Full Service Partnership Tool Kit

California Institute for Mental Health 2012
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Appendix A: Introduction to Example Programs of Community-Defined Practices

Community-Defined Programs:

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
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.
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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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.
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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 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 care² 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.\textsuperscript{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.\textsuperscript{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 \textit{“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”}\textsuperscript{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, 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.

2. Cultural competence theory, scholarly studies, and research literature.

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 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

Implementation Strategies (cont’d)

may include:

- 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 for 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.

Implementation Strategies (cont’d)

■ Remember that family members may experience shame when discussing experiences of trauma with a provider who is a cultural stranger and who represents power in the mainstream culture. Acknowledge the potential impact of immigration experiences on children and family members.

■ Consider that children are likely to experience more distress if their parents have difficulty coping with the effects of immigration. Referrals to support and clinical intervention services can be helpful for caregivers and parents who experience significant psychological distress or mental illness following immigration.
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 strate-
Implementation Strategies (cont’d)

gies 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 dif-
ferently.

■ Assess for acculturation conflicts within families. For example, in many fami-
lies 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 con-
flict. 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 mem-
bers in communicating and accepting each others’ values and beliefs.

■ Recognize that differences in family members’ acculturation levels may re-
sult 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.
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\textsuperscript{10} 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 completion of the cultural formulation as part of the assessment and treatment planning process, consider using client- or person-centered treatment planning that is developed in alignment with client values and goals. Developing an understanding of clients based on how they view themselves — rather than based on stereotypes or cultural assumptions about a clients’ treatment preferences — will enhance the success of treatment. Some clients may wish to include their family in the treatment planning process, while others may defer to the expertise of the treatment team to devise prescriptive treatment planning and goal identification. Allowing the client to make that decision is entirely consistent with a person-centered treatment planning process.
Social Determinants of Mental Health (Socioeconomic Status)

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).
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.
Impact of Culture on Roles

Purpose

To define the significance of traditional and changing familial roles in the treatment process. To solicit identification and understanding of the varying cultural values and norms related to familial roles. To encourage provider understanding of the impact of traditional and changing familial roles on the mental health of children, youth, and their family members.

Definition

Assessment of the *impact of culture on roles* should enhance understanding of the reasons why adjustment to a new culture often requires changes in traditional family roles. For example, many parents who come to this country must rely on their children to assist in translating and navigating new systems such as schools, transportation, banks, and social services. Reliance on children for essential tasks increases children’s responsibility and in some cases
results in a corresponding decrease in parental authority. Traditional gender roles may be supplanted when women are able to obtain employment more easily than men. The absence of older relatives to care for the children and do housework may result in husbands assisting wives in such activities. Thus, family expectations related to role of immediate family in contrast to extended family, gender roles, levels of authority, and parenting practices may be modified during the acculturation process. Changing family values and expectations regarding roles can be a significant source of stress.
Implementation Strategies

- Develop an understanding of family roles and expectations common in clients’ culture of origin as well as in their adoptive community.

- Engage the family in discussions of family roles and changes that have occurred due to acculturation. Identify sources of family conflict regarding role expectations. Guide the family in managing these role conflicts effectively by validating each member’s experience and helping each family member to understand the differing expectations of other family members.

- Explain to children and youth that the cultural familial role values that are inherent to their parents and caregivers may differ from mainstream examples. Assist children and youth in reconciling new role expectations at school or in the community, expectations at home, and traditional cultural roles.

- Create a safe environment for parents and caregivers to explore traditional parenting practices in comparison to mainstream parenting practices. Explain to parents and caregivers that their children will be subject to conflicting desires as they seek to reconcile new mainstream cultural familial roles with traditional cultural familial roles.

- Avoid misinterpreting parenting practices among varying cultures and/or ethnicities as abusive. Consultation with cultural brokers may help determine whether a given practice is abusive or within the norm for a particular culture. As always, compliance with mandated reporting requirements should be maintained, and consultation should respect each client’s confidentiality when appropriate.
Understanding and Treating Culture-bound Syndromes

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 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.

Boufee 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.

- Consider the presence of culture-bound syndromes when working with children, youth, and family members who may be experiencing symptoms that don’t match DSM IV symptoms or criteria. Providers should encourage staff members to listen carefully to explanations of symptoms that children, youth, and family members say they experience. Because culture-bound syndromes are so varied, providers cannot rely on a single type of diagnostic or therapeutic approach. In some cases, culture-bound syndromes may result in behaviors that are simply eccentricities that do not need treatment. For some people, a therapeutic approach may be most helpful.

- Explore the child’s and family’s understanding of the nature and causes of the symptoms, as well as potential interventions. Inquire about the kinds of help or cures that have been tried and the results of these interventions.
Purpose

To promote strength-based treatment by helping providers identify and understand cultural strengths of children, youth, and families in full service partnerships (FSPs).

Definition

*Awareness of cultural strengths* refers to understanding how such strengths relate to the treatment that children, youth, and families are receiving. Ethnic-specific protective factors are culturally embedded qualities that can buffer against harmful experiences and enhance resiliency and well-being in children’s families. These qualities include buoyant ethnic identity, strong and supportive relationships with family members, and cultural traditions and ceremonies. Despite adversities, some children and youth have greater likelihood of success than children of other origins. Research suggests that the race, culture, or ethnicity of adolescents has a
Definition (cont’d)

significant influence on the ways in which they confront adversity.\textsuperscript{13} Identifying, focusing on, and utilizing the strengths of cultural identity can lead to enhanced resiliency in children and youth.

Implementation Strategies

- Identify cultural strengths of the child, youth, and family. Sources of resiliency may include favorable ethnic and cultural identity, a sense of belonging to a community, close family ties, spiritual beliefs, and cultural rituals and ceremonies.

- Implement treatment strategies and interventions that capitalize on existing resiliency factors and mitigate risk factors.

- Develop an understanding of the strengths of the larger cultural traditions and beliefs of the child, youth, and family, and identify ways to help them use those attributes in pursuing treatment goals. Explore culture-specific tools and strengths for achieving wellness, such as alternative and indigenous healing methods. Assist the child, youth, and family in incorporating those cultural strengths into the treatment process to build self-esteem and self-efficacy.

- Understand the role of culturally sanctioned healers and healing practices, and encourage or facilitate their use when appropriate and desired by the family. This approach validates the family’s traditions, beliefs, and values. Additionally, encouragement and use of methods and interventions that are familiar and trusted by the family will help to overcome some of the fear and mistrust that many minorities experience.

- Implement treatment strategies that focus on building, supporting, and maintaining an ethnic identity characterized by self-confidence. Research has shown that a strong and secure ethnic identity can buffer minority children and youth from stress. Consequently, treatment approaches that enhance ethnic identity may improve outcomes for children and youth.
Culture-Sensitive, Trauma-Informed Treatment

Purpose

To identify strategies for ensuring culturally sensitive treatment for children, youth, and families who have experienced trauma.

Definition

More than half (50.2%) of all children who were reported as maltreated in 2001 were White, 25% were African American, and 14.5% were Latino or Hispanic, according to the National Child Abuse and Neglect Data System. Environmental risk factors, such as inadequate housing, single-parent families, substance abuse problems, stress related to acculturation and discrimination, lower levels of education, and cultural history of oppression increase the likelihood of children in non-dominant cultures experiencing trauma. Consequently, offering culture-

**Definition (cont’d)**

*Sensitive, trauma-informed treatment* to children, youth, and families when they are suffering the effects of trauma is important. While many of the practices that this tool recommends are effective when working with Latino and Hispanic clients, remaining flexible also is essential. The intervention that works with one family may not be appropriate for another.
Implementation Strategies

■ Establish a welcoming environment and focus on building rapport at initial contact. Ensure that the reception staff helps the family feel at ease by offering a warm and genuine greeting, engaging the family in polite conversation, and supplying the reception area with books, signs, brochures, and information about activities in various languages specific to the cultures served.

■ Improve cultural responsiveness of trauma-informed treatment by taking into account the levels of acculturation that the family has achieved. Often, children and parents acculturate differently; the child or youth may speak English and feel comfortable in the values of American culture, while parents speak only their native language and identify more closely with the values of their country of origin. Assess levels of acculturation by asking specific questions focusing on language, how many generations the family has resided in the United States, and learning from the family about their experiences of acculturation. In addition, consider using an objective acculturation measure (e.g., Acculturation Rating Scale for Mexican-Americans – II - ARSMA II; Societal, Attitudinal, Familial, and Environmental Acculturative Stress Scale for Children - SAFE-C). (Refer to the “Acculturation” tool for more information.)

■ Conduct a culturally modified trauma assessment. Doing so at the outset of treatment can be instrumental in encouraging the family to engage and remain in treatment. The assessment process, whenever possible, should be broken into several sessions rather than completing it during the first one or two treatment contacts. All assessment tools should be translated into the family’s preferred language. Thorough assessment includes nine key areas:
  ➢ Cultural identity.
  ➢ Immigration experiences of generations within the family.
Implementation Strategies (cont’d)

- Trauma and other forms of psychological distress occurring before, during, and after migration (e.g., poverty, war, exposure, torture, parental separation, hunger, death of traveling companions, needs deprivation, substandard living environments, racism).
- Acculturation differences among family generations, particularly between youth and their parents and grandparents.
- Cultural values of the family.
- Cultural beliefs regarding the cause of the presenting problem.
- Attitudes and expectations of the therapeutic relationship and process.
- Family support.
- Experiences of discrimination.

Assess for stress and trauma symptoms associated with the immigration process. Immigrant families may experience stressful and traumatizing events in the process of immigrating to the United States and as they become accustomed to their new life. For example, the border crossing may involve circumstances that are terrifying and traumatic for children and families, such as exploitation by “coyotes” or other people, necessity of hiding or running to escape detection, and food and water deprivation. In addition, family members may continue to fear deportation after settling in the United States.

Remember that many refugees experienced symptoms of post-traumatic stress disorder due to exposure to war-related violence. Help these families recognize and understand these symptoms, and assist them in finding treatment.
■ Increase effectiveness of treatment by developing understanding of the family’s cultural values and incorporating these into the treatment goals and plan. Cultural values have an important role in helping the family to make sense of trauma within a cultural context. The family’s cultural values can lend increased meaning to traumatic events.

■ Focus on outreach and building relationships before beginning to treat trauma. Consider the provider’s heavy investment in the process of engagement with families. Be aware of and respect family loyalty and privacy needs, which are particularly relevant when the trauma involves sexual abuse.
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

*Using 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 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.
Health-Care Access Disparities

Purpose

To educate FSP Providers regarding racial and ethnic disparities in access to health care, and to assist them in responding to health-care needs of children, youth, and families.

Definition

*Health-care access disparities*, the lack of equality in medical care for ethnic minorities and non-Latino Whites, has been well-documented in the past decades. Ethnic minorities are less likely to have access to health care and fare more poorly than non-Latino White counterparts across health indicators such as life expectancy and infant mortality. These disparities are particularly pronounced for individuals with mental illness, because physical health disorders are more prevalent among persons suffering from mental illness than among the general population. Providers, as advocates, can help families to access health care, to make appropriate use of health-care
services, and to ensure, as much as possible, that discrimination and/or bias of health-care providers and systems do not prevent families from obtaining the health care they need.
Implementation Strategies

■ Assist the family in gaining entry into the health-care system, which may involve linking families with free clinics and informing them about other beneficial resources. Providers can help family members complete forms and apply for benefits, as needed, and to navigate the often complicated bureaucracy of health-care services. Patient navigator programs can be invaluable in improving access to services.

■ Guide the family in accessing programs or contacting organizations that can perform needed medical care, dental care, eye care, and other health-related services. Identify the type of care needed and then help family members access care that is affordable and physically accessible. Explore public transit options for children, youth, and families, help them find services near their home, and consider furnishing transportation when it is needed.

■ Recommend health-care providers who can meet the needs of family members. FSP providers should become familiar enough with family members to be able to assist them in assessing the potential biases of available providers, and in recognizing providers who will have difficulty establishing rapport with the family.

■ Identify health-care providers from the family’s own culture whenever possible. Same-culture providers are likely to easily establish rapport and be trusted by the family as a result of understanding the family’s cultural influences and explanations for illnesses. At minimum, providers should be willing to listen and respect the cultural influences of the family when assessing and treating conditions.

■ Assist families financially, to the extent feasible, in covering costs that may impede their access to appropriate care.
Each of the tools listed below has specific resources that you can locate in the general resource section on pages 55–58. This guide lists and links pertinent resources within each tool name.

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Articles


✔ **Assessment**

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

✔ **Book**


✔ **Database**


✔ **Glossary**


✔ **Tutorial**

Addressing 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.
Stigma and Reluctance to Seek Services

Purpose

To assist providers in understanding stigma and reluctance of members of non-dominant cultures to participate in mental health services.

Definition

Ethnic and cultural minority children, youth, and families experience numerous barriers to care, including mistrust of social service agencies, fear of deportation, and stigma associated with mental illness. Often the very experiences of social injustice and oppression that increase the mental health problems also contribute to stigma that minority clients perceive and to their reluctance to seek services. Providers can unintentionally exacerbate the impaired access and reluctance by misunderstanding and/or ignoring cultural issues such as religious preference related to service provision, cultural expectations regarding gender roles, high levels of stigma of mental illness within the community, and failure to provide treatment choices.
Implementation Strategies

■ Recruit and employ staff members who are representative of the cultural communities they serve, and who have specific linguistic skills or cultural knowledge that can increase the family’s ability to trust and engage in services.

■ Build relationships with linguistic interpreters, community-based health organizations, sources of refugee and immigrant services, welfare agencies, and other community service providers to create presence in communities, to develop an understanding of community perceptions of mental health and mental health services, and to build trust with community members.

■ Address reluctance and fear through educational activities, outreach, and engagement activities that help the family understand the treatment process and decrease the level of fear. Additionally, educating the family early about the treatment process decreases incidences of perceived failure due to lack of familiarity with mental health evaluation and therapy.

■ Develop an understanding of the child, youth, and family’s worldview and causes of their reluctance to engage in services.

■ Engage the child, youth, and family in treatment planning and in developing goals to ensure that individual and cultural needs are identified, respected, and given attention. Children, youth, and families need to be fully involved in service planning, development, and review at both the family and structural levels. This involvement helps ensure that services are relevant, accessible, and acceptable. For example, initial assessments should be completed in a spirit of partnership with parents and their children, including the assistance of an interpreter when necessary.
Implementation Strategies (cont’d)

- Employ a multidisciplinary approach to enhance access to services, paying particular attention to avoiding fragmentation and gaps. Complexity and difficulty in meeting needs in a culturally relevant manner discourages families from engaging in the treatment process.

- Prepare and assist families in identifying alternative supports throughout the treatment process. Seeking treatment may cause alienation of extended family or cultural community support. The longer-term goal is to enhance the capacity of the immediate family to advocate, influence, and direct services themselves.

- Discuss stigma cultural beliefs regarding mental illness respectfully. Inform clients and family members regarding the provider’s approach to mental illness, theories of causes of mental health problems, and approaches to treatment. When applicable, recognize the significance of religious beliefs and spirituality for children and families.
School and Family Interface

Purpose

To identify strategies for full service partnership providers to improve school interface for children, youth, and families they serve.

Definition

School and family interface refers to coordination between the education system and children, youth, and families of differing cultures. Children, youth, and families of non-dominant cultures may encounter difficulty in achieving school success. Any obstacles are exacerbated for a child or youth who experiences mental health problems. Ethnic minority parents may find advocacy for their child in schools particularly difficult to achieve due to language barriers and lack of familiarity with the school system. The importance of school success in children’s mental health requires providers to assist parents in advocating for their children in schools and in ensuring that personnel in school systems are responsive to children’s needs.
Implementation Strategies

- Assist the child, youth, and family in identifying the effects of mental illness on school performance and success. Develop goals that enhance school success and become a part of the treatment process.

- Attend school meetings with the family as requested, and act as an advocate for the child, youth, and family in communicating with the school regarding the child’s mental health needs.

- Distribute educational information prepared to help parents understand the mainstream school system and the rights and responsibilities they have as parents in interacting with the school system. After obtaining appropriate legal clearances, communicate appropriate information regarding the child’s mental illness to help teachers meet the child’s educational needs.

- Explain how the child or youth and family members can identify and use tutoring, interpreter services, language acquisition educational opportunities, and other supports and services to enhance school success.

- Become acquainted with the supports available within the school system specific to the family’s culture, and help the family to connect to those culture-specific services and supports.
Level of Parental Burden

Purpose

To define level of parental burden and identify strategies for providers to assist families in coping with their child’s mental illness. To provide strategies for decreasing the burden of caregiving for their children with mental illness.

Definition

Level of parental burden refers to the pressure of obligation and added responsibility experienced by parents in caring for a child or youth with mental illnesses.

➢ Objective burden refers to behavioral difficulties such as disruptive behaviors and other troublesome symptoms; to the potential disruption in normal life routine, social activities, and employment for parents and families; and to implications in isolation and financial stability.

➢ Subjective burden refers to the emotional reactions of parents to the child’s mental illness.
Definition (cont’d)

Parental worry, anxiety, sadness, resentment, difficulty sleeping, guilt, shame, stigma, fear, grief, loss, anger, and rejection are aspects of parental burden. Cultural beliefs regarding mental illness and treatment can exacerbate or reduce a parental burden. Cultural values affect the family’s perceptions of the child’s needs, the amount of help sought and given, understanding of the cause of and control over symptoms, and – ultimately – the degree of sympathy or tolerance for the child. Additionally, the added stigma affects the family’s relationships with the outside world.
Implementation Strategies

- Recognize and acknowledge that caregiving can be very trying for immigrant families who have limited support and resources. Help parents identify their cultural beliefs regarding their obligation to provide full care for mentally ill children. Offer guidance to help parents process feelings of helplessness, being overburdened, and feeling trapped and frustrated.

- Identify conflicts that arise from levels of acculturation that differ between children and families. Ameliorate conflicts by helping family members understand each other’s worldview based on their different acculturation levels. Assist in reducing parental burden by helping the child, youth, and family focus on methods for restoring family harmony.

- Assist families in recognizing the impact of social stigma-related increased parental burden resulting from mental illness of a family member. Counsel the family in identifying and taking advantage of social supports, resources, and opportunities that can decrease social isolation.

- Explore parents’ sense of personal control over their child’s mental health condition. Assist them in exercising personal control over development of coping resources such as social supports, knowledge of community resources, and development of financial resources, to decrease their burden.

- Educate parents about the child’s mental illness, the child’s level of personal control over symptoms and behaviors, and appropriate expectations for the child. Guide parents in setting realistic expectations of the child to decrease subjective burden.
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 novel- las 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 provide strategies for ensuring culturally appropriate and accurate mental health assessment.

Definition

*Ethnic-specific assessment* is the process of identifying culturally appropriate needs of the child, youth, and family by means of ethnic-specific tools. Racial and ethnic disparities are as widespread in the diagnosis and treatment of mental illness as they are in other areas of health care. One reason for these disparities is bias in the assessment process. Assessment tools often are not validated or normed with ethnic minority groups. (Refer to the “Cultural Self-Awareness” tool for information regarding personal bias in providers.)
Implementation Strategies

■ Note the child, youth, and family’s ethnic or cultural reference groups. For immigrants, observe the degree of involvement of both the culture of origin and the host culture. For non-immigrants, explore the extent to which such clients feel connected to and part of a community.

■ Pay attention to language knowledge, fluency, and preferences.

■ Develop an understanding of culturally relevant distress idioms, culture-bound syndromes, cultural explanations for the mental health condition, and expectations of the treatment process. As a part of the assessment process, ask these and related questions:
  ➢ What do you think has caused your mental health condition?
  ➢ Why and when do you think it started?
  ➢ What do you think your mental health condition does to you?
  ➢ How severe do you consider the problem?
  ➢ How has your mental health condition changed during the past week, month, or year?
  ➢ What have you been doing for your mental health condition so far?
  ➢ What kind of intervention do you think you should receive?
  ➢ What are the most important results you hope the intervention will achieve?
  ➢ What are the main problems your mental health condition has caused for you?
  ➢ What do you fear most about your mental health condition?

■ Be especially sensitive to the likelihood of cultural shame associated with the mental illness. Respect the family’s face-saving needs, and ensure total confidentiality.
■ Recognize and acknowledge the family’s preference for cultural-specific healing methods. Work with the family to incorporate cultural-specific healing practices that will enhance the treatment process and further engage them in the therapeutic process. Note culturally relevant interpretations of social stressors, available social supports, and levels of functioning and disability. Encourage the incorporation of culturally relevant kin networks, religious practices, and social environmental supports that will contribute to the success of treatment interventions.

■ Use available assessment tools that have been normed and validated for the client’s ethnic group. When these are not available, other sources of information and information obtained through the interview should be given more weight.
Utilizing Cultural and Ethnic Resources

Purpose

To assist providers in identifying cultural- and ethnic-specific resources to enhance the treatment process, and to develop strategies to apply them effectively.

Definition

Often providers need assistance in bridging the gap between cultures in order to ensure effective treatment. Providers can greatly assist children, youth, and families by teaching them ways of utilizing cultural and ethnic resources, and through that instructional process can develop a collaborative and productive relationship that enhances families’ comfort and understanding of mental health treatment. Use of cultural brokers and/or ethnic-specific resources is a beneficial alternative for providers in agencies where culturally diverse resources are not yet fully developed or available.
Implementation Strategies

- Explore cultural differences between providers and the child, youth, and family, during assessment and treatment. The ability to recognize the need for assistance demonstrates competency and respect for the individual needs of the family. When evaluating the need for cultural resource assistance, consider these questions:
  - Do diverse belief systems related to health, healing, and wellness exist?
  - Can cultural differences in perceptions of mental illness and behavioral issues be identified?
  - In what ways does culture influence the family’s help-seeking behaviors and/or attitudes toward mental health professionals?
  - Does the family desire to use indigenous and traditional healing practices as a part of the treatment process?

- Consider consulting or collaborating with cultural brokers in the treatment process when cultural barriers or differences exist.

- Work through the provider agency and outside resources to find the appropriate culture-specific service or cultural broker to assist the treatment process. When seeking an appropriate cultural broker, consider these questions:
  - Can the individual act as a liaison between the provider and the child, youth, and family?
  - Is the individual sufficiently well versed in the family’s culture to act as a cultural guide?
  - Will the individual be able act as a mediator between the two cultures, if necessary, to reach the best possible outcome for the family?
  - Can the individual assist the family by acting as a catalyst for change?
Implementación de Estrategias (cont’d)

- Identificar el recurso específico de la cultura o el broker cultural que es el más adecuado a las necesidades de la familia con la que el proveedor está trabajando. Los brokers culturales pueden ser cualquiera de las siguientes:
  - Atención de alcance o paraprofesional de salud mental o otro trabajador de atención de salud.
  - Mentor par.
  - Miembro de la comunidad.
  - Líder administrativo.
  - Interprete lingüístico.
  - Anciano o líder tribal.
  - Shaman.

- Identificar los recursos específicos de la cultura o los brokers culturales que son fácilmente accesibles a la familia y al proceso de tratamiento. Idealmente, los brokers culturales estarán disponibles a través de diversos contextos que sean fácilmente accesibles y familiares a la familia, tal como:
  - Centros de salud comunitarios.
  - Organizaciones comunitarias.
  - Iglesias, mezquitas, kivas, plazas, templos, y otros lugares de culto.
  - Escuelas.
  - Centros comunitarios para migrantes.

- Ayudar a las familias a desarrollar relaciones beneficiosas con las redes de apoyo a largo plazo para reducir la dependencia del sistema de atención de salud y favorecer la independencia de la familia.

Implementation Strategies (cont’d)

- Identify the culture-specific resource or cultural broker that is most suited to the needs of the family with which the provider is working. Cultural brokers may be any of the following:
  - Outreach or paraprofessional mental health or other health-care worker.
  - Peer mentor.
  - Community member.
  - Administrative leader.
  - Linguistic interpreter.
  - Tribal elder or leader.
  - Shaman.

- Identify culture-specific resources or cultural brokers that are easily accessible to the family and to the treatment process. Ideally, cultural brokers will be available through various settings that are easily accessed and familiar to the family, such as:
  - Community health centers.
  - Community-based organizations.
  - Churches, mosques, kivas, plazas, temples, and other places of worship.
  - Schools.
  - Migrant community centers.

- Assist families in developing beneficial relationships with community supports over the long term to reduce dependence on the health-care system and enhance the family’s independence.
Each of the tools listed below has specific resources that you can locate in the general resource section on pages 78–80. This guide lists and links pertinent resources within each tool name.

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<td>Provision of Appropriate Language Services</td>
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<td>Ethnic-Specific Assessment</td>
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<td>Utilizing Cultural and Ethnic Resources</td>
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✔ Articles


✔ **Assessment Tool**


✔ **Books**


✔ Report


✔ Tool Kit


✔ Websites


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\(^{15}\) 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*,\(^{16}\) 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.


Implementation Strategies (cont’d)

■ Develop skills of “dynamic sizing” and “scientific-mindedness.”

➤ 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.)

Implementation Strategies (cont’d)

- 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.

- 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.
Assessing Cultural Skills

Purpose

To identify methods for assessing and developing the cultural skills of FSP team members.

Definition

Organizations and individual providers increase effectiveness by ensuring culturally competent service provision. Numerous guidelines and tools are available for developing and assessing cultural skills for both the individual and organization. Regular and ongoing cultural competence training and assessment help to ensure that children, youth, and families of diverse cultures and backgrounds are afforded competent and effective treatment.
Implementation Strategies

■ Identify tools for measuring cultural competence, and implement the use of appropriate instruments.

■ Operate education and training programs to ensure that providers improve their cultural competency skills. Training programs should be ongoing in order to give staff members recurrent opportunities for participation. Conduct evaluation of the training to ensure that cultural competence of providers is improved and that the mental health of children, youth, and families is promoted. The evaluation process further identifies any impediments to attainment of cultural competence within the organization.

■ Endorse and support attainment of cultural competence continually. Provider motivation and learning increase and are sustained when accompanied by demonstrated commitment to cultural competence over a long period.

■ Develop clear goals and values in enacting culturally competent services, and communicate those goals to the staff. Foster a clear understanding of culturally competent behaviors and expectations for providers.

■ Engender awareness of cultural diversity within the provider staff as well as in local communities.

■ Ensure availability of resources, including educational materials and information, assessment tools, and training follow-up. Encourage use of resources available inside and outside of training.
Culturally Varying Views on Developmental Milestones

Purpose

To teach providers that cultural differences exist in developmental expectations and to promote individualized, culturally sensitive approaches to assessment of the achievement of developmental milestones.

Definition

Developmental milestones are viewed differently across cultures. Children may first attain milestones such as becoming accustomed to sleeping separately from parents, spending time away from home in day care or school, and acquiring responsibilities in the home at different ages, depending on the cultural expectations of the child and family. To help identify developmental concerns, providers must be aware of culturally varying views on developmental milestones, by retaining a focus on cultural norms within the child’s family and community as well as variations within the individual and community. Ascertain what
is considered normal in the child’s culture or community. Find out if the child’s or family’s expectations differ from those of their community or of the dominant culture. Investigate whether expectations differ depending on the child’s gender (e.g., if girls are expected to contribute toward household upkeep or caregiving of siblings or infirm relatives). Understanding, assessing, and respecting culturally specific developmental expectations are important in ensuring that the treatment process adequately accommodates the needs of the child or youth.
Explore, as part of the assessment process, the caregiver’s expectations about the timing of developmental milestones.

Ensure that the assessment of the child’s development takes into account the provider’s knowledge and expertise on child development, the caregiver’s expectations, and community norms.

Prevent parents from forming unrealistic developmental expectations. When working with a family whose culture is unfamiliar, consult with cultural brokers and/or extended family or community members (with informed consent) regarding the child’s behavior, in order to determine whether the behavior represents a departure from behavior that is considered normal in the child’s culture.

Understand and respect the cultural beliefs that may influence parental explanations for areas of concern. At times, parents may disagree on the causes of developmental problems. For example, the provider may attribute a behavior to a neurological deficit, while parents may believe it is caused by a spiritual event.

Utilize cultural-specific resources as appropriate when developmental milestone deficits are of concern. Identify and utilize culturally responsive assessment approaches for children and youth as needed.
Organizational Assessments for Cultural Competence

Purpose

To assist organizations and providers in adequately assessing the level of cultural competence of FSP programs.

Definition

Organizational assessments for cultural competence may be used to identify areas of cultural competence strength and areas for growth in FSP programs. Numerous types of assessments can be used to evaluate cultural competence in organizational commitment to cultural competence, provision of language-appropriate services, and policies and practices related to cultural competence.
Implementation Strategies

- Gather data on demographic needs of the community served to evaluate the organization’s ability to meet the community’s cultural and linguistic needs.

- Choose a relevant and valid form of measurement to assess the level of cultural competence in relationship to the needs of the clients served.

- Develop realistic, specific, measurable goals to reach the level of cultural competence necessary to serve the agency’s demographic population. Topics worthy of consideration may include:
  - Focusing on recruitment of bilingual and bicultural providers and staff members.
  - Identifying and building partnerships with sources of cultural- and ethnic-specific services within the community.
  - Identifying and accessing cultural brokers for various populations served.
  - Developing ongoing mandatory cultural competence training for the entire staff.
  - Shaping the organization’s environment to be culturally welcoming and supportive.

- Initiate action plans to advance cultural competence goals with individuals or groups assigned to administer action plans and timelines.

- Engage in recurrent assessment of community needs and organization capacity to serve those needs. Adjust cultural competence goals and practices as the organization and community undergo change.
Each of the tools listed below has specific resources that you can locate in the general resource section on pages 94–96. This guide lists and links pertinent resources within each tool name.

<table>
<thead>
<tr>
<th>Name of Tool</th>
<th>Resource Number(s)</th>
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</thead>
<tbody>
<tr>
<td>Developing Cultural Self-Awareness or Cultural Humility</td>
<td>7,10,11,12,13,15</td>
</tr>
<tr>
<td>Assessing Cultural Skills</td>
<td>4,6,9,16</td>
</tr>
<tr>
<td>Culturally Varying Views on Developmental Milestones</td>
<td>2,5</td>
</tr>
<tr>
<td>Organizational Assessments for Cultural Competence</td>
<td>1,8,14,16</td>
</tr>
</tbody>
</table>
✔ Articles


**Assessments for Cultural Competence**

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

   Retrieved from http://mighealth.net/eu/images/0/0b/Banc.doc


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


✔ **Books**

Essay


Guide


Training Workbook


Website

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.
Ethnic Disparities in the Child Welfare System

Purpose

To develop awareness of the disproportionality of ethnic minority children in child welfare systems (CWS). To enhance the provider’s awareness of factors that may result in disproportional representation of minority children in these systems, and to develop strategies for resolving these inequities.

Definition

*Ethnic disparities in the child welfare system* result in disproportionate representation of minorities. Disproportionality is particularly dramatic for African American children, who are more likely than White children to be reported as victims of child abuse, to be the subject of investigations that are substantiated, to be removed from their homes, and to spend more time in the foster care system.
Definition (cont’d)

While ethnic minorities experience greater exposure than White children to risk factors for child maltreatment, national incidence studies suggest that minority children do not experience greater rates of maltreatment. Therefore, many social scientists have suggested that biases in reporting, investigating, substantiation, and placement account for the ethnic disparities in child welfare involvement. Developing an awareness of these biases is critically important in addressing disparities in the CWS.
Implementation Strategies

■ Develop an awareness of disproportionality in local communities. Questions to ask include:
  ➢ What are the child welfare statistics for the county?
  ➢ Who is overrepresented in the CWS and criminal justice system?

■ Recognize the impact that overrepresentation of ethnic minority communities can have on a family’s willingness to engage in the treatment process.

■ Identify strategies to reduce disparities, such as promoting agency awareness of disproportionality, collecting accurate data on race and ethnicity, identifying areas of potential bias in the process, and improving relationships with ethnic and cultural minority communities.

■ Engage cultural brokers and community leaders in developing strategies to resolve disparities in the CWS.

■ Understand and acknowledge the family’s perspective on how and/or why they have become or are at risk of becoming involved in the legal system and CWS. Maintain an objective and supportive stance.

■ Build a constructive working relationship among the treatment team, child welfare providers, and the family. Identify and recognize common goals and mutually beneficial outcomes.

■ Help families recognize areas in which risks can be overcome through treatment processes and building of protective factors (e.g., parenting skill building, creating opportunities for children and youth to engage in beneficial, meaningful activities) that will increase the likelihood of becoming independent of the CWS systems.
Implementation Strategies (cont’d)

- Create a safe environment for parents and/or caregivers to explore and process their perceptions of the various systems. Assist the family in processing concerns in a constructive, solution-focused manner and in advocating for themselves. Guide families in ways of building useful and mutually beneficial communication and collaboration with representatives of the CWS and other social service systems.
Purpose

To assist providers in understanding and recognizing the impact of socio-cultural factors, and to identify strategies for resolving detrimental socio-cultural conditions in the treatment process.

Definition

_Socially isolating factors_ such as poverty, incarceration, special education, physical disabilities, gang involvement, immigration status of children and parents, domestic violence, and child welfare services involvement often increase the social isolation of children, youth, and families experiencing mental health issues. Ethnic minority children, youth, and families have greater exposure to these adverse conditions, which can play a critical role in their ability to effectively participate in the treatment process and build resiliency. FSP providers should consider these factors in the assessment and treatment planning processes and help families find ways of overcoming these obstacles.
Implementation Strategies

- Include assessment and consideration of socially isolating factors in the assessment process. Determine the family’s economic status and the level of stress it creates for the family. Evaluate the living environment of the family and associated risk factors (e.g., neighborhood violence, drug use).

- Explore with the family any resources available for building resiliency. Determine the role of the extended family and other potential family supports, and incorporate them into the treatment process.

- Note culturally relevant interpretations of social stressors, available social supports, and levels of functioning and disability. Encourage incorporation of culturally relevant kin networks, religious practices, and social environmental supports that will contribute to the success of treatment interventions.

- Identify social factors that cause the family significant stress, shame, stigma, and discrimination. Assist the family in identifying and using personal and community resources – including culturally appropriate social networks, and connection to community agencies and services that can assist in addressing the socially isolating factors – to overcome those stressors.

- Act as advocates for the family, linking them to social and cultural services that are equipped to reduce these socio-cultural disparities. Seek programs that are located in areas that are easily accessible and safe for the families. Providers should be prepared to meet families in their own communities to assist them in developing safety within their high-risk environment.
Each of the tools listed below has specific resources that you can locate in the general resource section on page 105. This guide lists and links pertinent resources within each tool name.

<table>
<thead>
<tr>
<th>Name of Tool</th>
<th>Resource Number(s)</th>
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<tbody>
<tr>
<td>Ethnic Disparities in the Child Welfare System</td>
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<tr>
<td>Socially Isolating Factors</td>
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Articles


Tool Kit

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”

19 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.”20 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.

20 (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 Children, Youth, and Families

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 children, youth, and families are interventions that have been shown scientifically to reduce or eliminate symptoms of mental illness, or to improve outcomes for people with
Definition (cont’d)

mental health problems. 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 children, it identifies interventions that are considered “mental health treatments” (as opposed to “mental health promotion”) and programs for children (ages 17 and below). The NREPP is intended to be used as a “decision support tool.” Interventions listed in this registry meet minimum criteria that include at least one experimental study supporting their use. 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:

- Its scores meet agency standards for efficacy and readiness for dissemination with specific populations.
- It is directed at target outcomes identified by the organization or community.
- It is appropriate to the individual needs of the child, youth, and family.
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 0–17. 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 Children and Youth (Ages 0–17)</th>
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<tbody>
<tr>
<td>Children’s Summer Treatment Program (STP):</td>
</tr>
<tr>
<td>Incredible Years:</td>
</tr>
<tr>
<td>Multidimensional Treatment Foster Care (MTFC):</td>
</tr>
<tr>
<td>Multi-systemic Therapy (MST) for Juvenile Offenders:</td>
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<tr>
<td>Nurturing Parenting Programs:</td>
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<tr>
<td>Parent-Child Interaction Therapy:</td>
</tr>
</tbody>
</table>

Interventions tested with 50% or more of the population selected: None

<table>
<thead>
<tr>
<th>Evidence-Based Practices for Latino/Hispanic Children and Youth (Ages 0–17)</th>
</tr>
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<tbody>
<tr>
<td>Brief Strategic Family Therapy*:</td>
</tr>
<tr>
<td>Celebrating Families!:</td>
</tr>
<tr>
<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>Challenging Horizons Program (CHP):</td>
</tr>
<tr>
<td>Child-Parent Psychotherapy (CPP):</td>
</tr>
<tr>
<td>Coping Cat:</td>
</tr>
<tr>
<td>Intervention</td>
</tr>
<tr>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Family Behavior Therapy:</td>
</tr>
<tr>
<td>Incredible Years:</td>
</tr>
<tr>
<td>Multisystemic Therapy (MST) for Juvenile Offenders:</td>
</tr>
<tr>
<td>SOS Signs of Suicide:</td>
</tr>
</tbody>
</table>

*Interventions tested with 50% or more of the population selected*

Evidence-Based Practices for Black/African American Children and Youth (Ages 0–17)

Brief Strategic Family Therapy:                                        
<table>
<thead>
<tr>
<th>Intervention</th>
<th>Link</th>
</tr>
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<tbody>
<tr>
<td>Chestnut Health Systems – Bloomington Adolescent Outpatient (OP) and Intensive Outpatient (IOP) Treatment Model:</td>
<td><a href="http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=140">http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=140</a></td>
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<tr>
<td>Coping Cat:</td>
<td><a href="http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=91">http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=91</a></td>
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<tr>
<td>Family Behavior Therapy:</td>
<td><a href="http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=113">http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=113</a></td>
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<tr>
<td>Incredible Years:</td>
<td><a href="http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=93">http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=93</a></td>
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<tr>
<td>Multisystemic Therapy (MST) for Juvenile Offenders*:</td>
<td><a href="http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=26">http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=26</a></td>
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<tr>
<td>SOS Signs of Suicide:</td>
<td><a href="http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=53">http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=53</a></td>
</tr>
</tbody>
</table>
Trauma-Focused Cognitive Behavioral Therapy (TF-CBT):  

*Interventions tested with 50% or more of the population selected

### Evidence-Based Practices for Asian Children and Youth (Ages 0–17)

**Child-Parent Psychotherapy (CPP):**  

**Coping Cat:**  

**Incredible Years:**  

**Interpersonal Psychotherapy for Depressed Adolescents (IPT-A):**  

**Multidimensional Treatment Foster Care (MTFC):**  

**Multisystemic Therapy (MST) for Juvenile Offenders:**  

**Multisystemic Therapy With Psychiatric Supports (MST-Psychiatric):**  

**Parent-Child Interaction Therapy:**  

**Seeking Safety:**  

**SITCAP-ART:**  

**SOS Signs of Suicide:**  

**Surviving Cancer Competently Intervention Program:**  

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

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### Evidence-Based Practices for Native Hawaiian/Pacific Islander Children and Youth (Ages 0–17)

**Multisystemic Therapy With Psychiatric Supports (MST-Psychiatric):**  

*Intervention tested with 50% or more of the population selected
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 comunicación* for “child-directed interaction.”

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Culture-Specific Interventions

**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.
- 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:
  - 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 131–132. This guide enables you to focus on the pertinent resources linked directly to each tool.

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


Appendix A

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Community-Defined Programs:

1. Asian Pacific Family Center East: IMPACT! – A Youth Development and Leadership Program ................................................................. 136

2. Beats, Rhymes, and Life: Rap Therapy for TAY of Color .................. 139

3. Latino Health Access: Promotor Program .......................................... 142

4. Sacramento Native American Health Center: Warrior Down Program ........................................................................................................ 146

5. Transcultural Wellness Center ................................................................ 150
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.

23 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=UUls2TAEGPvBBatJyagyXJoVw&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.