Full Service Partnership Tool Kit

California Institute for Mental Health

2012
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Full service partnership (FSP) programs were designed under the leadership of the California Department of Mental Health in collaboration with the California Mental Health Directors Association, the California Mental Health Planning Council, the Mental Health Services Oversight and Accountability Commission, mental health clients and their family members, mental health service providers, and other key stakeholders of the mental health system. Although in existence since 2005, full service partnership programs are continuing to develop the distinguishing characteristics that lead to good outcomes for mental health clients and their families.

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

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

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

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

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

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

The Cultural Relevance Tool Kit is meant to be used in conjunction with the Philosophy and Practices Tool Kit for a particular age group.
Background

California continues to lead the nation in ethnic and cultural diversity, with approximately 57% of the population identifying as ethnic minorities. Of the minority population, 37% are Hispanic or Latino (any race); 13% Asian; 6.2% African American; 1% Native American; 4.9% multiracial; and 0.4% Native Hawaiian or Pacific Islander.¹ Given the demographics of this state, mental health providers and mental health organizations must be prepared to meet the needs of dynamic, culturally rich, and diverse client communities.

Disparities in Mental Health and Mental Health Services

Ethnic minorities constitute a significant portion of the population in need of services, yet receive fewer mental health services and poorer quality 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;\textsuperscript{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 “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 and community-defined practices.

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.
Understanding the Client’s Cultural Identity

Purpose

To assist providers in developing an assessment process that fosters a strong and positive therapeutic relationship and promotes a deep and compassionate understanding of the client’s worldview.

Definition

*Understanding the client’s cultural identity* requires knowing the way in which the client perceives his or her ethnicity, race, gender, age cohort, and any other characteristic of culture that is an important component of self-concept.
Implementation Strategies

- Develop cultural formulations by reviewing the Diagnostic and Statistical Manual IV-TR’s “outline for cultural formulations.”\(^8\) Assess and understand each client’s cultural identity using this outline:
  - Cultural identity of the individual.
  - Cultural explanation of the individual’s illness.
  - Cultural factors related to psychosocial environment and levels of functioning.
  - Cultural elements of the relationship between the individual and the clinician.
  - Overall cultural assessment for diagnosis and care.

- Assist clients in expressing their stories. Develop a set of questions that the staff can use to inquire about clients’ cultural stories.\(^9\) These may include asking clients to tell where they are from and how they arrived, to describe their family and culture, and to discuss their upbringing and values.

- Maintain an accepting attitude.

- Collaborate with cultural ambassadors or cultural brokers to develop working relationships with persons who are culturally similar to the clients served, and seek information about the culture. For example, staff members could spend time at an ethnically specific senior center, make connections with staff or volunteers there, and ask for information about older adults from that culture.

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Train the staff in using cultural and racial identity development models. (Refer to the “Acculturation” tool.). For example, consider the following stages:\textsuperscript{10}

- Stage 1 — Initial conformity to the prevailing culture.
- Stage 2 — The beginning of questioning initial conformity through awareness of racism and stigma, thereby taking pride in one’s own culture and race.
- Stage 3 — Embracing one’s own ethnic and cultural activities and norms while no longer conforming to the dominant culture.
- Stage 4 — Becoming independent of one’s own ethnic background and culture by developing an autonomous cultural and ethnic identity.
- Stage 5 – Combining one’s ethnicity and culture with that of the prevailing culture, while maintaining a separate interest such as advocating on behalf the individual’s culture and ethnicity.

Utilize guidelines such as the Standards for Multicultural Assessment\textsuperscript{11} for ethnic-specific assessment. Acknowledge older adults’ desires (when appropriate) to maintain aspects of traditional culture in order to keep their culture alive.\textsuperscript{12}

Develop an understanding of the cultural identity differences between the client and the service provider.

Understand that offering food or giving small gifts is a common practice in some cultures, and that clients may be offended if offers are refused. For example, in some Middle Eastern cultures, hosts may become insulted if a


Implementation Strategies (cont’d)

guest in their home declines an offer of food. Likewise, in some Latino cultures, persons may feel slighted if a gift or food offering is refused. Although counselors generally should decline large gifts, accepting small gifts or food from clients is clinically permissible and culturally appropriate in many cases. Help clinical staff members determine the best course of action in each case by discussing the cultural context, the staff’s level of comfort in accepting the food or gift, and the potential ramifications for the therapeutic relationship.
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\(^{13}\) 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.

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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.
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, Somali, and other populations that are not reflected in U.S. Census categorization may be crucially important in some counties. By interviewing key cultural leaders and representatives of community-based organizations (CBOs), county service agencies may develop a more comprehensive awareness and understanding of such cultural and ethnic groups.

Developing Knowledge

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

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

- Train the staff to research each client’s country of origin. Discuss with the client the tentative understandings gained from staff’s research, and seek clarification, corrections of misinterpretations, and elaboration.
Implementation Strategies (cont’d)

- Study major events and experiences to which members of the agency’s cultural clientele may have been subjected.\(^{14}\) Clients and conditions to consider 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”\(^{15}\).

- 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


Implementation Strategies (cont’d)

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.

- Be aware that older adults are more likely to have firsthand experience of more pronounced forms of racism and discrimination\(^{16}\) given that they have lived during earlier periods.

Purpose

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

Definition

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

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

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

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

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

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

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

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

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

Purpose

To understand the client’s views on the causes and treatments of mental illness. To assist the FSP staff in engaging clients by collaborating to reach an understanding of the causes and treatment of mental illness by taking into account the perspectives of the client as well as the provider.\(^ {17} \)

Definition

*Perceived causes of illness and help-seeking behavior* differ among cultures. Exploring clients’ explanations of the causes of their mental health problems and the kinds of interventions, treatments, or healing practices commonly used in their community is critical for engaging the client in a collaborative and strong therapeutic alliance. Clients’ understanding of mental health and mental illness may differ from that of the

Definition (cont’d)

provider. Clients consequently may seek help in different ways or through avenues other than through the mental health system, and they may express illness through culture-bound syndromes, or “localized, folk, diagnostic categories that frame coherent meanings for certain repetitive, patterned, and troubling sets of experiences and observations.” While the client’s views may differ from that of the FSP team, validating clients’ perspectives and coming to a mutually agreed-upon treatment plan that incorporates both the client’s and the provider’s beliefs and practices will increase the likelihood of client engagement and treatment adherence.
Implementation Strategies

- Become knowledgeable about what older adult clients from different cultural backgrounds are likely to believe about what causes their mental illness and what is most likely to help them recover. For example, Chinese, Mexican, and Native American elders may believe their illnesses are caused by imbalances, so treatment could be oriented toward restoring balance; African American, Native American and Latino elders may believe that spiritual causes are involved, and therefore spirituality may be involved in resolving the illness. Alternatively, in some cultures psychological problems are seen as the result of a person’s wrongdoing, or that of his or her ancestors. Understand that older adults from many cultural backgrounds may be more likely to believe that their problems are caused by physical or medical factors, and may seek help from a medical doctor rather than from a mental health practitioner.

- Gain understanding of the complementary and alternative medicine (CAM) approaches to medical and mental health problems that older adults may be likely to use.

- Ask clients questions such as “What do you believe caused this problem?” Consider initiating an opening to talk about spirits, as well as curanderos and other folk healers.

- Consider using Arthur Kleinman’s explanatory model of illness to elicit

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the client’s perspective of illness. These include asking what the client’s name for the illness is, the cause, and other questions through which to understand the client’s viewpoint of the illness.

■ Maintain an accepting attitude. Let the client and family know that their ideas are valued in developing the care plan.

■ Ask if the client has any ideas about ways to get better, and use the answer to develop a plan that incorporates both client and provider approaches.

■ Inquire if the client has requested anyone else to help with the problem.

■ Ask patients what worries them most about their illness. Learn about normative help-seeking behaviors in targeted ethnic groups when developing outreach strategies. For example, dementia may be considered a normal part of aging, and therefore community education and outreach through trusted community members may be necessary before caregivers would accept interventions.

■ Become familiar with culture-bound syndromes common to the cultures the FSP team generally serves. Culture-bound syndromes are more likely to be evidenced in first-generation immigrants than in subsequent generations, particularly among older adults who spent most of their lives in their country or immersed in their culture of origin. Characteristics of these syndromes may include specific terminology from their cultures, with corresponding definitions as used in the client’s culture of origin. For example, ataque de nervios is “an out-of-consciousness state resulting from evil spirits among Latinos.”

Religious and Spiritual Beliefs

Purpose

To enhance rapport building and to build on clients’ strengths by understanding each client’s belief systems with regard to religion and spirituality.

Definition

*Religious beliefs* may include a person’s thoughts and behaviors regarding formalized rituals, traditions and/or group activities. *Spiritual beliefs* may include a person’s thoughts and beliefs about existence, transcendence, a higher power, the universe, the meaning of life, and other aspects of life that are beyond themselves. These beliefs may be particularly important to older adults as they age and begin to contemplate death and dying.
Implementation Strategies

- Understand that spiritual beliefs are important to a majority of older adults; 85–95% of older adults have been found to endorse significant religious and/or spiritual beliefs\textsuperscript{25,26,27} that may affect their mental health, their mental illness, and openness to treatment.

- Train staff members about sensitive ways to inquire about the client’s spiritual beliefs and behaviors.

- Become familiar with spirituality assessment tools, such as:
  
  - The HOPE questions for spiritual assessment:
    - H – sources of Hope, meaning, comfort, strength, peace, love, connection;
    - O – Organized religion;
    - P – Personal spirituality and practices;
    - E – Effects on medical care and end-of-life issues.\textsuperscript{28}

  - Joint Commissions on Accreditation of Healthcare Organizations (JCAHO) questions:\textsuperscript{29}
    - “Are spirituality or religion important to you?”
    - “Are there certain spiritual beliefs and practices that you find particularly helpful in dealing with problems?”

Implementation Strategies (cont’d)

“Do you attend a church or some other type of spiritual community?”

“Are there any spiritual needs or concerns I can help you with?”

- Consider focusing on how clients may use their religious or spiritual beliefs to cope with illness, and/or how such beliefs may conflict with or influence medical decisions.30

- Teach the staff how to help clients enhance religious or spiritual practices that serve as strengths and coping skills.

- Facilitate development of collaborative relationships with faith communities in which the program’s clientele frequently participate. Learn from these faith leaders about some of the beliefs and practices, and refer clients to specific faith centers as appropriate.

- Learn about culturally sanctioned healing practices such as sweat lodges, shaman spiritual practices, and herbal remedies, and explore ways to validate these approaches within the therapeutic plan.

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The Role of Family and Decision Makers

Purpose

To ascertain and understand the older client’s preferences regarding level of engagement of his or her family in the mental illness diagnostic and treatment process, and to determine the propriety of the role of family members as a component of effective treatment.

Definition

Exploring the role of family and decision makers involves determining who the client views as intimate, significant others, and the roles that the client wants those people to take in their lives and in their treatment. Clients may also choose to exclude specific or all family members from their treatment process. This exploration may encompass immediate family members, including the client’s children or spouse, or it may include more extended family, including “fictive kin.”
Implementation Strategies

- Remember that many cultures assign greater importance to the family or community (collectivism) than to the individual (individualism).

- Learn about the values of local communities and the ways in which these influence clients’ approach to treatment, and the extent to which clients desire the involvement of significant others in their care.

- Assess who may be the “gate keeper” or the primary decision maker in the family. For example, Latino older adults (most often women, and particularly, elders) may be more likely to defer decisions to adult children; Asian elders, in contrast, may be more likely to defer to male family members. Find ways to connect with members of the family, including key decision-makers, while respecting the client’s right to decide who will participate in treatment.

- Evaluate what the older adult prefers regarding whom the staff should include in the treatment decisions. Empower the client to be as involved as he or she wants to be, while also respecting the client’s preferences, even if those desires conflict with the staff’s recommendation.

- Consider that while awareness of culturally defined hierarchies in families is important, this awareness should not prevent the provider from assessing for elder abuse when signs are present. If the older adult appears to defer completely to family members, consider consulting with a cultural broker to determine whether this behavior is culturally normative or is indicative of a harmful relationship.

- Recognize that members of some cultures believe that an older adult should not be told of his or her diagnosis or other bad news. Providers can gain an understanding of cultural norms regarding disclosure of medical information by gently questioning the client and family or observing fam-

Implementation Strategies (cont’d)

ily interactions. In addition, cultural brokers may be able to advise about common cultural norms and practices relevant to disclosure of diagnostic or other information. The Stanford Curriculum in Ethnogeriatrics and other resources may help providers determine a course of action.

- Deliberate carefully before disclosing diagnostic information to an older adult FSP client if withholding such information is the cultural norm for the client. The staff person will have to decide whether or not to reveal such information, and how to disclose it. An important consideration is the source of the diagnosis. For example, if the diagnosis is made by someone outside the FSP team, collaboration among the diagnostician and the provider may be advisable to determine the best approach. When possible, engage the family in a discussion regarding the potential ramifications of disclosing information to the client.

- Consider asking the older adult in a private conversation how much he or she wants to know about the illness, if you perceive that the client’s wishes differ from those of the family. Ask the client to identify who should make decisions about treatment.

- Discuss, when possible, the issue of disclosure at the outset of treatment, so that the client and family are empowered to decide who will be given diagnostic and other pertinent information.

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

To build upon strengths and promote self-esteem and self-efficacy.

Definition

*Strengths and protective factors* are individual characteristics, cultural values, and practices that enhance clients’ mental health, self-esteem, and recovery, and that buffer clients from the effects of adversity.
Implementation Strategies

- Help clients develop a positive ethnic identity. Some minority older adults may experience internalized racism. Coach clients in examining the ways in which experiences of racism and discrimination contribute to a negative sense of self and to the development of mental health problems. Explain that gaining an understanding of the history and impact of oppression can help clients counteract these experiences and empower them to confront and circumvent oppression. Empowering activities may range from writing a journal to engaging in local advocacy efforts.

- Acknowledge and build upon the reverence and respect that older adults in many ethnic communities gain as they age.

- Consider what degree of family involvement is appropriate in the client’s culture. For example, in many Latino groups, family involvement is more intense than in non-Latino White cultures. Awareness of these differences will enable counselors to increase their sensitivity and responsiveness to client preferences for family involvement.

- Encourage culturally congruent spiritual practices when desired by the client.

- Ask clients which traditions and practices that they are carrying on from their cultural background give them the greatest sense of pride.

- Ask clients which traditions and skills they would like to teach the younger generation.

- Encourage and help the older adult to use writing, audio, or video to record proud memories from his or her life, to pass on to the next generation.

- Help elders investigate community centers where they might be able to participate in ethnic dancing, traditional art or beading, gardening or cooking classes, or other meaningful cultural traditions, at a community senior center or ethnic community center.
Cultural Views on Death, Dying, and Grieving

Purpose

To assist providers in working with older adults by exploring how the older adult’s culture of origin approaches the process of grieving, dying, the event of death, and what is thought to occur after death. To explain how providers can help clients articulate their hopes, wishes, fears, and sources of grief.

Definition

*Cultural views on death, dying, and grieving,* as well as events after death, differ among individuals and groups. To care for adults with serious medical illnesses in a compassionate and culturally responsive manner, providers must develop an understanding of and be responsive to the client’s cultural beliefs and attitudes regarding the experience of death.
Implementation Strategies

- Learn about how the communities served view talking about death and dying. Members of some cultures consider such talk inappropriate or a death wish, and may believe that such a discussion can have the power to bring about death.

- Study the cultural beliefs regarding the appropriate place to die, who should be present, who should make decisions about the dying person, and what is the appropriate treatment of the person’s body.

- Familiarize yourself with common cultural beliefs about what occurs during the moment of death, and after death, including prescribed rituals.

- Help the staff gain comfort in discussing these issues with clients.

- Inform clients about the value of considering their preferences for treatment should they become seriously ill, and encourage them to discuss those preferences and consideration of advance directives with their primary-care physician.

- Learn about each culture’s typical mode of grieving, and the nature of emotional expression in the grieving process.
Purpose

To understand how individuals and families from different cultures view dementia and other forms of cognitive impairment, in order to speak with them sensitively and enable them to receive help.

Definition

Older adults may experience cognitive functioning changes, including decline in cognition as a characteristic of normal aging, lapses in attention, changes in perception due to sensory deterioration, judgment impairment, dementia, and delirium. To adequately serve older adults of diverse ethnic and cultural backgrounds, providers must be familiar with signs of cognitive impairment and dementia and the differing ways in which various cultures acknowledge and cope with these symptoms.
Implementation Strategies

- Study differences in cultural views on cognitive impairment and dementia. For example, research suggests that Hispanic and Chinese family caregivers tend to believe that Alzheimer’s disease is a normal part of aging. Research each culture’s views on caregiving. Some studies show that Hispanic and Chinese family caregivers may delay seeking help until late in the process. Native American caregivers may view caregiving as sacred, to be undertaken with “passive forbearance.” African American and other ethnic minority families are more likely than non-Latino White families to provide care within the family and community, and less likely to seek professional help for dementia.

- Help the FSP staff develop a culturally attuned understanding of caregivers’ susceptibility to depression, anxiety, and associated secondary disabilities or illnesses caused by the primary disability. For example, African Americans are less likely than Whites to report stress associated with caregiving.

- Develop referral options for clients with dementia, as well as for caregivers.

- Validate caregivers’ cultural values regarding caregiving responsibility. Assist caregivers in obtaining help that is culturally congruent and from providers that are culturally acceptable.

- Explore options for obtaining support and respite, including community support networks, family, and friends.

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Use of Complementary and Alternative Treatments

Purpose

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

Definition

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

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

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

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

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

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

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

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

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

■ Ensure that the staff has easily accessible up-to-date information regarding local resources and social service agencies. Schedule monthly “field trips” to local service agencies as a means of encouraging staff members to establish connections with them.
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.
Each of the tools listed below has specific resources that you can locate in the general resource section on pages 58–61. This guide enables you to focus on the pertinent resources linked directly to each tool.

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Cultural Barriers to Care

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

Purpose

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

Definition

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

- Recruit and hire staff members who speak languages prevalent in the program’s service area.

- Develop relationships with graduate schools that train ethnically and linguistically diverse students; develop a training program and career ladder that encourages trained students to remain as staff members.

- Create and translate written forms in a level of language that is accessible for persons with little or no formal education. Consider making photo novellas for certain uses, especially health education.

- Train the staff to pay close attention to the vocabulary they use and to match their diction to the client’s educational level. Teach the staff how to assess for level of verbal and written literacy.

- Evaluate the client’s literacy level carefully. When working with members of cultures in which written language is limited, be certain to review written material carefully and at a pace that the client finds comfortable and sufficient for good comprehension.

Working with Language Translators

- Develop a network of trained language translators. Ensure that translators are trained in cultural sensitivity, and discourage them from applying their own interpretations of the content.

- Specify, when possible, use of translators who share the client’s ethnic background and who have mental health training.

- Maintain eye contact with the client and/or family members.

- Speak clearly, in a regular voice, one to two sentences at a time. Allow extra time for translation and for the family to ask questions.

- Use simple language and avoid jargon.
Implementation Strategies (cont’d)

- 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.
Cultural Responsiveness in Clinical Encounters

Purpose

To enhance rapport and relationship building by identifying potential cultural differences in areas such as communication approaches, values, and experiences, and addressing these differences.

Description

Cultural differences between providers and clients may exacerbate barriers to care for minority clients. To reduce barriers and provide effective cultural responsiveness in clinical encounters, providers should be aware of the ways in which their cultural values and behaviors may conflict with those of their clients, and should endeavor to respond to and surmount these differences either through direct disclosure and discussion or through flexibility in their approach and behaviors.
Implementation Strategies

- Develop a training plan to enhance staff ability to relate in a culturally sensitive manner. Train and assist the staff in understanding cultural differences and expressing genuine respect and regard for clients of diverse backgrounds.

- Engage the client in sensitive inquiry about perceived cultural differences between himself or herself and the service provider. For example, ask questions such as “I notice that you and I appear to come from different cultures. I’m middle aged, White, and a woman; you’re older, a man, and I think from an African American background. How do you think that might affect our work together?” This training also may include acknowledging that certain topics are often thought to be too personal, but that they need to be discussed to enable the service provider to help the client.35

- Encourage staff members to explore how their own culture, values, beliefs, and stereotypes may affect the client-patient relationship.

- Learn and implement methods of showing age- and ethnically appropriate respect for older adults.

- Become familiar with culturally appropriate body language, including touching and gestures. For example, in some cultures, eye contact is expected, whereas in some Asian and Native American cultures, eye contact may be considered impolite or aggressive.36

- Research and incorporate culturally appropriate treatment tools.37

- For African Americans, consider addressing racial differences and experiences with discrimination directly; consider personalizing relationships through self-disclosure or discussing non-therapy topics; be

Implementation Strategies (cont’d)

receptive to topics of spirituality, emotional expressiveness and humor; consider involving an extended kinship network.38

➢ For Latino clients, consider ways to help the staff to incorporate characteristics of simpatia (high frequency of affiliative verbalizations), respeto (respect), personalismo, (informal, personal attention), familismo (sense of family obligations, closeness with family, and use of family as referents), platicando (leisurely chatting to create an accepting atmosphere), and confianza (mutual trust).39

➢ For Native Americans, consider linking with a pre-existing social relationship that the client has established in the community; contemplate the appropriateness of avoiding eye contact, possibly including other persons; begin with informal chatting about subjects of common interest; focus on a social frame of reference that the client and staff share; and demonstrate understanding of the client’s tribe, as well as the history of genocide of the American Indian community.40,41

➢ Train staff members in social etiquette that is culturally appropriate for working with Asian and Asian American clients. Incorporate “gift giving,” such as producing an immediate treatment benefit or suggesting practical strategies that the client may implement to alleviate symptoms; identify shared client-staff points of reference or experiences; openly elicit and receive descriptions of alternative medicine interventions; and emphasize structured, directive, problem-solving approaches.42,43

Implementation Strategies (cont’d)

- Therapeutic use of *dichos* — sayings, idioms, or proverbs in Spanish — can be effective with clients. Dichos can be used to facilitate an understanding atmosphere in the mental health therapeutic relationship, to build rapport, to enhance client participation, to strengthen cultural values and client self-esteem, and to aid client articulation of expression. Use dichos to enhance rapport and engagement, and as a tool for discussing significant problems that can benefit from a therapeutic response.

- Gain an understanding of cognitive behavioral therapy (CBT), which has been shown empirically to be effective with older adults\(^{44,45}\) in treating depression, anxiety, and insomnia, and has been shown to be promising in treating other disorders in older adults.\(^{46}\) Initial findings suggest that CBT is effective in treating Japanese and Asian Indian elders, Chinese American elders, and diverse ethnic minority elders.\(^{47,48,49,50}\)

- When using CBT, integrate culturally responsive CBT approaches such as allowing extra time for developing rapport with minority clients; incorporate concepts or stories from clients’ cultures; ensure that clients are informed about CBT, processes and potential outcomes; and focus on somatically targeted interventions.

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Immigration Status and Lack of Insurance

**Purpose**

To be able to serve persons whose documentation status interferes with their qualification for needed FSP services, and/or whose lack of insurance prevents them from receiving services.

**Description**

Lack of immigration documentation prevents many clients in need from accessing mental health services. To adequately serve local communities, FSP providers need to develop strategies for serving individuals whose pursuit of mental health-care services may be hampered by *immigration status* or *lack of insurance* coverage.
Implementation Strategies

- Understand the county government’s policy on serving undocumented clients.
- Develop funding streams that are not dependent on insurance benefits.
- Enact active outreach and engagement strategies. Develop working alliances with individuals and organizations that are known and trusted in communities where persons without legal documentation are likely to reside. Develop strong benefits establishment staffing.
- Research foundations locally and elsewhere in California that have a stated interest in older adults, or in mental health or human services, and work with those organizations to identify opportunities for grant funding.
- Enter discussions with the county department of mental health to search for financial resources to serve prospective clients who lack insurance.
- Recognize that some clients may be reluctant to discuss documentation status.
- Discuss fears regarding deportation with clients who are candid about documentation status, and identify situations that may jeopardize the clients’ residency in the U.S. Whenever possible, ensure clients’ safety and anonymity.
- Be aware of increased risk for undocumented clients. For example, undocumented clients may experience workplace harassment, discrimination and hate crimes. Further, undocumented families may experience prolonged or permanent separation if a family member is deported.
- Be aware of local activities of U.S. Immigration and Customs Enforcement personnel. For example, if I.C.E conducts raids in local communities, documented as well as undocumented Latino clients may be reluctant to seek services, attend sessions, or engage in other activities that may lead to detection and deportation.
Physical Immobility and Medical Barriers to Service

Purpose

To effectively reduce barriers, by first learning how medical illnesses and disabilities create barriers that impede older adults from receiving mental health services.

Definition

Racial and ethnic minority groups experience poorer health compared to non-Latino Whites. Approximately 39 percent of non-Latino Whites report very good or excellent health, while only 24 percent of African Americans and 29 percent of Latinos report very good to excellent health. In older adulthood, disparities are particularly pronounced in rates of chronic disease. For example, older adults from ethnic minority groups and from lower income groups experience diabetes and heart disease more frequently than members of the general population, and African American older adults have higher rates.

51 Centers for Disease Control and Prevention. (2007). The state of aging in America. Atlanta, GA.
Definition (cont’d)

of hypertension. To improve the likelihood that older adults will obtain needed services, FSP programs must develop service strategies that overcome *physical immobility and medical barriers to service.*
Implementation Strategies

- Research the medical illnesses and resulting disabilities prevalent among local ethnic and cultural groups.

- Identify and partner with local agencies that perform services specifically for ethnic minority individuals with chronic illness. Doing so is particularly important because ethnic minority older adults bear a significant burden of the health disparities in chronic disease. For example, organizations that conduct culturally relevant outreach and education regarding chronic illness, community health workers or promotores, and culturally responsive diet and exercise programs may be important partners for FSP programs. Collaboration with community partners may strengthen relationships with communities and may also enhance coordination of care.

- Increase staff knowledge of typical medical illnesses and disabilities and effective interventions for afflictions that affect the elders in the subgroups the FSP serves.

- Develop transportation options for clients by becoming familiar with available community resources, including “dial-a-ride” and paratransit services, and/or furnish transportation directly.

- Initiate psycho-education at the beginning of treatment to explain the differences between physical and mental illness.\(^{52}\)

- Conduct field-based services in clients’ homes, and train staff members about conditions that frequently arise when conducting in-home services.

- Develop close working relationships with medical providers.

- Co-locate services within primary-care clinics.

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Implementation Strategies (cont’d)

- Establish co-located services in other senior gathering places, such as senior centers and adult day health-care centers.
- Learn and encourage physical health promotion behaviors, including exercise, meditation, and healthy eating habits, and teach them to clients.
Reducing Stigma, Shame, Fear, and Mistrust

Purpose

To overcome reluctance to participate in mental health treatment because of stigma, shame, fear, and/or mistrust.

Definition

Stigma in mental health refers to the negative perceptions that people develop about individuals with mental health problems. Stigma manifests differently across cultural groups. Evidence has demonstrated the importance of reducing stigma, shame, fear and mistrust as an important developmental phase in initiating effective treatment. Understanding the nature and degree of stigma common in the client’s family and community, as well as the client’s perception of mental illness, enables providers to engage clients more effectively and to help clients cope with their own feelings regarding the mental illness as well as the response of others in their community.
Implementation Strategies

- Research the cultural attitudes regarding seeking mental health services in local communities. Many older adults and ethnic minorities believe that seeking mental health treatment indicates shame, weakness and/or fear that it will lead to undesirable outcomes — e.g., institutionalization, being labeled crazy, poor or discriminatory treatment, or being subjected to experimentation (for example, the Tuskegee experiments among African Americans).  

- Learn about ethnically appropriate ways to develop rapport and show respect, such as those described in Module 4 of the Stanford Curriculum in Ethnogeriatrics. Consult with culture brokers about appropriate ways to show respect to older adults of specific ethnic backgrounds. Addressing the client with respectful titles (e.g., Mr., Mrs., Dr., Rev.) is one such way. Speaking quickly can convey the notion of impatience; some cultures, including some Native American groups, consider speaking slowly as a sign of respect.

- Post signs and display reading material of interest to individuals of the diverse ethnic and cultural groups served. For example, signs should be posted in various languages, and magazines that celebrate ethnic and racial diversity such as Latina, Essence, and Heart & Soul, should be available in waiting areas.

- Train staff members about obstacles that impede building rapport cross-culturally and on special approaches to establishing a relationship in a cross-cultural context. For example, expressing personalismo (interpersonal warmth and friendliness) in relationships is a value that is common in Latino culture. Thus, spending additional time and effort engaging Latino clients

Implementation Strategies (cont’d)

in conversation and expressing warmth in interpersonal interactions may enhance rapport.

- Show respect to clients in a manner that is culturally appropriate and that communicates deference to older clients. Indications of respect may include showing respect in greeting the client first when meeting a family, and greeting elders with the appropriate title (e.g., Señor, Mr., Reverend, or Doctor) and their last name. Culturally appropriate use or avoidance of eye contact should be studied and implemented.55

- Adopt de-stigmatizing language in discussing mental health problems. For example, many ethnic and cultural minorities feel more comfortable with phrases like “stress,” “feeling down,” and “mental health problems” rather than “mental illness.”

- Use terms that can be translated easily, and be aware of the limitations of interpretation. For example, many mental health terms cannot be translated accurately into Spanish, Hmong, or some other languages. Discuss ways to convey key concepts effectively with interpreters.

- Clarify the limits of confidentiality, and discuss client privacy, particularly when working with interpreters.

- Develop working alliances with churches, temples, mosques, and other trusted community organizations. Establish constructive relationships with dependable, recognized community leaders and community members, including beauticians, barbers, and community center staff members. Develop relationships with these community liaisons based on trust and respect, and encourage reciprocity in recommending prospective clients to FSP services.

Implementation Strategies (cont’d)

- Ethnic minority groups may have divergent definitions of the terms “older adult,” “elder,” and “elderly.” For example, in Hmong culture, individuals are often considered elders at age 40, while in the public mental health system adults are classified as “older adults” at age 60. Determinants of what defines this later stage of life may be based on chronological age, financial productivity, health status, physical appearance, sexual potency, family roles, or other defining characteristics. Research the expected roles of older adults and expected treatment of them in different cultures.

- Help staff members become aware of their own cultural attitudes toward aging and older adults, and be particularly mindful of demonstrating appropriate respect and esteem for older adult clients.

- Be aware of the effects of power, oppression, racism, white privilege, sexism, heterosexism, and ageism on clients. Train the staff about the impact that these forms of oppression exert on clients’ mental health, self-esteem, and coping strategies.

- Be sensitive to the impact of racism on the therapeutic relationship. In some instances, assigning providers whose racial and ethnic background is similar to that of the client can be advantageous.

- Acknowledge power differentials in the therapeutic relationship; divergence in socioeconomic status, education, and roles may exacerbate perceived power differentials. To empower clients, make sure that they are aware of their rights and of their role in the decision-making process.
Addressing the Barrier of Cognitive Limitations

Purpose
To fully and responsively serve the older adult population within an FSP by recognizing and accommodating cognitive impairment among mentally ill older adults.

Definition
Older adults who experience deterioration in cognitive functioning face changes in their ability to live independently and to cope with mental health problems. Delivery of effective treatment for minority older adults with cognitive impairment requires addressing the barrier of cognitive limitations. That entails recognizing the early signs of cognitive decline and/or dementia, using culturally appropriate assessment strategies, and developing treatment strategies that take into account cognitive deficits.
Implementation Strategies

- Research the risk factors for cognitive impairment that are relevant to the cultural groups the provider serves. For example, persons with limited education and poor health care are at higher risk of developing cognitive impairment; persons with a history of schizophrenia, alcoholism, or head injury also are at higher risk.

- Understand and anticipate the barriers that impede people with cognitive impairment from receiving FSP services. These barriers may include (a) persons’ cognitive difficulty finding and securing transportation to the FSP services; (b) hesitation by the FSP to serve cognitively impaired individuals; (c) prejudicial perception among service providers that cognitively impaired individuals cannot benefit from mental health services; (d) prejudices among FSPs that MediCal or MHSA will not pay for services for an individual with cognitive impairment; (e) staff lack of knowledge about how to serve a person with impairment; and (f) lack of knowledge about where to refer cognitively impaired clients for alternate or adjunct services.

- Develop a referral network to help clients receive a geriatric medical assessment to determine the cause of cognitive impairment and possible medical treatments.

- Ensure that a diagnosis of cognitive impairment is based on a comprehensive assessment that includes interviewing important family members or caregivers to identify changes in baseline functioning. Research suggests that cognitive screening tools may be biased and may lead to misdiagnosis of dementia in non-impaired minority clients.

- Develop a referral network of neurologists and neuropsychological assessment centers to help clarify an older adult’s cognitive status, and retained abilities.
Train the staff in methods of performing mental health services for clients on the caseload who develop dementia, and for clients with mild to moderate dementia who have been referred to the FSP.

Develop mutual referral relationships with the local chapter of the Alzheimer’s Association and the Area Agency on Aging.

Develop a list of referrals for caregivers.

Learn culturally appropriate ways to work with family caregivers of elders with dementia. Learn about the different ways in which families of diverse cultural backgrounds cope with dementia in elderly family members.
Understanding Ageism

Purpose

To teach staff members to understand their own preconceived assumptions about older adults and aging, as well as the assumptions intertwined in the society they serve, in order to be equipped to combat these assumptions and provide optimal care.

Definition

*Understanding ageism* involves recognizing that ageist bias is considered one of the most common and accepted forms of prejudice. Societal attitudes toward older adults are often based on stereotypes and assumptions. These stereotypes may lead to subtle and overt prejudiced attitudes and discriminatory behavior toward older adults.
Implementation Strategies

- Assist providers and staff in identifying pervasive and personal ageist assumptions and ideas (e.g., “it’s a bummer to get older” or “we’re searching for the fountain of youth.”) Discuss attitudes about growing older, death, and dying.

- Recognize differences in the manner in which old age is viewed across cultures. In many cultures older adults are revered, and death is viewed as a normal and accepted part of existence. Facilitate FSP team member discussions about the ways in which each member’s family and community view growing old age, dying, and death.

- Conduct exercises in which ageist notions are identified and challenged. Thought-provoking exercises may include asking questions such as:
  - “What does your culture say about age?”
  - “To what extent do you value a person’s age as a sign of his or her worth?”

- Challenge ageism among the staff by questioning ageist statements when they are expressed.

- View differences across ages as strengths rather than as problems.

- Train the staff in cross-generational relationships. Such training could include encouraging staff members to discuss age differences openly with clients, and asking clients how they feel about being served by someone younger than them (if that is the case). Train the staff to convey respect through gestures such as wearing professional attire, calling before visiting, and addressing the client by the appropriate title and surname until told otherwise by the client.

- Be aware of ageism as it occurs in partner agencies and other systems in which the program’s clients participate. Advocate on behalf of older adults when ageism occurs.
Reducing Agency and System Barriers

Purpose

To identify and reduce barriers to care within the agency and in the larger mental health system.

Definition

The ability to perform culturally relevant services requires a commitment to cultural competence at all levels of the organization and system. Systems that promote cultural responsiveness through agency policies and practices, training, monitoring and evaluation, and quality improvement must be embedded in FSP programs, as a means of reducing agency and system barriers.
Implementation Strategies

- Assess the agency’s effectiveness in the five essential elements of cultural competence:
  1. valuing diversity,
  2. performing cultural self-assessment,
  3. managing for the dynamics of difference,
  4. institutionalizing cultural knowledge, and
  5. adapting to diversity policies, structure, values, and services.

- Develop a plan for addressing weaknesses found in agency self-assessment; include ongoing cultural competence training for all staff members. Enroll the entire agency staff in training, including managerial, administrative, and maintenance staff members.

- Schedule forums in which staff members can discuss diversity issues within the agency. Be aware that many ethnic minority staff members experience additional work burden because of their ability to work with non-English speakers and because of the barriers they encounter in seeking adjunct services for their minority clients. Validate the experiences of these providers and ensure that they are adequately compensated when they experience greater work burden.

- Host a forum in which minority clinicians and providers can discuss their recurring feelings of excessive burden, isolation, or discrimination that they experience.
Implementation Strategies (cont’d)

experience. For example, a process group for minority clinicians may help relieve some of the additional stress experienced. Supervisors with minority backgrounds may serve as mentors for clinicians needing additional support.

- Offer salary incentives for people with bilingual abilities.
- Include cultural competency in performance evaluations.
- Consider establishing events in the agency that celebrate different ethnic traditions, and encourage staff members to describe traditions from their ethnic and cultural heritage. Share food from various cultures, and mark holidays of diverse traditions.
- Consider holding periodic staff meetings in which cultural issues are discussed directly. Staff members could explain an aspect of their culture that is important to them, possibly using a “show and tell” approach.
- Consider asking staff members during meetings to respond to the question “If you had an interaction during the past month that involved a cultural diversity predicament, how did you feel, what happened, and how was it resolved?”
- Conduct exercises with the entire staff, including direct-treatment staff as well as administrative staff, and ask them to explore personal assumptions or biases they hold regarding various cultures.
- Use data on ethnicity and language preferences, client satisfaction, and penetration rates to assess progress in reducing disparities in mental health services.
- Adapt the county’s cultural competency plan as a roadmap for implementing culturally competent or proficient and relevant services, recruiting a diverse workforce, and creating a countywide plan for reducing ethnic and cultural disparities.
**Implementation Strategies (cont’d)**

- Help the agency develop a strategic hiring plan that specifies how ethnically, racially, and linguistically diverse staff members will be recruited, hired, and retained.

- Consider placing in the waiting room items such as magazines that would be familiar and welcoming to diverse clients, and incorporate decor that reflects the ethnic and cultural makeup of the community served.

- Consider offering culturally familiar food, either meals or snacks at special events or as snacks in the waiting room.

- Hire or network with “cultural ambassadors” – people who are members of and understand the culture of the clients served, and who will educate the FSP staff about cultural issues and can work directly with the clients. Cultural ambassadors may collaborate with the FSP staff to strengthen outreach and case management functions. Allow community persons to educate the FSP staff about cultural values, beliefs, traditions, rituals, and common practices.

- Work closely with community-based organizations that have a history of a strong and positive relationship with the communities served. Build networks and partner with community-based organizations, including faith-based organizations. These agencies may be able to perform some services to which FSP staff members might otherwise have to devote time; they additionally may assist in identifying clients in need of services, and may help to create a bridge to the FSP’s services.
Each of the tools listed below has specific resources that you can locate in the general resource section on pages 90–92. This guide enables you to focus on the pertinent resources linked directly to each tool.

<table>
<thead>
<tr>
<th>Name of Tool</th>
<th>Resource Number(s)</th>
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<tbody>
<tr>
<td>Provision of Appropriate Language Services</td>
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<tr>
<td>Cultural Responsiveness in Clinical Encounters</td>
<td>2,4,5,6,9</td>
</tr>
<tr>
<td>Immigration Status and Lack of Insurance</td>
<td>-</td>
</tr>
<tr>
<td>Physical Immobility and Medical Barriers to Service</td>
<td>8,25</td>
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<tr>
<td>Reducing Stigma, Shame, Fear, and Mistrust</td>
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<tr>
<td>Addressing the Barrier of Cognitive Limitations</td>
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<tr>
<td>Understanding Ageism</td>
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</tr>
<tr>
<td>Reducing Agency and System Barriers</td>
<td>18</td>
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✔ Articles


✔ Books


✔ Curriculum

✔ Manual


✔ Organizational Assessment


✔ Report


✔ Websites


25. WebMD: http://www.webmd.com
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.
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\(^60\) 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*,\(^61\) and discuss it in the context of FSP service provision.

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

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

- Develop skills of “dynamic sizing” and “scientific-mindedness.”\(^62\)

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Implementation Strategies (cont’d)

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

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

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

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

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

Purpose

To improve providers’ ability to establish strong therapeutic working alliances by recognizing differences in communication styles and encouraging flexibility in approaches to communication.

Definition

Understanding of client-provider communication differences results from knowing that individuals across cultures may vary in the ways in which they communicate. For example, the use of eye contact and/or hand gestures, emotional expression, and physical touch varies among cultures. To improve relationships in a cross-cultural counseling context, providers should be aware of differences in communication styles, and should endeavor to communicate in a manner that is comfortable to the client.
Implementation Strategies

- Learn the ways in which differences in communication styles can lead to misunderstandings that can hamper client engagement and treatment processes.

- Develop an understanding of the following dimensions of communication:\textsuperscript{63}
  - direct-indirect;
  - elaborate-succinct;
  - personal-contextual;
  - instrumental-affective; and
  - nonverbal communication.

- Explore personal communication styles, and assess those of the client. Although providers probably will not be able to completely alter their communication style to match that of their clients, developing an awareness of differences may help providers avoid miscommunication. For example, if the provider’s tendency is to be effusive in first greeting clients but the culturally normative behavior for the client dictates a more reserved approach, the provider should adapt to approaching the client in a more restrained manner.

- Coach the staff in developing comfortable ways to initiate conversations with clients about differences between the culture of the provider and that of the client.

Reducing Stereotyping

Purpose

To increase awareness and reduce stereotyping of attitudes and behaviors.

Definition

Stereotypes are prejudicial beliefs and images that influence attitudes and behavior based on an oversimplified understanding of a cultural group. Stereotypes may be unconscious or conscious, are often inaccurate, and may be manifest in overt discriminatory behavior or in subtle and covert behaviors or microaggressions. Microaggressions are defined as “... brief and commonplace daily verbal, behavioral, or environmental indignities, whether intentional or unintentional, that communicate hostile, derogatory, or negative racial slights and insults toward people of color.” Reducing stereotyping by facilitating the identification of stereotypes and reducing behavior based on stereotypes is critically important for improving cultural competency in FSP programs.

Implementation Strategies

- Help staff members become aware of the stereotypes they hold. Consider having the staff complete an implicit association test. The most frequently cited implicit association test that examines underlying associations regarding race is the Implicit Association Test (IAT), developed by Project Implicit, a multi-university research collaboration. While the test is not a definitive predictor of racist views, it may be used as a tool for discussing assumptions, stereotypes, and subtle and unconscious expressions of racism. Facilitate a discussion regarding the ways in which stereotypes affect FSP staff members’ views, attitudes, behavior, and work with clients.

- Administer exercises that enable staff members to become acquainted with people of different ethnic or cultural backgrounds, sexual identities, ages, and socioeconomic status, as a means of helping to reduce stereotypes. These exercises may include team-building or ice-breaker types of activities that create a structured environment for team members to share information about themselves.

- Train supervisors and treatment team leaders in developing awareness of stereotyping within their agency, evident in the comments and actions of staff members.

- Teach sensitive methods of gently making staff members aware of stereotyping behaviors that they have demonstrated.

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65 Project Implicit: [https://implicit.harvard.edu/implicit/demo/selectatest.html](https://implicit.harvard.edu/implicit/demo/selectatest.html)
Embodying Respectful, Collaborative, Empowering Values

Purpose

To develop and exemplify general values and principles for sensitive and responsive mental health treatment of ethnic and cultural minority older adults.

Definition

Establishment of an effective working relationship with ethnic and cultural minority older adults requires providers to convey respect to clients. Actions embodying respectful, collaborative, empowering values contribute to development of clients’ ability to make decisions that best meet their needs and desires.
Implementation Strategies

- Model respectful attitudes toward clients and older adults. Clinicians often “decompress” by joking about clients. Supervisors, administrators, and clinicians should discourage disparaging or disrespectful humor by gently steering conversation away and modeling appropriate ways to cope with countertransference or stress.

- Emphasize the values of compassion, individualized assessment, individual diversities, individual freedom, and choice.

- Recognize a tendency to condescend to older adults when it occurs, and coach providers to shift to an egalitarian approach.

- Train the staff about ways to maintain respect and collaborative treatment, even when an older adult is experiencing physical or cognitive decline.

- Monitor for staff attitudes that indicate a caretaking approach rather than a preferable empowering, self-determining approach in working with older adult clients. Treat clients as full “partners.”

- Understand that obtaining and incorporating clients’ ideas in the decision-making process may, at times, be hampered by clients’ limited English proficiency, limited understanding of psychiatric constructs, divergent cultural views on mental illness, or physical and/or cognitive impairment. In these cases staff members may be tempted to make decisions for the client, based on the provider’s opinion of the best course of action. Be aware of this pitfall, and strongly discourage unilateral decision making. Although obtaining clients’ opinions may take more effort, doing so typically results in an enhanced working relationship and improved treatment adherence.
Each of the tools listed below has specific resources that you can locate in the general resource section on pages 105–106. This guide enables you to focus on the pertinent resources linked directly to each tool.

<table>
<thead>
<tr>
<th>Name of Tool</th>
<th>Resource Number(s)</th>
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<tr>
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<tr>
<td>Reducing Stereotyping</td>
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<tr>
<td>Embodying Respectful, Collaborative, Empowering Values</td>
<td>6</td>
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</tbody>
</table>
✔ Articles


✔ Assessments

4. 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](http://www.multiculturalcenter.org/access.cfm)

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

✔ Books


✔ Essay

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.
Age as a Component of Cultural Diversity

Purpose

To develop sensitivity about how older adults may see the world, and about the stature and experiences of older adulthood in this society, in order for FSP staff members to serve older adults effectively.

Definition

*Age as a component of cultural diversity* is an indicator of the ways in which the time period when a person was born and raised creates aspects of group identity and culture. The client’s identifying era should factor in the treatment approach just as significantly as ethnicity, race, and other elements of culture.
Implementation Strategies

- Understand that age as a stage of life creates a subgroup that has unique features.
- Conduct age-related sensitivity training.
- View movies that may elucidate the culture of later life, or generate discussion about aging culture, while cautioning against perpetuating negative stereotypes of aging and ethnic groups often found in movies.
- Gain knowledge about the aging population, including demographic data within California.
- Develop understanding of the cultural views of older adults.\(^{66}\)
- Conduct staff training to illuminate the significant differences between themselves and older adults in various indicators, including medical, physical, cognitive, social support systems, and generational differences, all of which may have a profound effect on the how the staff members form diagnoses and treatment plans.

Understanding Gender Roles

Purpose

To assist providers in addressing gender role expectations in treatment.

Definition

Understanding gender roles means knowing that expectations vary widely between cultures and within cultures. Some older adults may endorse strict divisions of labor, responsibilities, and decision-making between men and women, while others may believe in a shared and egalitarian distribution of roles. For many immigrant older adults, the process of acculturation influences gender role expectations. Couples who come to this country may find that their roles shift away from traditional gender expectations. For example, women often find work outside the home and thus become more active in generating income and making spending decisions. Providers should be prepared to work with older adults with a range of gender expectations and to respect these diverse values.
Implementation Strategies

- Encourage the staff to consider the following gender role issues:
  - traditional versus non-traditional gender roles within their age cohort and ethnic group;
  - shifts in gender roles related to aging;
  - difficulties adjusting to changing gender role expectations through acculturation;
  - disparities in cultural expectations regarding the role of older men and older women in families, and the custom of older adults living with younger family members as they age;
  - the ways in which gender role expectations influence clients’ desire to make decisions or delegate decision-making responsibility to others, or the extent to which clients rely on others for assistance and support;
  - determination of how their concepts of gender roles affect the ways in which clients interact with their family, the power dynamics in families, and the role of family members in decision-making;
  - the perceptions of gender roles from the differing perspectives of their culture of origin, members of their local community, friends, and family.

- Remember that the gender role expectations of providers and clients often differ. At times conveying respect for differing views on gender roles may be difficult. For example, providers may believe that a male spouse controls decision-making to a degree that is harmful to the female spouse. Respecting cultural differences in gender roles while advocating on behalf of clients who are in a less powerful familial role requires diplomacy. Providers must recognize conflicting ethical responsibilities and attempt to achieve a balance that benefits the client and respects individual cultural differences and autonomy. Additional supervision or consultation may be required. Engaging the services of a cultural broker or community leader may be beneficial.
Lesbian, Gay, Bisexual, Transgender, and Questioning Issues

Purpose

To understand the concerns of lesbian, gay, bisexual, and transgender older adults, in order to help the FSP staff engage and treat these clients more effectively.

Definition

*Lesbian, gay, bisexual, transgender, and questioning (LGBTQ) issues* encompass a broad range of considerations that influence older adults who are, by virtue of their sexual identity, members of a minority group. Awareness of these impediments and dilemmas they are likely to encounter, and identification of strategies for coping with these problems, will enhance the therapeutic effectiveness of FSP programs in working with this clientele.
Implementation Strategies

- Gain an understanding of how gay and lesbian older adults have lived their lives during an earlier historic time, different from their younger counterparts. Society was less accepting of openly gay and lesbian individuals when older gays were in their teenage and young adult years, in contrast to greater enlightenment characteristic of recent years. As a result, older gay and lesbian clients are most likely to have withheld their sexual orientation from family members, friends, and significant others, and have “stayed in the closet.”

- Remember that many older adults may have experiences related to exposure to the AIDS epidemic, which was particularly prevalent in gay males in the ’80s.

- Help LGBTQ older adult clients connect with and build supportive networks. Doing so is crucially important for enhancing their mental health and wellness, because LGBTQ older adults are more likely than heterosexual older adults to live alone and less likely to have children. Thus, LGBTQ older adults may lack a social safety net and feel isolated or marginalized.

- Consider that LGBTQ older adults may experience rejection by others in their community, church, or family. In fact, many older adults may choose to “go back in the closet” and hide their sexual identity. While this strategy may mitigate the experience of discrimination and homophobia, it makes clients feel more lonely and marginalized. Assist clients in working through these issues.

- Consider inviting staff and/or community members to view films such as Gen Silent and Ten More Good Years, which depict the difficulties that LGBTQ adults encounter as they grow old.
Implementation Strategies (cont’d)

- Help staff members understand ways in which they and other members of the service agency manifest and exhibit heterosexism, homophobia, and stereotypes about homosexual persons. Provide opportunities for staff members to discuss and challenge prejudices.

- Review forms and procedures for elements of heterosexism (e.g., questions about marriage and spouses on initial assessment, and gender expectations for residential partners).

- Help staff members develop sensitivity in assessing the sexual orientation of clients. Ask them to consider introducing this subject area with a statement such as, “I am going to ask you questions about your sexuality, to help me understand you better. If you are not yet comfortable about discussing the questions, with me, let’s postpone talking about them until a later time.”

- Talk with cultural ambassadors about views toward homosexuality within specific ethnic cultures. Ask if clients should be encouraged to reveal their sexual orientation to family members, friends, and significant others, often referred to as “coming out” in the U.S. If a cultural ambassador favors such a disclosure, seek his or her advice for formulating an approach to the discussion.

- Assess any potentially ingrained staff attitudes about religion or other personal beliefs that could be pivotal in determining whether or not a treatment provider is suitable to work with a given client.

- Help the staff to examine and resolve any internalized heterosexism or biases against lesbian, gay, bisexual, or transgender persons.
Purpose

To ensure that victims of elder abuse, including those from diverse ethnic and cultural backgrounds, are adequately understood and treated.

Definition

Elder abuse is a term referring to any knowing, intentional, or negligent act by a caregiver or any other person that causes physical or emotional harm or a serious risk of harm to a vulnerable adult.\textsuperscript{67}

Implementation Strategies

- Work to understand the isolation that a victim of elder abuse can experience. Common feelings may include humiliation, shame, or guilt for being abused, while conflicted by feeling connected to and protective of the abuser.

- Consider the ways in which being a member of a minority ethnic or cultural group may increase a client’s sense of isolation. Many minority clients may be unaware of elder abuse protective laws and resources for abuse victims. Inform clients about culturally appropriate resources.

- Guide clients with limited English proficiency in accessing help. Be aware of resources available in other languages for older adults, and tell them phone numbers that they can call to receive service in their native language.

- Seek advice from cultural brokers or cultural experts about applicable cultural norms when working cross-culturally. That’s important because determination and resolution of elder abuse may be ensnared in cultural differences between caregivers and clients, as well as impeded by language barriers.

- Ensure that staff members can recognize risk factors and signs of elder abuse.

- Train the staff in sensitive outreach and engagement approaches in pursuing treatment for elder abuse victims.

- Help the staff develop patience and strategies in working with older adults who may be experiencing victimization yet may be reluctant to accept help. For example, don’t withdraw help simply because a client refuses to accept a recommendation to resolve elder abuse. Give clients choices and time to consider options. Abused seniors may have no one other than mental health staff members to suggest courses of action, and to give them choices and the opportunity to refuse.
Ensure that all staff members who work with older adults understand their legal responsibilities as mandated reporters of elder abuse and neglect, as defined in the California Welfare and Institution code.
Each of the tools listed below has specific resources that you can locate in the general resource section on pages 119–121. This guide enables you to focus on the pertinent resources linked directly to each tool.

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<td>Elder Abuse</td>
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Websites


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.\(^{68}\) 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”⁶⁹ 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.

---

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.”\(^{70}\) 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.

\(^{70}\) (SAMHSA, 2011).
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 Older Adults

Purpose

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

Definition

_Evidence-based practices for older adults_ are interventions that have been shown scientifically to reduce or eliminate symptoms of mental illness, or to improve outcomes for individuals with mental
health problems. 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 older adults, it identifies interventions that are considered “mental health treatments” (as opposed to “mental health promotion”) and FSP programs for older adults (age 55 and older). Although this Tool Kit uses the age of 60 as a defining cutoff for “older adults,” the NREPP uses the age of 55 as a cutoff. The NREPP is intended to be used as a “decision support tool.” These interventions are scored by independent raters on several dimensions, and the scores are listed on the NREPP website.

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

- 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 older adult being served.
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 55 and older. 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.)

### Evidence-Based Practices for American Indian/Alaska Native Older Adults (Ages 55 and older)

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Details</th>
</tr>
</thead>
</table>

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

### Evidence-Based Practices for Latino/Hispanic Older Adults (Ages 55 and older)

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Details</th>
</tr>
</thead>
</table>
## Implementation Strategies (cont’d)

### IMPACT (Improving Mood – Promoting Access to Collaborative Treatment):

### OQ-Analyst:

### Partners in Care:

### Pathways’ Housing First Program:

### Program of All-Inclusive Care for the Elderly (PACE):

### Surviving Cancer Competently Intervention Program:

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

## Evidence-Based Practices for Black/African American Older Adults (Ages 55 and older)

### Acceptance and Commitment Therapy (ACT):

### Cognitive Behavioral Therapy for Late-Life Depression:

### Eye Movement Desensitization and Reprocessing:

### ICCD Clubhouse Model:

### IMPACT (Improving Mood – Promoting Access to Collaborative Treatment):

### JOBS Program:

### OQ-Analyst:

### Partners in Care:
## Implementation Strategies (cont’d)

### Pathways’ Housing First Program:

### Program of All-Inclusive Care for the Elderly (PACE):

### Prolonged Exposure Therapy for Posttraumatic Stress Disorders:

### Surviving Cancer Competently Intervention Program:

### Telemedicine-Based Collaborative Care:

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

### Evidence-Based Practices for Asian Older Adults (Ages 55 and older)

- Acceptance and Commitment Therapy (ACT):

- ICCD Clubhouse Model:

- OQ-Analyst:

### Evidence-Based Practices for Native Hawaiian/Pacific Islander Older Adults (Ages 55 and older)

- OQ-Analyst:

*Interventions tested with 50% or more of the population selected: None*
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
the content of the intervention to include culturally relevant topics – for example, the impact of racism, discrimination, or acculturation. Given that one of the hallmarks of EBPs is the use of empirical methods to determine efficacy, cultural adaptations should be enacted only after empirical study has produced evidence supporting the effectiveness of the modifications.

**Example of a Culturally Adapted Evidence-Based Practice**

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

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

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

**Essential Elements of Community-Defined Practices**

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

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

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

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

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

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

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

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

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

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

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

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

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

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Implementation Strategies

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

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

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

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

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

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

Note: For the purpose of this tool, “community” refers to a group of individuals with shared experiences, culture, and values that have a significant influence in their day-to-day activities.
Each of the tools listed below has specific resources that you can locate in the general resource section on pages 146–147. This guide enables you to focus on the pertinent resources linked directly to each tool.

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<thead>
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<th>Resource Number(s)</th>
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<tr>
<td>Culture-Specific Interventions</td>
<td>1,9,10</td>
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<tr>
<td>Community-Defined Practices</td>
<td>5</td>
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Articles


✔ Report


✔ Websites

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


General Resources


5. National Center for Cultural Competence (NCCC) – Georgetown University Center for Child and Human Development website: http://www11.georgetown.edu/research/gucchd/nccc/


Appendix B

Introduction to Example Programs of Community-Defined Practices .... 152

Community-Defined Programs:
1. Asian Pacific Family Center East: IMPACT! – A Youth Development
   and Leadership Program .......................................................... 154
2. Beats, Rhymes, and Life: Rap Therapy for TAY of Color ............... 157
3. Latino Health Access: Promotor Program .................................. 160
4. Sacramento Native American Health Center: Warrior
   Down Program .............................................................................. 164
5. Transcultural Wellness Center .................................................. 168
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.

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73 Office of Multicultural Services CRDP website: [http://www.dmh.ca.gov/Multicultural_Services/CRDP.asp](http://www.dmh.ca.gov/Multicultural_Services/CRDP.asp)
74 California Department of Mental Health. (2009). Request for proposal: California reducing disparities project – prevention and early intervention mental health services act. Retrieved from [https://mail.cimh.org/owa/redir.aspx?C=a89026b60f7d421e92318d8aa8e39565&URL=http%3a%2f%2fwww.dmh.ca.gov%2fMulticultural_Services%2fdocs%2fFINALRFPStrategicPlanningWorkgroups6-10-09.pdf](https://mail.cimh.org/owa/redir.aspx?C=a89026b60f7d421e92318d8aa8e39565&URL=http%3a%2f%2fwww.dmh.ca.gov%2fMulticultural_Services%2fdocs%2fFINALRFPStrategicPlanningWorkgroups6-10-09.pdf)
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=UUs2TAEGPvBBatJyagyXJOv w&index=4&feature=plcp](http://www.youtube.com/watch?v=me1EqOMfsR4&list=UUs2TAEGPvBBatJyagyXJOv w&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 Alvarez 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’Otul 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.