet needs.

- Create opportunities for self-help and peer support services focused on deaf and the blind clients.\(^25\)

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Purpose

To recognize that spirituality and religion may serve as key protective elements in times of stress, depression, or other adversity, and to incorporate appropriate discussion in interactions with clients.

Definition

_Spirituality and religion_ can frame how a client views the world and how causality is attributed. Spirituality is defined as “a person’s deepest sense of belonging and connection to a higher power or life philosophy, which may not necessarily be related to an organized church or religious institution.”\(^\text{26}\)

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\(^{26}\) The California Mental Health & Spirituality Initiative, CiMH, Center for Multicultural Development. Retrieved from [http://sites.google.com/site/mbspirit/site/](http://sites.google.com/site/mbspirit/site/)
Implementation Strategies

- Consider creating program or county parameters for supporting clients’ spiritual interests within the context of their mental health service recovery plan. Involve clergy representatives, clients, family members, and mental health staff members in the development of these parameters.

- Build partnerships with churches, temples, and spiritual healers within the communities served by the FSP program. Partnerships should include reciprocal support, education, and outreach.

- Consider supporting client-led spiritual activities.

- Ask about spirituality or religiosity as part of the initial assessment of each client. Utilize information as a source to understand the client’s coping strategies, support systems, values, and beliefs.

- Ask interested clients to identify their preferences among the array of spiritually connected services, which may include meditation, music appreciation, yoga, support groups, and services at local churches, temples, or synagogues.

- Initiate contact with and educate religious, cultural, and faith leaders within the community about mental illness and mental health resources available, for purposes of establishing collaborative relationships.

- Explore the utilization of space for community groups or already existing groups and activities at local faith, religious, and cultural centers, as means of integrating client services within the community.

- Involve any individuals in the community the client believes may be helpful in the recovery process and goal attainment, with documented authorization from the client. They may include anyone with whom the client has spiritual connections, including members of the clergy, yoga instructors, or herbalists.
Rural and Frontier Populations

Purpose
To identify specific populations of individuals from rural communities who do not present for mental health services, yet may benefit from outreach from the mental health system.

Definition
*Rural and frontier populations* include residents of isolated small communities and surrounding areas who are unserved or underserved by the mental health system.
Implementation Strategies

- Identify an individual from the mental health system who has established credibility, trust, and respect among rural and frontier populations. The best candidates are people who are from the unserved or underserved community that the program is attempting to reach to and serve.

- Consider the role of MHSA Community Services and Supports, Outreach and Engagement funds to enable county programs to allocate one or more cultural brokers (Refer to the Domain #2 tool titled “Using Cultural Brokers.”).

- Ask cultural brokers to identify the needs of unserved and underserved community members, and to work with the mental health system or provider to create services that meet those needs.

- Recognize that cultural brokers often function in multiple simultaneous roles — as translators, advocates, conflict mediators, and liaisons between mental health agencies and unserved or underserved communities.
Each of the tools listed below has specific resources that you can locate in the general resource section on page 115. This guide enables you to focus on the pertinent resources linked directly to each tool.

<table>
<thead>
<tr>
<th>Name of Tool</th>
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<tr>
<td>Sexual Orientation: Lesbian, Gay, Bisexual, Transgender, and Questioning Populations</td>
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<tr>
<td>Veterans</td>
<td>6,7</td>
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<tr>
<td>Deaf or Hearing-Impaired and Blind or Visually Impaired Clients</td>
<td>2,4</td>
</tr>
<tr>
<td>Spirituality and Religion</td>
<td>3,5,8</td>
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<tr>
<td>Rural and Frontier Populations</td>
<td>-</td>
</tr>
</tbody>
</table>
Resources

✔ Study

Lesbian, Gay, Transgender, and Questioning Populations:


✔ Websites

2. California Council of the Blind: [http://www.ccbnet.org](http://www.ccbnet.org)


4. Deaf Counseling, Advocacy and Referral Agency, funded by the California Department of Social Services, Office of Deaf Access: [http://dcara.org](http://dcara.org)


6. Perelman School of Medicine, University of Pennsylvania, Center for the Treatment and Study of Anxiety — About Prolonged Exposure Therapy: [http://www.med.upenn.edu/ctsa/workshops_pet.html](http://www.med.upenn.edu/ctsa/workshops_pet.html)

7. Seeking Safety: A Model for Trauma and/or Substance Abuse: [http://www.seekingsafety.org](http://www.seekingsafety.org)

8. Spiritual Competency Resource Center: [http://www.spiritualcompetency.com](http://www.spiritualcompetency.com)
Specific Practices

The Specific Practices domain includes several tools intended to assist counties in exploring effective treatment options for ethnic and cultural minorities. The domain explores and analyzes four types of interventions: evidence-based practices (EBPs), culturally adapted EBPs, community-defined practices (CDPs), and culture-specific treatments. The first tool, “Overview of Specific Practices,” presents a rationale for the review of practices as well as a brief description of each category of practice.
Overview of Specific Practices

Purpose

To help counties explore options for conducting culturally relevant interventions for diverse communities.

Definition

Decades of research have documented disparities in mental health care for ethnic and cultural minorities. Ethnic minorities tend to be less likely than the general population to receive mental health treatment and less likely to receive high-quality mental health care. The causes of these disparities are multifaceted, and efforts to improve access to and quality of care for ethnic minorities have taken several approaches. One approach has been to identify the specific treatment options that are effective with minority communities.

Several tools have been developed to assist counties in exploring effective treatment options for ethnic and cultural minorities. This domain reviews four types of interventions: evidence-based practices (EBPs), culturally adapted EBPs, community-defined practices (CDPs), and culture-specific treatments. The domain presents these practices discretely, with recognition that overlap exists among categories. These categories are continually evolving as research enhances understanding of the meaning of these categories and identifies further treatments within each category. Here is an overview of specific practices:

**Evidence-based practices:** Some EBPs have been tested and yielded positive outcomes with ethnic and cultural minority groups. These are listed in the specific age-group EBP tools in this domain, and are identified based on information from the National Registry of Evidence-based Programs and Practices (NREPP). In addition, while many EBPs have not been tested with ethnic minority clients, theoretical literature suggests that an EBP may be appropriate in some cases for a community, despite lack of evidence supporting its use with that particular group. For example, if the culture in the community emphasizes family relationships, interpersonal warmth, and interdependence, an EBP that reflects those values may be effective. In the absence of other effective interventions, implementation of this EBP may be appropriate.

**Culturally adapted evidence-based practices:** Studies have suggested that EBPs may be effective with a specific community in some cases when implemented with adaptations. For example, an EBP might work best with a particular community when it includes discussion of acculturation issues or an emphasis on interpersonal warmth or “personalismo.” Cultural adaptations vary across EBPs and across communities; however, given the emphasis on empirical study that is central to EBPs, adaptations generally are adopted only after research suggests that they improve the efficacy of the practice.
Definition (cont’d)

**Community-defined practices:** A “set of practices that communities have used and determined to yield positive results as determined by community consensus over time and which may or may not have been measured empirically but have reached a level of acceptance by the community” are known as community-defined practices. In 2009, the California Department of Mental Health initiated the California Reducing Disparities Project – which funded five strategic planning groups representing African Americans, Latinos, Asian/Pacific Islanders, lesbian, gay, bisexual, transgender, and questioning people, and Native Americans – to explore community-based practices.

**Culture-specific programs:** In a few instances, interventions have been created for a specific cultural group, and have been tested using empirical methods.

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The National Registry Of Evidence-based Programs And Practices (NREPP)

Purpose

To provide an orientation to the National Registry of Evidence-based Programs and Practices (NREPP) that will assist providers in using this tool to identify programs and practices that have proven efficacy with specific populations.

Definition

Mental health scholars and progressive social services agencies have placed increasing national emphasis during recent years on implementation of evidence-based interventions that have demonstrably improved outcomes for clients in mental health. To facilitate broad-scale implementation of these practices, mental health researchers are intent on identifying, investigating, and compiling lists of treatments that work. One of those research initiatives is the National Registry of Evidence-based Programs and Practices (NREPP), the focus of this tool. The “Resources”
Definition (cont’d)

section at the conclusion of this domain identifies sources for examples of other approaches.

The NREPP is a “searchable online registry of mental health and substance abuse interventions that have been reviewed and rated by independent reviewers.”\(^\text{29}\) As of early April 2012, the registry contained 230 interventions, more than half of which are prevention programs.

The NREPP includes interventions that have undergone a review process. To qualify for the review process, interventions must have been scrutinized in at least one published experimental or quasi-experimental design study that documents evidence that the intervention results in beneficial behavioral outcomes. Once selected for review, interventions are evaluated for:

1. the quality of evidence supporting the efficacy of the intervention, and
2. the readiness for dissemination.

Based on a review of materials, independent raters score the interventions and make recommendations regarding inclusion of the interventions in the registry.

The NREPP is intended to be used as a “decision support tool.” That is, users should not assume that interventions listed have sufficient evidence to be appropriate for their communities. Instead, users should carefully examine the information presented to determine whether the interventions listed meet the user’s or agency’s standards for evidence, whether the intervention is appropriate for the cultural community and for the agency, and whether the intervention responds to the needs of the community.

\(^{29}\) (SAMHSA, 2011).
Implementation Strategies

Use the NREPP database as a first step in identifying potential interventions to be implemented.

To access the NREPP database, go to http://www.nrepp.samhsa.gov/ and click on “Find an Intervention.”

- Consider using advanced search for interventions by different categories, including:
  - Areas of interest.
  - Specific ethnic groups.
  - Age groups.
  - Outcomes categories.
  - Geographic location.
  - Setting.

For example, a user might be interested in identifying mental health treatments for Native American young adults to address social functioning in urban locations, and in inpatient settings.

To perform an advanced search in the NREPP database (at http://www.nrepp.samhsa.gov/) click on “Advanced Search,” then select various interventions.

- Learn how to select and implement interventions through the NREPP online course. This course is designed to help walk users through five basic steps of application of evidence-based approaches:
  - Exploration.
Implementation Strategies (cont’d)

- Installation.
- Initial implementation.
- Full implementation.
- Program sustainability.

The course also is intended to guide users in selecting treatments, determining agency needs and resources, and matching interventions with agency needs and resources.

On the NREPP website (http://www.nrepp.samhsa.gov/) select “Learning Center.”
Evidence-Based Practices for Adults

Purpose

To assist programs in identifying interventions that have been validated by evidence demonstrating their effectiveness with specific ethnic or racial groups. Drawing upon principles of the National Registry of Evidence-based Programs and Practices (NREPP), this tool identifies interventions for which at least one experimental study supports their use with specific populations. Each county or organization should evaluate the array of data presented for each intervention to determine whether the empirical evidence meets the individual agency’s standards for evidence.

Definition

Evidence-based practices for adults are interventions that have been shown scientifically to reduce or eliminate symptoms of mental illness, or to improve outcomes for individuals with mental health problems.
Definition (cont’d)

Criteria for the identification of EBPs vary across studies and organizations; however, the use of experimental or quasi-experimental studies to demonstrate efficacy is a hallmark of this approach.

Because this Tool Kit focuses on full service partnership programs for adults, it identifies interventions that are considered “mental health treatments” (as opposed to “mental health promotion”) and programs for adults (ages 26–59). The NREPP is intended to be used as a “decision support tool.” These interventions are scored by independent raters on several dimensions and the scores are listed on the NREPP website.

Agencies and organizations should examine the information presented in the NREPP to determine whether an intervention achieves three benchmarks:

1. Its scores meet agency standards for efficacy and readiness for dissemination with specific populations.

2. It is directed at target outcomes identified by the organization or community.

3. It is appropriate to the individual needs of adults.
Implementation Strategies

- Identify interventions for which at least one study validates their use with a specific group, ascertained by an “Advanced Search” conducted on the NREPP database, using the following search criteria: mental health treatment, age 26–59. Results are presented by ethnic or racial group. (A second category that is presented includes only those interventions that were tested with groups composed of more than 50% of the target population.)

<table>
<thead>
<tr>
<th>Evidence-Based Practices for American Indian/Alaska Native Adults (Ages 26–59)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acceptance and Commitment Therapy (ACT):</td>
</tr>
<tr>
<td>Dialectical Behavior Therapy:</td>
</tr>
<tr>
<td>Eye Movement Desensitization and Reprocessing:</td>
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<tr>
<td>ICCD Clubhouse Model:</td>
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<tr>
<td>OQ-Analyst:</td>
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<tr>
<td>Seeking Safety:</td>
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<tr>
<td>Telemedicine-Based Collaborative Care:</td>
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<tr>
<td>Trauma Recovery and Empowerment Model (TREM):</td>
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*Interventions tested with 50% or more of the population selected: None*
### Evidence-Based Practices for Latino/a Adults (Ages 26–59)

<table>
<thead>
<tr>
<th>Practice</th>
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<tr>
<td>Acceptance and Commitment Therapy (ACT)</td>
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</tr>
<tr>
<td>Partners in Care</td>
<td><a href="http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=126">http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=126</a></td>
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<tr>
<td>Pathways’ Housing First Program</td>
<td><a href="http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=155">http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=155</a></td>
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*Interventions tested with 50% or more of the population selected*
### Evidence-Based Practices for Asian Adults (Ages 26–59)

<table>
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*Interventions tested with 50% or more of the population selected: None*

### Evidence-Based Practices for Black/African American Adults (Ages 26–59)

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<th>Practice</th>
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*Interventions tested with 50% or more of the population selected*

<table>
<thead>
<tr>
<th>Evidence-Based Practices for Native American Adults (Ages 26–59)</th>
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</table>

*Interventions tested with 50% or more of the population selected: None*
Family-Focused Interventions

Family-focused interventions are evidence-based practices that involve working with the family as a whole. County mental health plans may not consider these practices appropriate for adult FSP programs due to county-provider contractual expectations related to FSP services, potential funding limitations, provider emphasis on expertise in children’s services, or local quality assurance and documentation guidelines. Before using family-focused EBPs with adults, the provider should verify that no conflicts with county-determined guidelines have been detected.

### Evidence-Based Practices for American Indian/Alaska Native Adults (Ages 26–59)

<table>
<thead>
<tr>
<th>Intervention</th>
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*Interventions tested with 50% or more of the population selected: None*

### Evidence-Based practices for Latino/a Adults (Ages 26–59)

<table>
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*Interventions tested with 50% or more of the population selected: None*
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<thead>
<tr>
<th>Evidence-Based Practices for Asian Adults (Ages 26–59)</th>
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<tbody>
<tr>
<td>Child-Parent Psychotherapy (CPP):</td>
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<tr>
<td>Parent-Child Interaction Therapy:</td>
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<td><em>Interventions tested with 50% or more of the population selected: None</em></td>
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<tr>
<th>Evidence-Based Practices for Black/African American Adults (Ages 26–59)</th>
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<tr>
<td>Celebrating Families!:</td>
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<td><a href="http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=100">http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=100</a></td>
</tr>
<tr>
<td>Child-Parent Psychotherapy (CPP):</td>
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<tr>
<td>Incredible Years:</td>
</tr>
<tr>
<td>Nurturing Parenting Programs:</td>
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<tr>
<td>Parent-Child Interaction Therapy:</td>
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<td>Partners with Families and Children: Spokane:</td>
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<table>
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<tr>
<th>Evidence-Based Practices for Native American Adults (Ages 26–59)</th>
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<tr>
<td>None</td>
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<tr>
<td><em>Interventions tested with 50% or more of the population selected: None</em></td>
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Culturally Adapted Evidence-Based Practices

Purpose
To convey information to counties regarding evidence-based practices (EBPs) that have been culturally adapted to improve their effectiveness and acceptance by diverse communities.

Definition
*Culturally adapted evidence-based practices* constitute one approach by which to improve access to and quality of care for ethnic minority communities. Culturally adapted EBPs render practices more acceptable and more culturally congruent for a specific group. Cultural adaptations can include changing or enhancing the method of delivery – for example, conducting the treatment in the primary language of the clients, translating constructs and forms, ethnically matching providers with clients, and using cultural traditions or customs to illustrate therapeutic concepts. Other cultural adaptations include changing
Definition (cont’d)

the content of the intervention to include culturally relevant topics – for example, the impact of racism, discrimination, or acculturation. Given that one of the hallmarks of EBPs is the use of empirical methods to determine efficacy, cultural adaptations should be enacted only after empirical study has produced evidence supporting the effectiveness of the modifications.

Example of a Culturally Adapted Evidence-Based Practice

**GANA (Guiando a Niños Activos):** GANA is a cultural adaptation of parent-child interaction therapy, an evidence-based program that improves parent-child relationships, increases parenting skills, and improves child behaviors. The GANA program entails several modifications to treatment, including a flexible approach, increased emphasis on engagement through phone contact, a focus on rapport building, and substitution of culturally acceptable terms such as maestro for “therapist” and ejercicios de comunicacion for “child-directed interaction.”

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Purpose

To provide information to FSP programs regarding culture-specific treatments or interventions created for a specific cultural group.

Definition

One way to improve access to and quality of care for ethnic minority communities is to develop discrete treatments or interventions for a specific group. Such *culture-specific interventions* generally accommodate the cultural values, norms, and traditions of the target group, by incorporating strategies that emerge from the cultural perspective of this group. These interventions differ from community-defined practices in that they have been studied through experimental methods and found to be efficacious. Some may overlap with the evidence-based practices listed in the “Evidence-Based Practices” tool.
Examples of Culture-Specific Practices

**Family effectiveness training:** Family effectiveness training combines bicultural effectiveness training – an intervention that focuses on reducing cultural conflict and acculturation stress within families – with brief strategic family therapy. Originally developed to reduce conduct problems in Cuban American adolescents, this treatment has been adapted for Latinos of other countries of origin. It addresses problems with family functioning and cultural conflict between parents and children, and results in reduced disruptive behaviors in children and improvements in family functioning.

**Cuento therapy:** Cuento therapy is a therapeutic modality aimed at reducing mental health problems and improving school achievement for children and youth. Originally developed for Latino children, it uses traditional stories as a cultural context for discussion of psychological issues.

**Nia:** The Nia intervention is designed to improve mental health, reduce suicidal ideation, and reduce exposure to domestic violence for African American women. It uses psychoeducation and support groups.
Community-Defined Practices

Purpose

To assist counties in identifying, supporting, and integrating community-defined practices (CDPs) into the range of mental health services available to clients, families, and communities. Community-defined practices hold the promise of improving access to, retention in, and quality of services for unserved, underserved, and inappropriately served ethnic and cultural groups.

Definition

Community-defined practices are “a set of practices that communities have used and determined to yield positive results as determined by community consensus over time, and which may or may not have been measured empirically but have reached a level of acceptance by the community” (Martínez, 2008). The term “practice-based evidence” sometimes is used in reference to CDPs. A community-defined practice
Definition (cont’d)

may be a specific treatment, or CDPs may consist of a set of interventions and activities, particularly in full service partnership programs. These interventions may include strategies to conduct outreach and/or to engage and build relationships with clients, families, and communities.

The majority of essential elements and typical characteristics of community-defined practices are contained within the set of practices that comprise the CDP, while some are characteristics of the organization that implements the CDP.

Essential Elements of Community-Defined Practices

*Cultural relevance*: Organizational practices and community-defined practices are specific to and reflect the cultural values, norms, and goals of the community.

*Immersion in the community*: Organizational practices and/or specific community-defined practices are characterized by ongoing community participation in most or all phases of program development and implementation, including:

- Assessment of community mental health needs in a manner that is aligned with community culture and values.
- Planning and program development, including identification of outcomes.
- Implementation of the program, which includes hiring staff members who live in the community and embrace the values of the community.
- Development of evaluation strategies and outcome measures.
- Implementation of the evaluation, a process in which community members participate in development of surveys, conduct focus groups and interviews, and contribute in other ways.
Definition (cont’d)

- Communication of information as part of a commitment to ensure that activities conducted by the organization are characterized by transparency. Information dissemination should be bidirectional. The organization should solicit comments, criticisms, and suggestions from the community and involve community members in decision-making processes, and it should deliver information to empower communities with knowledge about activities and progress. Strategies may include, but are not limited to, community educational forums, focus groups, and newsletters.

**Access:** Organizational practices and specific community-defined practices address barriers to access, such as language and cultural impediments, lack of transportation, stigma, caregiver concerns, financial insufficiencies, fear of deportation, racism or homophobia, and prior negative experience with social service systems. Strategies include but are not limited to: 1) conducting services in the primary language of the client served or providing appropriate interpreting services; 2) offering services in a location that avoids stigma and is accessible, welcoming, safe, and acceptable to community members.

**Program articulation:** Community-defined practices are characterized by a clear rationale for the selected strategies and interventions, which are defined and articulated sufficiently for replication by other communities.

**Evidence:** Community-defined practices are validated by evidence of their effectiveness in improving the mental health of clients in the target community. Strategies may include, but are not limited to, case studies, qualitative evaluations (such as focus groups and interviews), satisfaction surveys, small research studies, community consensus, and community-based support and endorsement.
Definition (cont’d)

Typical Characteristics of Community-Defined Programs

**Outreach and engagement:** The mental health services organization has clear and effective strategies for conducting outreach to the community and for engaging community members in accessing services by means of the chosen community-defined practices.

**Mental health education:** The organization has developed culturally responsive and appropriate education materials and/or tools to increase the community’s understanding of mental health and mental illnesses, and has implemented culturally appropriate strategies to engage and inform the target ethnic group.

**Community relationships:** The organization has an established history of strong, constructive relationships with the community served, and of maintaining bidirectional communication.

**Feedback and responsiveness:** The organization periodically solicits comments and suggestions from the community to inform quality improvement processes and to ensure continued relevance of services for the community served. Services performed under the community-defined practices umbrella are characterized by flexibility and responsiveness to changing community needs.

**Community workforce:** A large portion of staff members and providers are community members – people who were raised and/or are living in the community served, or individuals who identify culturally with the community served.

**Attention to culture-specific variables:** “CDPs are more likely to take into consideration [culture-specific experiences] including historical trauma; current trauma related to racism/ethnocentrism/White privilege; worldview; immigration status; generation in the United States; preferred language; socioeconomic status; and the presence and practice of traditional beliefs, values, and rituals, including spirituality and communication styles.”

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Implementation Strategies

- Build partnerships with community organizations including but not limited to community-based organizations (e.g., faith-based, religious or spiritual entities, local news media outlets, social service providers, immigrant and refugee programs, and cultural centers), school districts, college campuses, community leaders, cultural brokers, practitioners of alternative healing, and community members through ongoing outreach, education, dialogue, and services.

- Explore creative ways to support and fund community-defined programs to encourage development of new partnerships with underserved communities. Strategies include but are not limited to sole-source contracts and memoranda of understanding. In addition, counties may consider developing RFPs that take into account the unique assets of community-based organizations as well as the differences in infrastructure and resources for grant writing.

- Help build capacity in community-based organizations by offering technical assistance in areas identified in partnerships between the county and community-based organizations. Topics may include: grant writing, evaluation, and program sustainability.

- Foster partnerships between community-based programs and research institutions, local business partners, local political partners, private foundations, or county programs to enhance organizations’ capacity to conduct evaluation, to obtain funding, and to ultimately improve program sustainability.

- Solicit information through interviews or focus groups with community leaders and community members regarding existing community assets and programs. To obtain this information, counties may ask:
Implementation Strategies (cont’d)

- Where would individuals in this community most likely go when they need help?
- How can the county or other funding agencies support these practices?
- What adjustment (if any) should be made in the current service provision criteria to support and ensure the success of these practices?

Note: For the purpose of this tool, “community” refers to a group of individuals with shared experiences, culture, and values that have a significant influence in their day-to-day activities.
Each of the tools listed below has specific resources that you can locate in the general resource section on pages 143–144. This guide enables you to focus on the pertinent resources linked directly to each tool.

<table>
<thead>
<tr>
<th>Name of Tool</th>
<th>Resource Number(s)</th>
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<tr>
<td>Overview of Specific Practices</td>
<td>3,4,7,8</td>
</tr>
<tr>
<td>The National Registry for Evidence-Based Programs and Practices (NREPP)</td>
<td>11</td>
</tr>
<tr>
<td>Evidence-Based Practices for Adults</td>
<td>11</td>
</tr>
<tr>
<td>Culturally Adapted Evidence-Based Practices</td>
<td>2,5,6</td>
</tr>
<tr>
<td>Culture-Specific Interventions</td>
<td>1,9,10</td>
</tr>
<tr>
<td>Community-Defined Practices</td>
<td>4</td>
</tr>
</tbody>
</table>
Articles


Book


Report


Websites

8. California Reducing Disparities Project (CRDP), California Department of Mental Health Office of Multicultural Services: [http://www.dmh.ca.gov/Multicultural_Services/CRDP.asp](http://www.dmh.ca.gov/Multicultural_Services/CRDP.asp)


Appendix A

Introduction to Examples of Community-Defined Practices......................... 146

Community-Defined Programs:

1. Asian Pacific Family Center East: IMPACT! – A Youth Development and Leadership Program ................................................................. 148
2. Beats, Rhymes, and Life: Rap Therapy for TAY of Color ....................... 151
3. Latino Health Access: Promotor Program ............................................. 154
4. Sacramento Native American Health Center: Warrior Down Program ................................................................. 158
5. Transcultural Wellness Center .............................................................. 162
Introduction to Example Programs of Community-Defined Practices

To further illustrate the construct of community-defined practices, the CDP subcommittee (organized under the California Institute for Mental Health’s Full Service Partnership Advisory Committee) identified five programs that would serve as “example programs.” These CDPs were nominated by subcommittee members and were selected by consensus. Although the list of practices does not constitute a comprehensive survey of CDPs, it identifies a few example practices selected to epitomize the different types of practices that are being developed and implemented successfully by and for underserved communities.

The representative agencies and community-defined practices selected are:

1. Asian Pacific Family Center East: IMPACT! – A Youth Development and Leadership Program
2. Beats, Rhymes, and Life: Rap Therapy for TAY of Color
3. Latino Health Access: Promotor Program
4. Sacramento Native American Health Center: Warrior Down Program
5. Transcultural Wellness Center

As is evident from the program descriptions, these practices demonstrate the range of approaches utilized in communities. They also illustrate a common aspect of community-defined programs: while a few of these practices (such as Warrior Down or Rap Therapy for TAY of Color) consist of single interventions, the majority of these practices encompass a set of interventions embedded within a comprehensive community defined program. Central to the success of many of
these programs is their implementation by a community-based organization that has an established and constructive relationship with the community and that conducts outreach and engagement activities.

Concurrent with the California Institute for Mental Health (CiMH) process, the California Department of Mental Health (DMH) Office of Multicultural Services began implementing its California Reducing Disparities Project (CRDP). A central objective of this project is to fund strategic planning workgroups (SPWs) to “identify population-focused, culturally competent recommendations for reducing disparities in mental health services, and seek to improve outcomes by identifying community-defined, strength-based solutions and strategies to eliminate barriers in the mental health systems.” The SPWs entered the final stage of their work in early 2012; by March 2012 several had released reports for public comment. These reports include a list of community-defined practices. California Reducing Disparities Project administrators and SPW members hope that the studies, definitions, and examples of CDPs that CiMH compiled for this report will complement the efforts of the DMH SPWs, and that in combination, these efforts will foster implementation and dissemination of effective community-defined practices.

32 Office of Multicultural Services CRDP website: http://www.dmh.ca.gov/Multicultural_Services/CRDP.asp
Asian Pacific Family Center East: IMPACT! – A Youth Development and Leadership Program

Program Overview

Housed in the Asian Pacific Family Center East in eastern Los Angeles County, the IMPACT! program is a 26-week intervention designed to empower Asian immigrant youth and help them build self-esteem. The program serves the San Gabriel Valley cities of Diamond Bar and Walnut, along with unincorporated areas including Hacienda Heights and Rowland Heights. IMPACT! (an acronym for Inspire and Mobilize People to Achieve Change Together) uses a culturally competent, age-appropriate, and interactive life-skills curriculum to support Asian immigrant youths in their development of goal setting, effective communication, problem solving, and other functional skills. It also addresses substance use and HIV to facilitate peer refusal skills development, and explores peers, family, culture, and other relevant topics to enhance prosocial life choices.

CDP Essential Elements

Cultural relevance

IMPACT!’s participants are youth who have moved to the United States within the past five years and are dealing with the stress of adapting to a new environment, culture, and language. Many participants report feelings of incompetence and social isolation, insufficient family support, a lack of school connectedness, and language barriers, in addition to the “normal” stress of adolescent development and the high academic expectations and pressures their families exert on them. The IMPACT! program is culturally relevant in that it addresses difficulties directly related to culture and acculturation stresses. IMPACT! works with students to help decrease isolation, to develop skills and strategies to cope with adapting to a new culture, and to improve family and school connectedness.

Immersion in the community

The IMPACT! Program is embedded in the Asian Pacific Family Center (APFC), which is closely connected to the community served. The APFC disseminates a bilingual newsletter, hosts community recreational events, and solicits comments and suggestions about its programs through focus groups. In addition, many APFC staff members live in the surrounding community. The APFC continually seeks ways to improve the effectiveness of IMPACT! and its other programs through five operational functions:

1. **Assessment:** To assess the needs of youth in the community, the APFC conducted focus groups at the initial stages of program development. The organization formed an advisory council, which includes youth members, to perform ongoing assessment of present and evolving community needs. Recommendations by the advisory council influence program modifications. Rocco Cheng, former IMPACT! program director and now corporate director of prevention and early intervention services, states, “We actively solicit input from our parents, youth, schools, and ethnic associations for advice on what is needed in the community – and what is not. They are our eyes and ears, keeping us tuned in to what works and where gaps are.” One adaptation based on suggestions from the community has been expansion of the target population to include not only recent immigrant students but also students of immigrant parents, accompanied by expanded emphasis on the importance of bicultural competence.
2. **Planning and program development**: The IMPACT! program was developed to respond to the needs identified through the planning process. One such area of need that community members identified was the incidence of family and cultural conflicts beyond the scope of “normal” family conflict. These problems are rooted in parental expectations and pressure based on sacrifices parents make to move to a new country, and on youths’ feelings of being overwhelmed and perhaps resenting that burden. In response to those conflicts, the program developed sessions on family communication, bicultural competence, and structured family activities to enhance and strengthen familial relationships.

3. **Implementation of programs**: The IMPACT! program is conducted by providers primarily from the local community. In addition, based on comments and suggestions from youths and other community members, another program called CATALYST (Community Alliance To Advance Leadership and Yield Social Transformation) was created. After students complete the IMPACT! program, they have the option to continue onto CATALYST, which focuses primarily on community service and allows youths to practice and apply many of the skills that they learned in IMPACT!

4. **Development of evaluation strategies**: Evaluation strategies primarily utilize standardized outcome measures. However, focus groups and other qualitative approaches ensure that the community voice is captured in the evaluation of the program.

5. **Communication**: Schools, libraries, businesses, and other organizations show support by promoting programs and materials via websites, display boards, newspapers and other communication media. The APFC also disseminates information and outcomes of the program through its bilingual newsletter.

**Access**

With a welcoming environment, the center has established constructive relationships with the community, characterized by ongoing bidirectional communication and participation. Access to the program is enhanced by performing services in schools and in the primary language of each student. APFC has a long-standing relationship with the three local school districts and is often called upon to assist in translation, cultural broker activities, and crisis response. In addition, the APFC hosts community events such as parent and family workshops at many of the local schools and community organizations. In 2011 the APFC hosted its first Be Connected – Family & Community Day event, at which families gathered for informative workshops, fun activities, and a resource fair.

**Program articulation**

The IMPACT! program is based on a 26-week curriculum that encompasses communication skills, problem solving, substance abuse, family and cultural issues, and other relevant topics.

**Evidence**

A randomized control study that EMT Associates, Inc., independently conducted as a program evaluation function suggested that youth who received the intervention had better outcomes than those in the control group. In addition, comments and suggestions from focus group participants indicate that community members find the services to be invaluable to the overall well-being and success of their children and family. IMPACT! contributes to aspects of youth development that may easily be overlooked by schools, after-school tutoring centers, and other providers.
Typical Characteristics of Community-Defined Programs

Outreach and engagement
The organization distributes a bilingual newsletter, hosts community events, and employs staff from the community. The APFC’s partnerships with other service providers, schools, and law enforcement officials ensure that other agencies are aware of the IMPACT! program.

Mental health education
IMPACT! instructional programs teach coping skills such as time, stress, and anger management, conflict resolution, and problem solving. These skills equip youth to tackle some of life’s challenges. In addition, the APFC staff participates in several community health and information fairs throughout the year, where they set up informational booths. APFC staff members also attend monthly community forums and collaborative meetings, to exchange information with other community stakeholders about mental health, and to disseminate information about APFC resources and services.

Community relationships
The organization partners with several local school districts, offering multiple programs and services at many of the elementary, middle, and high schools. The organization additionally is an active participant in several local community collaborative meetings, and works closely with several law enforcement agencies, and with many Chinese and Korean local community civic and parenting organizations.

Feedback and responsiveness
As the needs in the community increased and resources decreased, the program expanded its target group to include middle school students, and shifted from school-based to office-based operations in order to allow more students to access the services.

Community workforce
The IMPACT! program providers are of Asian background, many are bilingual, and many come from the community served.

Attention to culture-specific variables
Experiences specific to life as an immigrant youth are central to the content of IMPACT!‘s program. The program helps participants confront social isolation, difficulty maintaining constructive relationships with family members, and inadequate connections with school. Program modules identify differences between the youth’s culture of origin and culture in the U.S., the difficulties encountered in navigating different cultures at home and at school, and strategies for developing bicultural competence. While exploration and discussion of issues constitute the primary focus, communication, problem solving, conflict resolution, and other techniques that are taught in other parts of the curriculum are linked as an application.
Beats, Rhymes, and Life: Rap Therapy for TAY of Color

Program Overview
Based in Oakland, California, Beats, Rhymes, and Life (BRL) grew in response to a critical need for more youth-centered, strength-based, culturally responsive therapeutic programs for youth of color. In 2004 Tomás Álvarez III, a social worker and BRL founder, conceived an innovative Rap Therapy model in which underserved and inappropriately served teens become engaged in mental health services through the process of creating rap music. Over the years, BRL has grown from a single Hip-Hop Therapy program into a community-based, nonprofit 501(c)(3) organization composed of social workers, artists, educators, activists, therapists, community members and youth – all dedicated to improving health and social outcomes among youth and young adults of color. BRL’s Rap Therapy program has been accredited as one of the first programs of its kind anywhere in the nation, and has laid the foundation for the development of other BRL programs and strategies for engaging and partnering with diverse youth communities. With therapeutic and youth development programs in Oakland, San Francisco, and Ashland, California, and South Bronx, New York, Beats, Rhymes, and Life is blazing a trail, demonstrating what is possible when community-defined solutions are used to promote individual and community wellness.

CDP Essential Elements

Cultural relevance
BRL places cultural relevance at the center of its three-pronged approach by utilizing popular cultural elements as primary vehicles for therapeutic work. Specifically, hip-hop culture and media arts form the cornerstone of BRL’s approach. Because of the importance of hip-hop music and media arts to African American, Latino, and Asian/Pacific Islander youth as well as to youth of other ethnicities, BRL’s approach enables the organization’s staff to connect with youth, engage them in services, employ a youth-centered approach that promotes leadership, build upon strengths, and facilitate therapeutic self-expression through music and multimedia projects.

Immersion in the community
BRL has ensured its immersion in the community by locating its practices in local schools and community centers, and by engaging in extensive outreach through dissemination of youth-produced music, social media, video projects, news media, and events. To aid dissemination efforts, BRL has developed a host of websites, including a site about the organization itself, a music site, and an online store. In addition, BRL youth and staff have created documentary films, media campaigns, and music recordings that are available to the public through their website and portal sites. The organization’s staff is involved in mental health promotion at statewide and national levels, through dissemination of programs nationwide, and membership on committees and work groups. BRL continually seeks ways to improve the effectiveness of its programs through five operational functions:

1. **Assessment:** By providing opportunities for youth to tell their story in ways that make sense to them, BRL gains important insight into specific needs and unique challenges faced by youth of color. BRL has worked with its youth participants to develop and adapt assessment tools that focus on strengths and opportunities as well as deficits and other problems.
2. **Planning and program development:** BRL’s youth-centered approach places youth in the planning and program development process. BRL youth have been instrumental in aiding the expansion and development of new BRL programs, including BRL’s Let’s Chat—a program created to diminish the prevalence of pregnancy among teenagers—and BRL Academy youth leadership development programs.

3. **Implementation of programs:** BRL strives to function as a staffing partner that reflects the racial and cultural composition of its target population. As of early spring 2012, five of BRL’s six staff members are people of color, and four out of six are male. BRL initiated efforts to create a “pipeline” program for alumni of its Rap Therapy program. Five African American youth (four males and one female) participate in an academy in which they learn how to co-facilitate the Rap Therapy program. The vision of BRL Academy is to create a pipeline to the helping professions for youth of color as a means of responding to workforce disparities that discourage youth from accessing services.

4. **Development of evaluation strategies:** BRL’s Rap Therapy program has been the focus of two empirical studies, and BRL is working with the Alameda County Health Care Services Agency to develop and implement outcome measures across all of its programs.

5. **Communication:** BRL disseminates information about programs and program outcomes through documentaries, news media, social media, conferences, and through production of music and movies. Youth gain confidence through the process of public dissemination of information about content that they and other TAY create. BRL empowers youth to speak on behalf of themselves and their peers, reinforcing BRL’s philosophy of “co-creating efficacy” among TAY and their communities.

**Access**

To ensure easy access for youth in the community served, BRL has embedded its programs in school and community organizations, and uses an approach that is strength-based and culturally relevant to TAY, particularly youth of color. Programs are underwritten mostly through a diverse funding model that includes subsidies from the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program, county contracts, foundation grants and in-kind support. All programs are offered in English but accommodate people who speak other languages. For example, participants in BRL’s Let’s Chat program created a video public service announcement on teen pregnancy awareness for Spanish-speaking parents and uploaded it to YouTube (http://www.youtube.com/watch?v=me1EqOMfsR4&list=UUs2TAEGPvBBatJyagyXJ0w&index=4&feature=plcp).

**Program articulation**

Based on principles of narrative therapy, BRL’s Rap Therapy program helps youth explore and evaluate their life narratives and their emotions. In the program, youth write rap music about their experiences, perform the rap for an audience of peers, facilitators, and therapists, and receive critiques from the group. BRL has disseminated program strategies through its website, by means of documentaries broadcast on radio, in print news media, and in a book: Therapeutic Uses of Rap and Hip-Hop, edited by Susan Hadley and George Yancy, with contributing author Tomás Álvarez III (2011, London, England: Routledge and Psychology Press). BRL has offered its Rap Therapy program through two school-based health centers. In each case the program has served as a point of access to other health and wellness services.

**Evidence**

The BRL Rap Therapy program has been the focus of two empirical studies, both of which reported positive outcomes. Among them were rates of attendance and retention greater than
90%, along with increases in self-efficacy, self-confidence, coping skills and constructive peer interactions. Many youth who complete BRL’s Rap Therapy program express a desire to remain connected to the program and organization. Five alumni of the Rap Therapy programs serve as interns in the BRL Academy, while four more youth are on a waiting list.

**Typical Characteristics of Community-Defined Programs**

**Outreach and engagement**

In addition to BRL’s active use of social media, news media, documentary films, and youth-created musical productions as means of publicizing its programs, BRL has developed strong relationships with community and institutional partners. For example, BRL partnered with the Alameda County Health Care Services Agency to build the Ashland Youth Center, a community center that will provide a variety of services, including health and wellness instruction, recreational activities, mentoring, arts and culture programs, and job-seeking assistance. BRL will be one of five lead agencies to operate the center after its anticipated December 2012 completion.

**Mental health education**

BRL performs ongoing education, advocacy, and promotion of its efforts to embrace community-defined solutions and utilization of innovative program models.

**Community relationships**

BRL has established a presence in the community by forging a strong relationship with schools, community-based organizations, and systems of care, and by disseminating the products of the youths’ work widely.

**Feedback and responsiveness**

BRL’s three-pronged approach (youth-centered, strength-based, and culturally congruent) enables development of age-appropriate and relevant programming that youth have had the opportunity to shape and form. Over the years, BRL has expanded its Rap Therapy program model into a TAG (therapeutic activity group) model capable of utilizing numerous activities as a catalyst for change and development. The TAG model encourages flexibility in program development and has enabled BRL to pilot other therapeutic groups, including an online youth magazine TAG and a media arts TAG.

**Community workforce**

Many of BRL’s staff members live in the communities in which they work or come from similar communities. They share some common experiences and are invested not only in serving youth but also in building the power of communities to help, heal, and grow themselves.

**Attention to culture-specific variables**

Through rap music, BRL participants explore events that relate to their lives and their communities. Many participants are African American youth who have experienced or witnessed violence in their families and neighborhoods, and face systems of oppression daily. Many have relatives or friends who have been threatened, harmed, or murdered as a consequence of these patterns of oppression. Participation in the group allows youth to tell their stories and explore the meaning of their experiences, as well as tap into and foster internal assets.
Latino Health Access: Promotor Program

Program Overview

The mission of Latino Health Access (LHA) is to assist in improving the quality of life and health of uninsured, underserved people through high-quality preventive services and educational programs that emphasize responsibility and full participation in decisions affecting health. Two significant approaches to the work at Latino Health Access are participation and empowerment. Needs identified through community assessment of conditions that compromise the health of residents are addressed through (1) educational health promotion programs to change individual and family health behaviors, (2) creation of awareness of the social determinants of health, and (3) fostering leadership and advocacy skills to create system change. A standout aspect of LHA and its role in the community is the use of promotores de salud – community health workers. Promotores and promotoras are LHA employees and community members who are able to teach and engage residents on a peer level. They speak the language of participants and understand impediments facing families served by LHA.

The Promotor Program at LHA has expanded to encompass many different aspects of health and mental health. Beginning with a diabetes program, LHA created an additional intervention in partnership with Orange County Health Care Agency’s Behavioral Health Services focused on helping individuals who have mental illnesses such as schizophrenia and bipolar disorder in combination with chronic diseases. With the Children and Families Commission of Orange County, LHA trained families with children 5 years of age and younger in child development, substance abuse prevention, and overcoming lack of access to services. In partnership with the Academic Center for Prevention of Violence and the Centers for Disease Control and Prevention, LHA promotores were trained to implement an evidence-based intervention called Families and Schools Together (FAST). With clinical psychologists Dr. Cristina Jose and Dr. Lyndee Knox, LHA has developed an evidence-based curriculum titled “Madres a Madres” (mothers to mothers), which the organization began piloting and improving in 2011. Promotores have been trained in concepts of mental health, mental illness, prevention, brain development, human development, discipline, depression, violence, self-help and mutual help groups, crisis management, personal interviews, and other topics, in order to implement various mental health intervention components.

While this CDP refers to children, youth, and families, it also has been successful with the older adult population.

CDP Essential Elements

Cultural relevance

LHA’s mental health programs focus on experiences central to life as a Latino immigrant in California.

Immersion in the community

involvement is pivotal to all aspects of program development, including needs assessments and development, implementation, and evaluation of interventions. LHA continually seeks ways to improve the effectiveness of its programs through four operational functions:
1. **Assessment, planning, and program development:** With the leadership of youth and adults, LHA personnel identified mental health, intra-family violence, lack of supervision, substance abuse, violence in teen dating, and depression as major issues affecting the community and deserving of intervention.

2. **Implementation of programs:** Trained promotores created and continue to (1) lead support groups on domestic violence and depression; (2) teach workshops; (3) carry out one-on-one interventions with participants; (4) conduct home visits; (5) organize retreats; (6) connect participants with services; and (7) support participants by referring them to transportation services, performing translation services, keeping them company, and offering advocacy while accompanying them to schools, medical office visits, and judicial system proceedings in courts. Our promotores are among the first line of contact in case of crisis within the families they serve. Promotores organize the community and build capacity among participants so they can learn to navigate systems and be independent.

3. **Development of evaluation strategies and outcome measures, and implementation of evaluations:** LHA partners with foundations and academic institutions to conduct evaluations. Promotores and promotoras are essential in the implementation of evaluation strategies.

4. **Communication:** LHA publishes a periodic newsletter and hosts an online portal for consumers and community members to access information regarding events and activities of the center.

**Access**

Program participants are first- and second-generation immigrants who have limited or no health insurance, and who face barriers to health care that include low reading levels, unfamiliarity with the health-care system, lack of proficiency in English, and traditional respect for physicians that inhibits them from asking probing questions. Promotores speak the same language, come from the same neighborhood and commonly share some life experiences with the community members they serve. By talking with the community members and valuing their concerns, the promotores gain the trust of clients, who are willing to allow program representatives to come to their homes. The Promotor Program also circumvents transportation-related barriers to care by delivering services at the participants’ homes or other preferred locale, including parking structures, laundromats, apartment complexes, and living rooms. Promotores have been extremely innovative in forging collaborations with medical and social service providers because they offer reciprocal value, such as cultural competency learning opportunities. Donation of items and time by volunteers allows LHA to perform services at a low cost for uninsured clients.

**Program articulation**

The Promotores Programs are based on nationally recognized principles for community health workers. The mental health programs include specific modules and content that are based on the needs identified by the community as well as evidence-based interventions (such as parent-child interaction therapy).

**Evidence**

Promotores interventions have been recognized by news media outlets, including Newsweek and a PBS television documentary, FAT: What No One Is Telling You. LHA also has been recognized with various awards. In 2008, the Governor’s Council on Sports and Fitness
Spotlight honored LHA as Nonprofit Organization of the Year Gold Medalist based on the Healthy Weight/Peso Saludable Program. In 2008 America Bracho, LHA’s executive director and founder, was presented with the James Irvine Foundation California Leadership Award, and a communication grant to disseminate lessons learned using the promotor model. In 2009, the PBS program Bill Moyers Journal broadcast a segment about LHA’s efforts to build a park and community center in the most park-deficient area of Orange County. A special piece featuring LHA’s Madres a Madres program also can be found on the Bill Moyers Journal PBS website. A pilot study of the Madres a Madres program, being conducted in collaboration with the Southern California Center of Academic Excellence on Youth Violence Prevention, is investigating the experiences of 200 participating families in Santa Ana, California.

Typical Characteristics of Community-Defined Programs

Outreach and engagement
LHA is known for being resourceful, creative, and innovative in the ways it conducts outreach, delivers services, and engages partners. Promotores conduct outreach by visiting neighbors, offering engaging activities in areas with a high concentration of individuals, and conducting provocative campaigns. Promotores also conduct outreach by collaborating with community partners such as schools, churches, community clinics, private providers, the Mexican Consulate, social service agencies, family resource centers, self-help networks, 12-step programs, apartment managers, Latino markets, and the neighbors themselves. Families that have benefited from their involvement with LHA are excellent sources for referrals.

Mental health education
One of the primary goals of the Promotores Program at LHA is the education of community members about mental health, healthy behaviors and choices, signs and symptoms of mental illness, and resources for coping with mental health problems. LHA strives to build capacity within the community to respond to these problems by identifying community leaders and equipping them with the knowledge and awareness of mental health issues that affect their communities.

Community relationships
LHA has a longstanding presence in the community it serves and employs primarily community members in program leadership and implementation. This strong presence has enabled LHA to develop a relationship with the community based on trust and mutual support. LHA conducts community events intended to celebrate Latino culture as well as to increase awareness of LHA programs and mental health issues that affect the Latino community. These events include the Día de Los Muertos celebration and the annual Tamalada, in which community members cook and sell tamales. The proceeds of the Tamalada help to fund the involvement of promotores and promotoras in programs.

Feedback and responsiveness
The programs were developed based on the needs identified by the community. LHA continues to solicit comments and suggestions from the community through the voices of the promotores.
Community workforce
The Promotor Program staff identified individuals from the community who have the lived experience of overcoming obstacles and learning to cope with the health problem that LHA targets. Due to their in-depth knowledge and the needs of the community, several community members emerged as promotores for LHA's domestic violence and depression programs.

Attention to culture-specific variables
The Promotor Programs confront problems related to acculturation, cultural conflict within families, cultural differences between the culture of origin and culture in the U.S., and other variables specific to the immigrant experience. Because the providers typically have cultural backgrounds similar to those of clients, they share the cultural values such as personalismo, familismo, and respeto common in Latino communities. This correlation enables promotores and promotoras to build strong alliances with clients and the LHA to create lasting relationships with the community.
Sacramento Native American Health Center: Warrior Down Program

Program Overview
The Warrior Down Program is an intervention that the Sacramento Native American Health Center (SNAHC) operates as a means by which to prevent relapses and to conduct recovery support services for Native Americans who are completing treatment, returning to the community from incarceration, or who have been on their recovery journey using traditional methods or 12-Step Medicine Wheel teaching methods. Re-establishment of life following treatment for alcohol or substance abuse or following incarceration requires a community effort. Without the support of a knowledgeable family and community members, many people who try to resume healthy, productive lives find themselves frustrated by unfulfilled needs in job training, education, housing, transportation, mental health care or medical support, social services, spiritual and cultural support, or connections with others who value sobriety and healthful approaches to living.

“Warrior down” is the cry used to signify that a warrior has been wounded or incapacitated in some way and needs help. The Warrior Down Program involves weekly group meetings that include talking circles and traditional cultural and spiritual practices. The program uses a peer-to-peer approach that equips clients with the training and skills they need to offer support and community referrals for others in recovery.

CDP Essential Elements

Cultural relevance
For many Native American people the path to healing is found through traditional cultural and spiritual practices. Healing processes can include talking circles, healing circles, and traditional ceremonies. Ceremonial activities have a distinctly spiritual focus and incorporate intergenerational activities that include both elders and children in the healing process. These activities are essential for the well-being of men and women in Native American communities. The teachings of the elders and the clan mothers embody wisdom and guidance. The spiritual practices serve as pathways to meaning and purpose in life, and the cultural activities create a social and emotional foundation for reconnecting and reestablishing a sense of belonging and identity.

Culturally appropriate aftercare and re-entry programs at SNAHC give Native Americans opportunities to reconnect to their communities and to create a healthy life that reflects a balance emotionally, mentally, physically, and spiritually. SNAHC personnel call this a life of “wellbriety.” The Warrior Down Program is one of the resources that can be used to help people achieve wellbriety as they re-enter the community following treatment or incarceration.

Immersion in the community
The Sacramento Native American Health Center Inc. (SNAHC) is a nonprofit 501(c)(3), federally qualified health center (FQHC) in downtown Sacramento. It is community-owned and operated, and governed by a nine-member, all-Native American board of directors. The health center’s dedicated team of highly trained clinicians offers a wide range of services, including adult medicine, pediatrics, mental health services, laboratory services,
comprehensive dental care for children and adults, substance abuse services, community education and prevention services, nutrition and diabetes care, and home visitation services. BRL continually seeks ways to improve the effectiveness of its programs through five operational functions:

1. **Assessment:** SNAHC periodically facilitates community focus groups that aid in collecting data, analyzing, interpreting, and reporting the needs and interests of the Native American community in Sacramento. They also are instrumental in community problem solving and program evaluation.

2. **Planning and program development:** The focus groups that SNAHC conducts are intended to help participants gain a deeper understanding of the Native American community’s views and experiences, and to serve as a forum in which to articulate their feelings and ideas about how the agency can improve service delivery or implement new strategies to assist them in achieving health and wellness.

3. **Implementation of programs:** The peer-to-peer approach of the Warrior Down Program ensures that clients form an important part of the support services offered. In addition, 72% of SNAHC staff members are from local and out-of-state tribes.

4. **Development of evaluation strategies and outcome measures, and implementation of evaluations:** The periodic meetings of focus groups allow the SNAHC to evaluate existing programs and to obtain critiques and suggestions directly from community members.

5. **Communication:** The SNAHC communicates with the community through meetings and events scheduled regularly at the center. Results of recent focus groups were shared with the community through a social gathering at the center.

**Access**

The SNAHC has a strong and constructive relationship with the Native American community in Sacramento, as well as with other minority groups. Community members serve in leadership positions (on the board), in provider positions, and in peer support positions. The SNAHC frequently hosts cultural and educational events, including the Family Gathering of Native Americans (described under the “outreach and engagement” segment, which follows). This relationship and contact with the community improves community members’ willingness to access services at the center. SNAHC, based in downtown Sacramento, schedules appointments during and after regular business hours. The Warrior Down Program celebrates Native American culture and offers support in a non-stigmatizing, peer support group format.

**Program articulation**

The Warrior Down Program utilizes traditional and 12-Step Medicine Wheel teaching methods, as well as culturally relevant practices such as intergenerational participation and support, and drumming and other cultural practices.

**Evidence**

Commentary during focus group meetings indicates that the program is effective in promoting healthy lifestyles and preventing relapse, and that community members are satisfied with the outcomes.
Typical Characteristics of Community-Defined Programs

Outreach and engagement
SNAHC hosts numerous events annually, including a Prevention Health Faire, Recovery Day Celebration, and Family Gathering of Native Americans (GONA), held every summer. The center places priority on implementing cultural practices with the ultimate goal of reducing the prevalence of chronic disease, including heavy alcohol consumption, within the American Indian community. Warrior Down participants are encouraged to volunteer as a form of giving back to the community while their families participate in the events.

Mental health education
The HOPE (Healing Our People Through Education) class that SNAHC conducts focuses on life skills development and relapse prevention. Mental health issues are discussed as part of the curriculum to assist community members in recognizing symptoms to prevent drug and alcohol use. An SNAHC bipolar support group that meets weekly helps patients build a network of support with other community members to cope with life as a bipolar patient.

Community relationships
The SNAHC was founded by Native American community members, and its core staff and clients are Native American. SNAHC is active in supporting, sponsoring, and hosting community events that celebrate Native American culture and traditions.

Feedback and responsiveness
SNAHC strives to communicate frequently with community members to obtain their comments and suggestions. For example, within the past year SNAHC hosted a series of focus groups with Native American community members. Focus groups were divided into five age groups: 12–15, 16–18, 19–30, 31–55, and an elders panel. The results of the focus group were shared with the community at a social gathering at which a five-year plan was disclosed. One of the most repeated requests is for the continued use of cultural groups, classes, and events, especially for spiritual cleansing.

Community workforce
Since the grand opening of SNAHC, its staff has grown to meet the needs of the community; 72% of staff members are Native American from local or out-of-state tribes. The organization’s goal is development of an experienced and capable Native American workforce composed of experts in their chosen fields.

Attention to culture-specific variables
SNAHC’s Warrior Down Program and several of its behavioral health classes, as well as counseling and therapy, incorporate education regarding historical trauma. In the 1980s Dr. Maria Yellow Horse Braveheart conceptualized discussion of historical trauma as a way to develop stronger understanding of why the “American Dream” has been elusive for many Native Americans. Historical trauma encompasses cumulative emotional and psychological wounding over an individual’s lifespan and across generations, emanating from massive group trauma.

For more than 500 years, Native Americans have endured physical, emotional, social, and spiritual genocide from European and American colonialist policy. History has proven that many great leaders of the tribes were ravaged and interned. These brave Native American
leaders did everything humanly possible in the face of the ongoing march of European American colonists across their land to protect their people and their way of life, sadly to little or no avail. They eventually saw countless genocidal violent acts perpetrated on their people and lands. Descendants of these early leaders to this day suffer the adverse effects of historical trauma grief, evident among members of the 583 tribes that the federal government recognizes. The effects of historical trauma include unsettled emotional trauma, depression, high mortality rates, high rates of alcohol abuse, and significant child abuse and domestic violence.

SNAHC is collaborating with community advocates, allies, teachers, and students of historical trauma with the objective of strengthening understanding of unresolved historical grief and developing a unified approach for healing these wounds. SNAHC offers community members an opportunity to learn or to pass along what the organization has learned about historical trauma experiences, prevention, intervention, and healing. Studies have shown that the historical trauma intervention approach yields significant reduction in anger, sadness, guilt, and shame. Several excellent Native American researchers have begun conducting research and creating instructional curricula that are beginning to create a more unified approach toward healing.
Transcultural Wellness Center

Program Overview

The Transcultural Wellness Center (TWC) is a full service partnership program that conducts mental illness recovery services for Medi-Cal-eligible or medically indigent Asian and Pacific Islander (API) clients and families. The TWC was created as a result of a stakeholder process that united diverse Asian/Pacific Islander providers, agencies, and community members in seeking mental health treatments and strategies that would benefit the various API groups in the Sacramento area. Psychiatrists, clinicians, and mental health counselors and recovery specialists from the targeted cultural communities perform services for TWC clients. Services are built around incorporation of TWC clients’ cultural identities, beliefs, and practice with the goals of rediscovering hope, fostering meaningful relationships within clients’ cultural communities, and empowering the clients in their relationship with the larger mainstream society.

CDP Essential Elements

Cultural relevance

The TWC staff helps clients define their personal vision of wellness, usefulness or meaningfulness, and healing. This process incorporates the cultural perspectives of clients, their family members, and the communities in which they are embedded. While TWC services include traditional psychopharmacologic, psychotherapy, psycho-education and social rehabilitation principles, the integration of our clients’ cultural values and perspectives has led to novel approaches. TWC performs services in the clients’ own language, or on rare occasions through use of a trained interpreter for clients from an API sub-culture that exceeds TWC’s cultural and linguistic abilities. Some clients engage in western medication support services in combination with traditional healers such as spiritual leaders, shamans, herbalists, and acupuncturists. Psychotherapy services frequently are done as part of home visits at the request of clients who have limited access to transportation. These home visits also parallel the encounters that traditional healers may use in the country of origin.

Given the tremendous disruption of community caused by the military conflicts that many TWC clients have endured, as well as the stigma of mental health, the program has a strong focus on sociocultural rehabilitation. For example, many TWC clients have discussed the stress of being displaced from their country of origin to the United States, where the life skills with which they were raised have limited applicability. That displacement can result in feelings of uselessness, disconnection from the younger, more acculturated generations, and overall sociocultural isolation. In response to this phenomenon and at the request of clients, TWC developed client-driven activities such as a farming group in which clients and staff members who share similar cultural backgrounds explore ways of farming that incorporate mother country and mainstream methods. Each such adaptive approach serves as a framework for clients’ ongoing work to preserve their cultural identities, values, and practices, while incorporating mainstream strategies and resources when applicable. Clients also participate in fishing groups, gender- and culture-specific support groups, and cultural celebrations hosted both at the agency and in the community.

Immersion in the community

TWC was built on a foundation of relationships with community members, leaders, and organizations. Participants in this diverse coalition came together to advocate for development
of a one-stop community resource that would respond to the unmet mental health needs of the API community in Sacramento. The process galvanized a community group to advocate at meetings of the Sacramento County Board of Supervisors and at the Sacramento County Department of Behavioral Health to voice the concerns of this community. Because of this foundation of community organizing, TWC has a strong presence and recognition in the API community. TWC continually seeks ways to improve the effectiveness of its programs through five operational functions:

1. **Assessment:** Early in 2012, the TWC program initiated a self-assessment process through client participation in interviews in which clients discussed their personal recovery as they participated in the program during the past year. The data gathered will help TWC assess its strengths and weaknesses of its program to enable the organization to make improvements in its services. TWC also works cooperatively with Sacramento County government personnel through performance outcome reports, surveys, and focus groups.

2. **Planning and program development:** In early 2012, TWC participated in client and community focus groups that the Sacramento County Department of Behavioral Health convened for the Vietnamese, Chinese, and Hmong communities. For the focus group meetings, TWC furnished interpreters for each language group. Clients participating in these focus groups were asked to describe how the services helped them, and to identify what problems they have encountered. Focus group participants also were asked what other kinds of services they would find helpful. Inclusion of TWC clients in these focus groups and assessments gives them a voice and sense of empowerment.

3. **Implementation and sustainability of programs:** The majority of TWC’s staff is bilingual and bicultural, and is drawn from the communities served. The composition of the staff enables TWC to sustain its culturally and linguistically competent program and achieve the continued acceptance and trust from the community that the organization serves.

4. **Development of evaluation strategies and outcome measures, and implementation of evaluations:** TWC utilizes focus groups to obtain information about client needs and satisfaction, as well as to help ensure ongoing cultural and linguistic competence.

5. **Communication:** Asian Pacific Community Counseling APCC/TWC publishes a newsletter that informs the community, clients, and supporters about programmatic developments within the agency as well as relevant news within the community that the organization serves.

**Access**

Barriers to access are significant in the Asian and Pacific Islander communities. Many API clients are unaccustomed to mainstream mental health access points, such as the mental health intake line, with which traditional cultural pathways to treatment often differ. For example, a common Vietnamese pathway to healing involves speaking with pharmacists rather than physicians or case managers as the first point of contact. Likewise, many API members utilize kinship networks, spiritual leaders, and community organizations as entry points. TWC has engaged with several community partners that characterize the network of access for the cultural communities that API serves. The organization also helps the families of its clients resolve transportation barriers, and assists in connecting them with community and county resources, linguistic translation services, and cultural brokering as needed to enable them to gain access to services. TWC encourages spiritual connectedness, and coordinates services with traditional healing and spiritual rituals as desired by the client. APCC/TWC coordinates services with several Sacramento community agencies, including the Hmong Woman’s Heritage Association, Asian Resources, Southeast Asian Assistance Center, My Sister’s House, and TOFA (To’utupu’o e’Otu Felenite Association).
TWC, located within the API community, is accessible, culturally welcoming and comfortable. Because stigma concerns many clients, TWC helps them and their families feel accepted at the agency’s functions, and encourages integration into the community through assisted and sponsored cultural programs and activities.

**Program articulation**

Not applicable. TWC is a comprehensive program that encompasses many interventions.

**Evidence**

The Sacramento County Department of Behavioral Health engages in annual program evaluations with TWC. The results of these evaluations indicate that the TWC program has been successful in reducing hospitalizations, emergency room and crisis visits, homelessness, and incarcerations.

**Typical Characteristics of Community-Defined Programs**

**Outreach and engagement**

The TWC staff participates regularly in community outreach activities appealing to the API communities through booths at community festivals and other events, and individually with families in their homes. Through such contact, the API staff is able to educate community members about mental illness and about resources available to them.

**Mental health education**

The psychoeducation programs that the staff conducts through participation in events and festivals inform community members about mental illness. API also assists in educating western medicine and mental health providers about API traditions and beliefs related to mental health and wellness.

**Community relationships**

TWC was formed by a community coalition and therefore began with a foundation of strong relationships with community members, leaders, and organizations. TWC coordinates services with community agencies – including the Hmong Woman’s Heritage Association, Asian Resources, Southeast Asian Assistance Center, My Sister’s House, and TOFA (To’utupu’o e’Otu Felenite Association) – and also partners with faith-based organizations and community groups, along with other traditional community resources.

**Feedback and responsiveness**

In order to continue meeting the needs of the API community, API recurrently assesses the programs now in practice and seeks to develop more services over time. From its outset, API has operated with the guidance of a community advisory council (CAC), made up of representatives from the communities that the organization serves. The CAC reviews program outcomes, suggests opportunities for improvements, and assists in linkages to additional community resources.

**Community workforce**

The majority of TWC staff members come directly from the Asian and Pacific Islander community, thereby giving them insights about the cultural values, history, beliefs, and needs of clients. This familiarity enhances client and family engagement and increases the likelihood of beneficial outcomes.
Attention to culture-specific variables

As TWC staff members work with each client and their family, they take into account the client’s cultural and family history and experience as a refugee or immigrant. Many of the past experiences of clients may have been traumatic as they and their families began new lives in the United States. To be responsive to these physical, psychological, and sociocultural traumas, TWC staff members are particularly attentive to problems emanating from loss and transition, as well as existential concerns related to fate, survival, belongingness, and death. TWC providers are well versed in the psychological, social, and biological treatment of PTSD. TWC also conducts medical-psychiatric consultations and case conferences for clients who have poorly defined or unexplained physical problems that are common among people who have experienced trauma. In addition, the TWC staff has expertise in identifying and attending to adaptive paranoia, which is a natural cultural response among people who have been victimized by discrimination. The TWC staff collectively performs direct mental health services in 11 languages, incorporating multiple API worldviews into treatment collaborations with clients and their families.