County of San Diego

Behavioral Health Services

Beyond the Talk:

A Resource Toolkit to Bridge the Cultural Gap

Mental Health
Southern Region Summit XVIII

April 2013

COUNTY OF SAN DIEGO HHSA HEALTH AND HUMAN SERVICES AGENCY

Live Well, San Diego!

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Forward

This October the US will mark the 50th anniversary of the Community Mental Health Act of 1963. John F. Kennedy and his staff used the findings from the Joint Commission on Mental Health (1961) to establish the community as the locus of future mental health care. The Commission identified over 550,000 people warehoused in state mental hospitals who lacked adequate care. JFK stimulated a series of new policies, federal funding, and lawsuits that established the rights of the mentally ill to receive effective treatment that would lead to recovery. Although we applaud both the Commission's work and the bold vision of JFK, there was a substantial lack of attention to the disproportionate numbers of people of color and the poor in state hospitals. In particular, African and Native Americans were much more likely to be involuntarily committed, miss-diagnosed with a severe illness, provided inadequate care, and retained in the hospital for extensive stays. Over the decades, it has become clear that the characteristics of other populations also increase their risk of being under-served. Two developments have helped to increase our attention to the importance of culture, race, ethnicity, language, and sexual orientation in mental health. Cross, Bazron, and Isaacs (1989) introduced the concept of cultural competence as a means of tailoring services that approximate the cultural needs and backgrounds of persons with mental illness. The second major development was publication of the Surgeon General's Report on culture, race, and ethnicity in mental health (2001). However, we continue to struggle with implementation, evaluation, and strategies for moving beyond conceptualization.

The California Department of Mental Health is a national leader in integrating cultural competence and population characteristics in the design and delivery of mental health services. Despite controversy, the state has made successful efforts to study, implement, and evaluate cultural competence in mental health services at the county and city level. In the past 3 years, the state provided funding for 5 unserved and underserved populations to develop reports that assessed the status of services. Each of the 5 reports chronicles an increase in homeless mentally ill, limited access to quality services, and culturally incompetent care. The Summit Conference held in San Diego was designed to help local California communities use these findings to make improvements in their services for the 5 populations. In some counties, systems of service have not integrated knowledge of cultural differences in clinical approaches to meet the needs of historically underserved populations. Part of the explanation for the limited application has been the lack of clear plans on how to move from concepts to practice. Culturally competent practice seeks to change the design of services as well as modify the ways that populations view mental health and seek help. Each of the 5 unserved and underserved groups in California developed extensive recommendations to move the state beyond traditional rhetoric to action that results in higher levels of access and quality of care.

The issue before us in 2013 is to not repeat our past errors in which we failed to explore the role of culture, social determinants, and policy in insuring equity and equality in mental health care.

King Davis, PhD., Professor & Director
The Institute for Urban Policy Research & Analysis
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Executive Summary

California's population is increasingly more diverse, while at the same time minority groups are poised to become the majority. Population changes such as these require a closer look at how to promote equitable outcomes in mental health. In December of 2012, over 450 behavioral health professionals, County Mental Health Ethnic Services Managers, administrators, policy-makers, consumers, and community members came together to do just that during the Cultural Competence and Mental Health Southern Region Summit XVIII (CCMH Summit XVIII). The Summit was sponsored by the County of San Diego Health and Human Services Agency (HHSA) Behavioral Health Services (BHS) Division with Mental Health Services Act (MHSA) Prevention and Early Intervention (PEI) funds and the County's *Live Well, San Diego!* initiative in partnership with Southern California Counties Ethnic Services Managers (ESMs).

In line with the PEI component of the MHSA, the CCMH Summit XVIII showcased the California Reducing Disparities Project (CRDP) and community-defined best practices identified in the reports that address behavioral health care through prevention and early intervention strategies. The CRDP was initiated in response to the call for State and national action to reduce mental health services disparities, increase health equity and seek solutions for underserved communities in California. Five diverse populations selected were: African Americans, Asian/Pacific Islanders, Latinos, Native Americans, and Lesbian, Gay, Bi-sexual, Transgender, Questioning (LGBTQ).

The theme of the CCMH Summit XVIII was "Beyond the Talk, Practicing the Walk: A Path to Bridge the Cultural Gap". This toolkit herein named *Beyond the Talk: A Resource Toolkit to Bridge the Cultural Gap* highlights key findings and recommendations contained in the CRDP reports, as well as those reflected at the CCMH Summit XVIII presentations which included: keynote addresses, plenary presentations, institutes, workshops, and media advocacy showcases. Also included are strategies that emerged from Conversation Cafés which were structured dialogues designed to build upon the CCMH Summit XVIII theme. The Toolkit lays out what the paths are to bridge cultural gaps, how to "practice the walk", and how to move beyond the talk into action, while demonstrating why mental health care disparities matter and what tools we can provide from each of the CRDP reports to address these concerns.

A Path to Bridge the Cultural Gap

A "cultural gap" can be thought of as a barrier experienced by an individual or a community that is often unserved or underserved and most often are from racially, ethnically and culturally diverse communities and lack access to appropriate and quality mental health services. Barriers take on many different forms some of which are specific to one of the five unserved and underserved populations while others broadly fall into overarching categories.

A "path" is a means or method of addressing the identified cultural gaps. Three of the multiple paths that were identified as strategies for bridging the gaps include; increased cultural competence of providers, stigma reduction and mental health literacy through media advocacy, and strengthened

community collaboration. The World Health Organization's (WHO) "Right to Health" outlines four elements they believe are critical to achieving health: availability, accessibility, acceptability, and quality. These can also be applied to mental health and are reflected in the five CRDP reports as critical to reducing disparities in mental health.

Practicing the Walk

"Practicing the walk" is the actual practice or doing what is suggested as paths to bridge cultural gaps. While there are many recommendations in the reports, seven overarching recommendations were identified amongst the CRDP reports to be included in the Toolkit:

1. Increase collaboration between counties and community-based organizations
2. Develop a culturally and linguistically competent workforce
3. Adapt or develop treatment modalities that are culturally and linguistically appropriate
4. Remove barriers to increase access to services
5. Collect inclusive demographic data to increase accuracy and efficacy of data
6. Build community capacity through training and support
7. Use media to reduce stigma and promote resources.

Specific recommendations for each of the CRDP focus populations are also included in the Toolkit. For a full listing of recommendations with each of the CRDP reports please visit: http://www.dmh.ca.gov/Multicultural_Services/CRDP.asp. Along with the CRDP recommendations, summit presentations and media advocacy showcases highlighted strategies for understanding client cultures, the use of data to identify and reduce disparities, and the use of media to reduce stigma and promote mental health services, which are also included in the Toolkit.

Beyond the Talk: A Call to Action

"A call to action" defines what is not currently being done that needs to be done, and how one can move beyond the talk into taking action. Nine steps have been identified by King Davis, Ph.D., a renowned leader and advocate for change in the mental health field, as critical components of collective action:

1. Convene a White House Conference 2014 on Race, Culture, and Ethnicity
2. Rescue and Revive Mental Health Coalitions like NAMBHA
3. Redefine and Re-Conceptualize Cultural Competence
4. Field Test Cultural Competence/Instruments
5. Federal Funding for Research on Practice Based Evidence
6. Participation on Federal Research and Policy Panels
7. Key Roles of Leadership in Mental Health Systems and Organizations
8. Activism in Legislation and Elections
9. Explore Concept of Social Determinants as a Factor in Disparities

CCMH Summit XVIII speakers and participants while participating at Conversation Café identified the following as critical components for action:

1. Contagious Passion
2. Consistent Follow-Up and Outreach to Unserved/Underserved Communities
3. Meet People Where They Are
4. Willingness to Learn from Others
5. White House Conference

We must also acknowledge that action begins with personal commitment. Rachel Guerrero, LCSW and retired Chief of the Office of Multicultural Services for the California State Department of Mental Health, offers the following eight steps to translate personal commitment into action:

1. Support your "edgewalker" (others who are taking risks); stop marginalizing them
2. Do your homework on equity, disparities, and related issues
3. Value communities as true partners in change
4. Learn how to authentically engage and include "Networks of Collaboration"
5. Stop working from a color blind viewpoint
6. Really grow a diverse workforce to match your community; all communities are looking for authentic engagement
7. Understand the diversity within communities
8. Grow your fearlessness

In order to enact our personal commitment we must understand where we are at personally and how we can move ourselves towards action. The critical factor in making collaboration a vital vehicle for reducing mental health disparities is a shared commitment to risk something different. The crucial step is a commitment to move forward. Take a moment to assess where you are personally with respect to readiness to take action. Our intent in designing this toolkit is to provide ideas on how you can move and take action.

Tools to Reduce Disparities

The CRDP reports contain a number of useful ways to address disparities in health and mental health outcomes. The tools on the following page were derived from the CRDP Reports and are included in this Toolkit.

SMART Recommendation/Action Criteria The African American CRDP Population Report recommends that pathways for eliminating mental health disparities in the Black population be bold, different, and culturally grounded. In order to do this the report offers the following criteria for specific recommendations and actions: **S**trategic (specifically targets African Americans); **M**easurable (allows for cultural vetting of program and services); **A**chievable (monitored against real indicators of African American mental health); **R**equired (addresses necessary and sufficient conditions); and **T**imely (allows for concrete guided action now). (African American Health Institute of San Bernardino County, 2012)
Selection Criteria for Promising Programs and Strategies The Asian Pacific Islander Strategic Planning Workgroup (API-SPW) identified community-defined promising programs and strategies to reduce existing disparities in the Asian American, Native Hawaiian and Pacific Islander (AANHPI) community and established criteria to be used as the parameters for selecting culturally competent promising programs and strategies to serve the AANHPI populations. (Pacific Clinics and the Asian Pacific Islander Strategic Planning Workgroup, 2013)
Core Components of Cultural Competency The Asian Pacific Islander Strategic Planning Workgroup defined core components of cultural competence and agreed on common elements from which they developed a list of core competencies in the areas of professional skills, linguistic capacity, community relations and advocacy, program design and service delivery, capacity building, use of media, and data collection and research. Three levels conceptualize cultural competence beyond the individual level, and to encourage recognition and support from organizations and systems to make cultural competence possible and meaningful. (Pacific Clinics and the Asian Pacific Islander Strategic Planning Workgroup, 2013)
LGBTQ Competency Considerations Several considerations for reducing disparities in mental health for the LGBTQ population are given in the LGBTQ CRDP report. These have been formatted into a tool that outlines each element of the tool with specific considerations that should be taken into account. (Mental Health America of Northern California & Equity California Institute, 2012)
Two Spirits The term two-spirit represents the Native American belief that individuals can carry both masculine and feminine spirits and their identity can therefore result in multifaceted variations of sexuality and gender expressions. The two-spirit term has been adopted by many lesbian, gay, bisexual, and/or transgender urban Native Americans as an all-encompassing term to define the fluidity of their identities. (Mental Health America of Northern California & Equity California Institute, 2012)
The Learning Collaborative Each of the CRDP Reports reflect input gathered from members of the communities that are directly impacted by disparities. As learning communities, they came together to problem solve, share information and experience, etc. (Native Vision Project Native American Health Center, Inc., 2012)
Medicine Wheel Tool The Medicine Wheel curriculum was developed by Tony Cervantes (Chichimeca Tribe) to depict accumulated knowledge, skills, and abilities of Native American cultures to address health and wellness. The Medicine Wheel is a tool to assess, intervene with, treat, and provide recovery support services for mental health, and for alcohol and other drug (AOD) problems. The Medicine Wheel is rooted in tribal cultures and belief systems which provide the resources and tools to address mental health and AOD service delivery. (Native Vision Project Native American Health Center, Inc., 2012)
The Five A's for Reducing Disparities in Latino Populations The Latino CRDP Report identified barriers that can be understood as problems related to accessibility, availability, appropriateness, affordability, and advocacy within the Latino population. Although the Five A's reflect the needs of the Latino community, this model can be used to review and analyze disparities among other unserved and underserved populations. (University of California, Davis Center for Reducing Health Disparities & the Latino Mental Health Concilio, 2012)

Although each of the tools listed on the previous page was developed with a specific population in mind, the spirit and intent may be applicable to other populations and/or inspire the development of new tools that are population-specific.

It has been said that, "A journey of a thousand miles begins with a single step" (Lao-tsu). May *Beyond the Talk: A Resource Toolkit to Bridge the Cultural Gap* inspire our shared journey towards reducing mental health disparities through prevention and early intervention.

I. Introduction

"It is time for parents to teach young people early on that in diversity there is beauty and there is strength. We all should know that diversity makes for a rich tapestry, and we must understand that all the threads of that tapestry are equal in value no matter their color."

- Maya Angelou, Author

When we embrace diversity, or the ways in which we are unique, we unleash the potential to tap into a source of collective beauty, wisdom and cultural wealth. However, our fear of difference can fan the flames of intolerance and injustice to the detriment of many, including ourselves.

In December 2012 over 450 behavioral health professionals, County Mental Health Ethnic Services Managers, administrators, policy-makers, consumers, and community members gathered at the Cultural Competence and Mental Health Southern Region Summit XVIII in San Diego, California. They came together to take a candid look at what it means to move "beyond the talk", to "practice the walk", and to actively build paths to bridge cultural gaps locally, regionally, and throughout our nation.

The Summit was sponsored by the County of San Diego Health and Human Services Agency (HHSA) Behavioral Health Services through Mental Health Services Act (MHSA) Prevention and Early Intervention (PEI) funds and the County's *Live Well, San Diego!* initiative, in partnership with the Southern California Counties Ethnic Services Managers (ESMs). The purpose of the Cultural Competence and Mental Health Southern Region Summit XVIII (CCMH Summit XVIII) was to answer the call to reduce mental health disparities with specific focus on five unserved and underserved populations in California. In line with the Prevention and Early Intervention (PEI) component of the MHSA, the CCMH Summit XVIII showcased community-informed practices not only in the African American, and Latino populations, but also included Asian Pacific Islander, Native American, and Lesbian, Gay, Bisexual, Transgender, Queer and Questioning (LGBTQ) communities that address mental health care through prevention and early intervention strategies.

The artwork that graces the pages of this report was created by CCMH Summit XVIII participants during the Conversation Café discussions.

Background

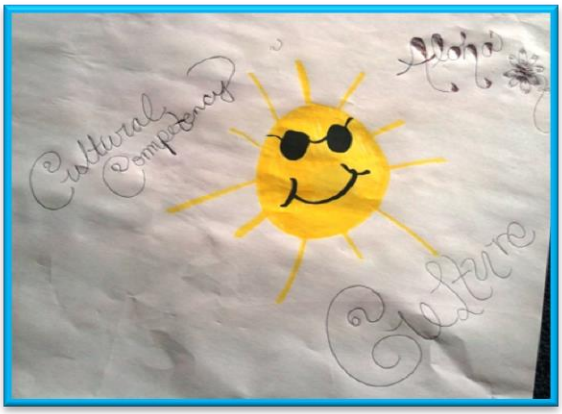
Mental Health Services Act (MHSA)

In January 2005, the Mental Health Services Act (MHSA), originally Proposition 63, was implemented in California. The Act combines prevention strategies with treatment strategies as an innovative approach to improve the public mental health system and thus enhances the quality of life for individuals living with serious mental illness who may also have a co-occurring illness of substance use. The voter-approved MHSA initiative provides for developing, through an extensive stakeholder process, a comprehensive approach to providing community-based mental behavioral health services and support for California residents.

> **"Dis·par·i·ty"** is defined as:
> **"The state of being different."**
> ***Synonyms:*** inequality - imbalance - dissimilarity – discrepancy
>
> - Merriam - Webster

Prevention and Early Intervention (PEI)

Prevention and Early Intervention (PEI), a component of MHSA, focuses on programs and interventions for all individuals before a serious emotional or behavioral disorder or mental illness develops. It emphasizes the need for prevention and early intervention efforts, giving special attention to children and youth, adults and older adults as well as multicultural and multilingual communities. The research literature as presented in the CRDP reports outline multiple health equity concerns that stem from social determinants of health, to include lack of access to care, available culturally relevant mental health services, quality of received care, and outcomes.



Training, Technical Assistance and Capacity-Building (TTACB)

In 2007, the Mental Health Services Oversight and Accountability Commission (MHSOAC) approved five PEI Statewide Projects, including the Training, Technical Assistance and Capacity Building (TTACB) Project. The primary goal of the TTACB is to enhance the knowledge and skill set of local partners such as educators, law enforcement, and primary health care providers who provide services outside the behavioral health system.

Cultural Competence and Mental Health Southern Region Summit XVIII

The CCMH Summit XVIII was designed to inform participants how they might strengthen their work together and act to reduce mental health disparities for the five unserved and underserved communities in California. Under the leadership of Dr. Piedad Garcia, Director of Adult/Older Adult Systems of Care, Ethnic Services Manager, Behavioral Health Services Division of the County of San Diego Health and

Human Services Agency, Tracy L. Fried, MSW consultant to the County of San Diego HHSA Behavioral Health Services Division, worked with the planning committee established by Dr. Garcia, to design, develop, and conduct the Summit.

The Learning Objectives for CCMH Summit XVIII included:

- Building an understanding of the role history and cultural traditions have in achieving community-defined behavioral health practices and related services.
- Recognizing how language, ethnic, and cultural traditions provides the foundation for developing culturally-specific intervention strategies.
- Providing prevention services which are comprehensive, culturally relevant, and sustainable.
- Understanding ways to engage and connect with the five unserved and underserved communities through culturally-informed outreach strategies.
- Increasing knowledge about community access points and resources to increase the access to behavioral health services.

The goals and objectives of the CCMH Summit XVIII were met with dynamic keynote addresses, institutes, workshops, and media advocacy showcases that complemented the work of the California Reducing Disparities Projects.

California Reducing Disparities Project

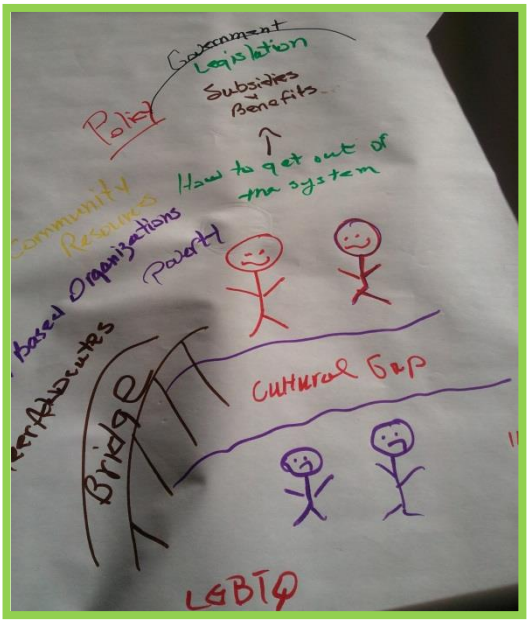
In response to the call for national action to reduce mental health disparities and seek solutions for the five unserved and underserved communities in California, the Department of Mental Health (DMH), in partnership with Mental Health Services Oversight and Accountability Commission (MHSOAC), and in coordination with California Mental Health Directors Association (CMHDA) and the California Mental Health Planning Council, have called for a key statewide policy initiative as a means to improve access, quality of care, and increase positive outcomes for racial, ethnic, sexual, and cultural communities. (California Department of Mental Health, 2010, p.1). Subsequently, DMH launched a two-year statewide prevention and early intervention effort funded with $3 million dollars in Mental Health Services Act (MHSA) state administrative funding.

Community Defined Evidence is defined as "A set of practices that communities have used and found to yield positive results as determined by community consensus over time. These practices may or may not have been measured empirically but have reached a level of acceptance by the community."

-Community Defined Evidence Project

The project focused on the following five populations: (1) African Americans, (2) Asian/Pacific Islander, (3) Latinos, (4) Native Americans, and (5) Lesbian, Gay, Bisexual, Transgender, Queer and Questioning (LGBTQ). As part of the project, five Strategic Planning Workgroups (SPWs), corresponding to each population, were formed to provide the California Department of Mental Health with community-defined evidence and population-specific strategies for reducing disparities in mental health. Each SPW conducted some form of community-based participatory research (CBPR) as a framework to guide their work to engage stakeholders. In CBPR, expert researchers conduct investigations collaboratively with the community. The researchers and community members are equally involved in the research process.

The PEI initiative is critical to reducing disparities and risk factors, and to building protective factors. According to the Institute of Medicine (IOM), prevention can be defined broadly as policies, programs and practices designed to reduce the incidence and prevalence of certain risk factors and resulting health, behavioral and social challenges (Institute of Medicine, 1994). Prevention services tend to focus on a broad population -- persons who have not yet experienced serious negative consequences, or inflicted serious social harms, associated with those risk factors. The IOM categorization of prevention into universal, selective and indicated populations has been widely adopted in the prevention field, and serves to bring a unifying framework to currently fragmented strategies and practices in prevention. When consistently applied, the IOM framework can be a valuable tool for creating a conceptually unified continuum of prevention services.



The ground-breaking California Reducing Disparities Project (CRDP) was funded from the PEI portion of the MHSA. MHSA is designed specifically to address the needs of the unserved, underserved, and inappropriately served populations. The CRDP illustrates this spirit as it is one of a kind wide scale project and is the largest investment in the nation to look into diverse community perspectives on mental health disparities.

Making the Case: Why Disparities Matter

The population of the United States is becoming increasingly diverse. Populations of color now constitute more than one third of the nation's population (Homes, Jones & Ramirez, 2011) and are estimated to grow to 54% of the U.S. population by 2050 (U.S. Census Bureau, 2008). By the middle of 2013, California will have a first: an equal number of Hispanic and white residents, according to estimates California's Department of Finance (Aguilera, 2013.)

Racial/ethnic diverse groups (African Americans, Asian/Pacific Islanders, Latinos, Native Americans), along with sexual minority groups (LGBTQ), transition age youth, older adults, and persons with

disabilities make up a large percentage of the population, that are underserved or unserved. This equates to difficulty in accessing and utilizing appropriate mental health services and support services. When they are able to access services, often the services are insufficient and inadequate due to multiple factors to include lack of cultural relevance and/or linguistic appropriateness. Culture influences the value that groups place on help-seeking and use of services. Various groups reject traditional mental health services based on beliefs that they are not needed.

Disparities in Mental Health Outcomes by Community

Unfortunately, disparities in mental health outcomes exist across a wide spectrum. The chart below illustrates how they are reflected in the populations as described in the CRDP Reports.

African Americans	▪ In 2007, U.S. African Americans were 30% more likely to be diagnosed with serious psychological distress than the general population. ▪ In 2007, U.S. African Americans were 50% more likely to report symptoms of depressive episodes than the general population. ▪ In 2007, U.S. African American students were more likely than their White counterparts in grades 9-12 to attempt suicide (females were twice as likely; males were 1.6 times as likely). ▪ During FY 2007-2008, less than 1% of California's nearly 2.2 million African American population used DMH services. ▪ African Americans are far more likely to have their first contact of mental health in an emergency room and are underrepresented in outpatient care. ▪ African American children experience missed opportunities in our public school system for prevention and early interventions associated with health screening and low academic scores, which could indicate mental illness. ▪ African American youth are over-diagnosed for conduct disorders, and under-diagnosed for depression.
Asian/Pacific Islander	▪ Asian American, Native Hawaiian, and Pacific Islander (AANHPI) women ages 65 and over consistently have had the highest suicide rate compared to other racial groups. ▪ Native Hawaiian and Pacific Islander (NHPI) adults had the highest rate of depressive disorders and the second highest rate of anxiety disorders among all racial groups (based on 2008 data from the CDC). ▪ Asian Americans with suicidal ideation or attempts were found to have perceived less need for help and would be less likely to seek help compared to Latinos. ▪ Based on the 2009 CDC data, NHPI high school students ranked the highest at 33.4% to have felt sad and hopeless every day for two or more weeks in a row. ▪ Looking at children receiving mental health care from California's

	county systems from 1998 to 2001, it was found that AANHPI children were more likely than White children to use hospital-based crisis stabilization services. ▪ In 2006 and 2007, API females ages 15 to 24 ranked second among all racial groups in suicide rate at 4% and 3.8%. ▪ In 2007, suicide was the third leading cause of death for AANHPIs ages 10 to 14 and the second leading cause of death for ages 15 to 34.
Latinos	▪ Latinos have less access to mental health services than do whites, are less likely to receive needed care, and are more likely to receive poor quality care when treated. ▪ Only about one in four (27%) Mexican-origin adults who had one or more psychiatric disorders in the past 12 months received any kind of service. ▪ Approximately three out of four Mexican-origin Latinos (73%) who have a diagnosable mental health disorder and who need services remain untreated. ▪ 85% of Mexican immigrants who needed services remained untreated. ▪ Approximately one quarter (24.2%) of U.S.-born Latinos received minimally adequate treatment for their mental health needs; in contrast, only 10% of Latinos born abroad, received treatment that met the requirements for minimally adequate treatment (less than half the statewide rate).
Native Americans	▪ American Indians and Alaska Natives in California have elevated rates of poverty, violence, substance abuse, depression, and other psychological maladies when compared to non-Hispanic whites. ▪ California Native Americans show significantly more difficulty than non-Hispanic whites when receiving or accessing mental health care. ▪ Native Americans within California have shared concerns about loss of culture, alcohol and drug abuse, and depression and suicide as contributing factors to mental health disparity. ▪ Western mental health service delivery focuses on individual locus rather than taking into consideration the Native American community as a whole.
LGBTQ	▪ Approximately 25% to 80% of gay men and lesbians access mental health services; these percentages are two to four times greater than heterosexuals. ▪ When compared to heterosexual men, gay and bisexual men are 3.0 times more likely to meet criteria for major depression and 4.7 times more likely to meet criteria for a panic disorder. ▪ Studies of suicidal risk report that up to 48.8% of gay men have death ideation, 21.3% have made a suicide plan at some point, and 11.9% to 14.6% have either made a suicide attempt and/or deliberately harmed themselves.

- Bisexual women are twice as likely to report some degree of suicidal ideation compared to heterosexual women, and closeted bisexual women are three times as likely as heterosexual women to have attempted suicide.
- A 2007 study of Latino and Asian American individuals found that suicide attempt rates for LGB individuals from these ethnic groups were 4 times (women) to 8 times (men) that of heterosexuals.
- LGBTQ young adults who reported high levels of family rejection during adolescence were 8.4 times more likely to report having attempted suicide, 5.9 times more likely to report high levels of depression, 3.4 times more likely to use illegal drugs, and 3.4 times more likely to report having engaged in unprotected sexual intercourse, compared with peers from families that reported no or low levels of family rejection.

The above excerpts demonstrate the need to increase health equity in mental health services and care. Through prevention and early intervention efforts, such as those described in this Toolkit, we are better positioned to prevent and reduce the effects of untreated mental health conditions thereby increasing wellbeing and recovery.

Beyond the Talk, Practicing the Walk: Finding a Path to Bridge the Cultural Gap

Past and current efforts to reduce disparities in mental health outcomes have not addressed the fundamental issues that led to inequities in the first place. Moving beyond the talk will require intentional change by individuals, families, community members, businesses, government, and other community institutions.

The CCMH Summit XVIII demonstrated that moving beyond the talk to "practice the walk"—engage in actions that lead to transformative change—to improve health and well-being and reduce disparities for all citizens will involve:

- **leadership**, including leaders from government, communities themselves, business, education, and the faith community, to work together;
- a **vision** shared by the community, of a California and nation free of disparities or discrimination;
- **action** by community institutions, by government, and by individuals and families, to realize that vision; and
- **accountability** through independent monitoring, community celebrations, transparency, disaggregation of data, and annual report cards, to ensure results.

Leadership to organize around a shared vision that inspires action and invites accountability is a critical first step. An equally important step is for individuals to be willing to learn to accept and value, or affirm differences. Poshi Mikalson, MSW, lead author of the LGBTQ CRDP Report compares this to the process of getting used to a fabulous pair of new shoes. First, one must try them on for size. Then, even though

the new shoes may be unlike any pair one has ever worn before, and may be uncomfortable at first, one must “stick with it” and keep them on. Whether wingtips or work boots, platform heels or ballet flats, this commitment will eventually lead to familiarity—and will be fabulous!

II. How to Use this Toolkit

The *Beyond the Talk: A Resource Toolkit to Bridge the Cultural Gap* was designed to provide support to a variety of professionals and community stakeholders working with consumers in the five unserved and underserved populations (African Americans, Asian/Pacific Islander, Latinos, Native Americans, and LGBTQ). This toolkit is intended to serve as a guide to assist individuals in becoming more culturally competent, sensitive and relevant in order to address the cultural gaps that contribute to disparities in mental health.

This toolkit is not prescriptive, but rather offers recommendations, tools, and examples from the field. For additional resources, the five California Reducing Disparities Project reports can be found at: http://www.dmh.ca.gov/Multicultural_Services/CRDP.asp and further information regarding the presentations at the Cultural Competence and Mental Health Southern Region Summit XVIII can be found at: http://www.culturalcompetencesummit.org/.

The primary purpose of the *Beyond the Talk: A Resource Toolkit to Bridge the Cultural Gap* is to:

- Make the case for why reducing disparities in mental health is important to improve outcomes for unserved and underserved populations
- Increase knowledge of strategies to aid in bridging cultural gaps to reduce disparities in mental health
- Encourage professionals to move "beyond the talk" into action
- Identify disparity reduction tools that are accessible and ready for implementation

The *Beyond the Talk: A Resource Toolkit to Bridge the Cultural Gap* is intended to provide the reader with knowledge and insight gleaned from the Cultural Competence and Mental Health Southern Region Summit XVIII and highlight information provided in the CRDP reports. In no way is this Toolkit intended to replace the full content of the CRDP Reports, rather to complement the findings and recommendations with accessible tools to impart positive change. Readers are encouraged to regularly refer and review the complete CRDP reports.

Parts of the Toolkit

There are four sections of this toolkit:

A Path to Bridge the Cultural Gap

This section familiarizes the reader with the terms "cultural gap" and "path" by defining and identifying them. A cultural gap points to what is missing or absent, that if present, would help unserved and underserved communities achieve positive mental health outcomes. A path is a means or method of addressing cultural gaps. This portion of the report includes cultural gaps and paths identified in the CRDP reports as well as in presentations given at the CCMH Summit XVIII.

Practicing the Walk

"Practicing the walk" means going beyond the rhetoric and moving towards action. This section outlines the overarching recommended actions that were reflected by all of the CRDP reports and recommendations specific to each population that were reflected at the CCMH Summit XVIII. It also outlines suggested actions to practice the walk from the field; this includes the Conversation Café and the workshop presentations given at the CCMH Summit XVIII.

Beyond the Talk: A Call to Action

From the beginning, the CRDP Reports and the Cultural Competence and Mental Health Southern Region Summit were focused on collective actions that can lead to significant results. This section identifies how to move beyond talking about change and what needs to be done to implement action. The efforts identified come from speakers and participants at the CCMH Summit XVIII.

Tools to Reduce Disparities

This section provides information from each of the CRDP reports that can be used as tools for action, self-reflection, and to increase culturally competent practices. Although each tool below was used by a specific CRDP report, the concepts may be applicable to other populations and/or inspire the development of new tools that are population-specific.

Tool	Source
SMART Recommendations/ Action Criteria	African American Report
8 Core Components of Cultural Competency	Asian Pacific Islander Report
Selection Criteria for Promising Programs and Strategies	Asian Pacific Islander Report
LGBTQ Competency Considerations	LGBTQ Report
Two Spirits	LGBTQ Report
The Learning Collaborative	Native American Report
Medicine Wheel Tool	Native American Report
The Five A's for Reducing Disparities in Latino Populations	Latino Report

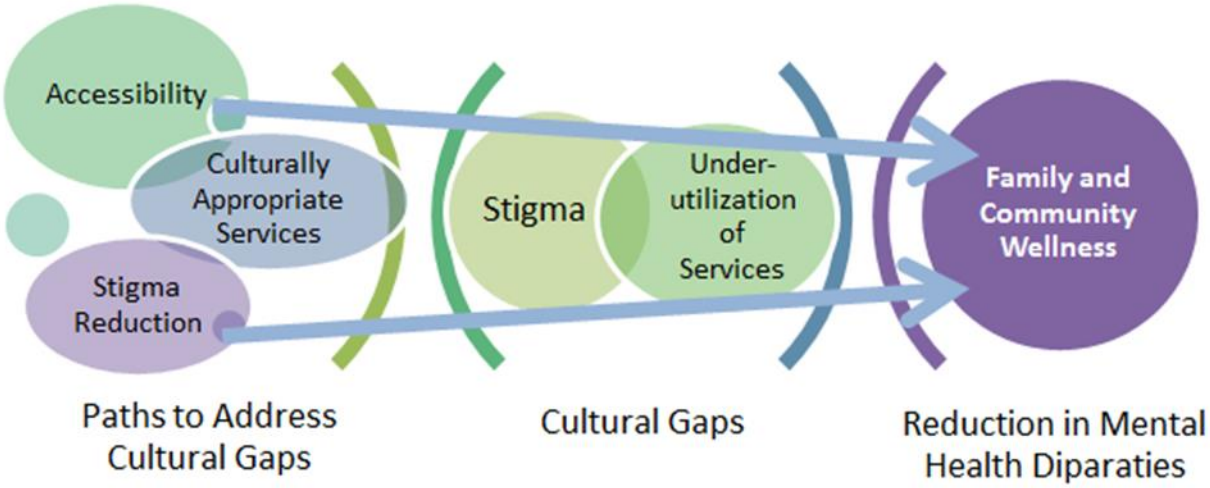
III. A Path to Bridge the Cultural Gap

The value of a path cannot be overstated, particularly when the path leads to a highly desired outcome. The California Reducing Disparities Project (CRDP) identified paths to address cultural gaps that were highlighted throughout the CCMH Summit XVIII.

What is a "Cultural Gap"?

One way to think about a "gap" is the distance between two points, such as (1) positive outcomes, including mental health and wellness, and (2) the disparities in outcomes that exist in many communities. A "gap" can also describe the reasons *why* the disparities in outcomes exist. Gaps point to what is missing or absent, that would otherwise enable the five unserved and underserved populations to access affordable, appropriate mental health services. The terms "barrier" and "challenge" are also often used to refer to gaps, and are used interchangeably with the term "gap" in this document.

The diagram below illustrates how paths address cultural gaps to contribute to a reduction in mental health disparities. The paths and gaps depicted in the diagram below are not all inclusive of the issues and concerns that have been identified by the CRDP reports. They are for demonstration purposes only and for the reader to use and add their own paths to address gaps in diverse communities.



CRDP Report Identified Cultural Gaps

It is evident that disparities in quality of life exist for unserved, underserved, and inappropriately served populations. Some of the disparity in quality of life, including positive mental health outcomes are partially reflected in differences in:

- Educational achievements
- Income, employment, and wealth
- Safe neighborhoods and quality housing
- Criminal justice involvement
- Degree of power within the political process
- Health and mental health literacy

Further, these disparities may be partially explained by racism and prejudice, biased institutional practices, limited community cohesion, and by poor individual choices and behaviors. Ethnic minorities are consistently disproportionately overrepresented across the board in high-need populations including risk for mental health issues, homelessness, incarceration, unemployment or underemployment, excess mortality, and exposure to violence and trauma.

To illustrate these differences more specifically, there were several challenges identified in the CRDP reports that are common across populations. The diagram on the right provides some examples of gaps that are common across all five CRDP populations. Whereas, the table on the following page demonstrates key barriers identified in the CRDP reports that are unique to the African American, Latino, Asian Pacific Islander, Native American, and LGBTQ populations.

Significant gaps that are unique to a particular CRDP population are as follows:

Population	Key Gaps (Barriers) to Appropriate Mental Health Services
African American	▪ Disproportionate child welfare and criminal justice involvement ▪ More likely to obtain treatment when in crisis rather than on a regular out-patient basis ▪ Too few African American providers in mental health workforce ▪ Misdiagnosis due to lack of cultural awareness ▪ Structural disconnect from faith communities
Latino	▪ Lack of availability of school-based, culturally and linguistically appropriate mental health services ▪ Immigration status challenges; social exclusion ▪ Viewing mental illness as "fate" (caused by God's will or by evil done by others) ▪ Concept of machismo counterintuitive to help seeking (generational trend) ▪ Lack of health insurance (Latinos have lower rates of health insurance compared to other ethnic groups)
Asian/ Pacific Islander	▪ "Medical necessity" may not take cultural specific conditions and symptoms into consideration ▪ It can be challenging to find interpreters with sufficient familiarity with mental health terminology to effectively communicate the information in culturally acceptable terms ▪ Many of the promotional and informational materials are not translated or the translation is not always culturally or linguistically appropriate. ▪ Conventional assessment tools developed based on Western cultures may not be appropriate for evaluation of community-driven programs and strategies
Native American	▪ Cultural genocide, legalized discrimination, and urban relocation ▪ Historical trauma response ▪ Use of census data to justify which populations receive funding (Undercount of Native Americans is due largely to misclassification) ▪ Mental health system of care is inappropriate for Native Americans
LGBTQ	▪ Lack of accurate information regarding LGBTQ individuals and communities among many providers, administrators, policy makers, and members of the general public ▪ Historical classification of homosexuality as pathology, a disorder or a form of mental illness ▪ Anti-LGBTQ policy initiatives ▪ Intersecting identities and coming out/staying in process poorly understood by providers

CCMH Summit Identified Cultural Gaps

In addition to the cultural gaps that were identified in the CRDP reports, the CCMH XVIII presentations (which include the keynotes, plenary panel, institute presentations, workshops presentations, and media advocacy showcases) and Conversation Café dialogues also uncovered gaps. The list below depicts the major types of gaps that were identified, some of which are common across populations, while others are unique to one or two of the priority populations. The classification of barriers identified below has been developed for the purposes of this report in order to better illustrate where certain challenges appear. These serve to validate and illuminate those previously discussed from the CRDP Reports.

- **System gaps**: Reflect barriers to the access of culturally and linguistically appropriate, affordable, and quality mental health services that are driven by policy, funding, institutional structure, etc.
- **Service gaps**: Those barriers that are program specific and have to do with how mental health programs operate and provide for (or fail to provide for) a focus on prevention and early intervention, cultural competence, and quality assurance.
- **Provider gaps**: The cultural gaps in this section refer to individual providers—the cultural responsiveness, training, sensitivity, etc. that they personally bring to their interaction with individuals and families receiving services.
- **Individual/Family gaps**: Cultural gaps that are specific to individual, family, or family culture and values are included in this section.
- **Community gaps**: Contributors to mental health disparities that reside in community values, mobilization, and advocacy.

The table on the following page displays challenges, identified by CCMH Summit XVIII Presentations and Conversation Café dialogues, grouped under the above mentioned classifications.

Cultural Gaps that Contribute to Mental Health Disparities as Identified by Summit Presentations and Conversation Café		
System	Institutional racism	System disparities
	Legal inequities	Complex system – hard to navigate
	Lack of school based mental health services	Lack of disaggregated data & proper outcomes evaluated
	Shortage of therapists & service providers & Structural barriers to care, including flexible hours of service	Content of university-based mental health training, research, and state licensure requirements may be at odds with certain cultural norms
	Government services (including County) have poor community image	
Services	Support for access to care	Underutilization of services
	Lack of services & consistency of care	Services not offered in native language
	Stigma, guilt, shame, culture, gender, trauma	Not directly responsive to needs of military families
	Multiple mental health providers; "piece meal" services; incorrect medication	Unreliable clinical tools (not normed on minority populations)
Provider	Clinician competence	Stigma-inducing practices
	Clinician bias & prejudice	Biased & inaccurate diagnosis
	Confidentiality (provider in same social circle(s) as participant/client)	
Individual/ Family	Help seeking barriers	Homebound &/or aging population
	Internalized oppression	Logistical: lack of transportation
	Lack of knowledge of where to get care/services	Stigma associated with mental health issues
	Isolated; lack of knowledge & awareness about the mental health system	Cultural traditions e.g. elder speaks on behalf of family
	No health insurance or limited coverage	
Community	Environmental impacts	Historical & complex trauma
	Prevalence of violence & trauma	Lack of advocacy for school based mental health services
	Poverty; Lack of access to care & support for access to care	Low community participation in stakeholder or collaborative planning of mental health services

Paths to Address Cultural Gaps

A discussion of gaps or barriers would not be complete without the clear delineation of the way forward. Throughout the CRDP Reports and the CCMH Summit XVIII, paths to address cultural gaps were identified to highlight the assets, resources, and possibilities for prevention and early intervention and the reduction of mental health disparities.

What is a "path"?

In this context, a "path" is a means or method of addressing the identified cultural gaps. Paths give us direction, point the way, and help us to move forward so that progress can be made in a systematic manner. A path is a course to follow, usually constructed with a particular purpose or destination in mind. In this case, the desired destination is reduction in mental health disparities through prevention and early intervention facilitated by culturally competent institutions and practices.

Paths to Address Gaps Identified in CRDP Reports

The paths listed below were identified in the CRDP Reports and at the CCMH Summit XVIII and are all based on a Prevention and Early Intervention (PEI) approach. The following paths refect specific strategies for reaching desired outcomes: (Please note this does not reflect all potential strategies to close the cultural gap. Refer to CRDP reports for additional comprehensive interventions to address gaps.)

Paths to Address Gaps

Increase Cultural Competence

Stigma Reduction and Education through Media Advocacy

Community Collaboration

Participation in Service Design & Policy

Increase Cultural Competence

Increasing cultural competence within a system is crucial to closing cultural gaps. In order for a system to become more culturally competent it is necessary for that system to build knowledge and skills around cultural competence. This can be done through workforce development meaning we actively teach staff about the culture of our organization, and of the families and communities we serve. We provide guidance, support, supervision, and opportunities to do the work of becoming culturally

proficient. When we see stereotypes or prejudices in the workplace, we call it out and educate and sensitize staff about beliefs, attitudes and behaviors that are offensive.

It is important to follow through with workforce development and institutional change to embed it within the organization in a meaningful and significant way so that we are facilitating change for personal and system transformation Policies and procedures are an additional way to ensure institutional change by defining culturally competent principles.

Below are some examples from presentations given at the CCMH Summit XVIII on how to develop a more culturally competent workforce:

Build Team Diversity	•Expand the diversity of your staff so that the makeup of your staff reflects the diversity of the community you serve. This means not only ethnic diversity, but diversity in personal experience so that they can relate to the experiences of their clients.
Expand Language Competency	•Interventions conducted in the consumer's native language have shown to be twice as effective as those that were not. Assess your staff's language competency in regards to the population you serve. Hire staff that are bilingual in the languages of your clients, and expand career and educational opportunities to current bilingual staff.
Provide Cultural Awareness Training	•It is imperative to hold cultural awareness training specific to the groups that you serve. For example if your data shows that there are LGBTQ individuals in your community, it would be worthwhile to give a presentation to your staff regarding working with the LGBTQ community.
Promote Educational Opportunities	•If your area has a shortage of mental health professionals, consider working with local universities to promote educational opportunities in your area. You can also work to enhance clinical staff skills. This can be done by researching and selecting trainings proven in a clinical setting then provide the training to your staff. Imperial County Behavioral Health Services (CA) took this initial step and provided training on: Cognitive Behavioral Therapy (CBT), Applied Suicide Intervention Skills Training ASIST), Non Violent Crisis Intervention (NVCI), Skilled Helper, and Motivational Interviewing (MI).

Stigma Reduction and Education through Media Advocacy

Reducing stigma was also identified as a path to reducing disparities. Stigma is far too often what keeps people from seeking the help they need. The use of media is a key strategy to reduce stigma and educate communities about mental health, and was identified in both the CRDP Reports as well as the presentations hosted at the CCMH Summit XVIII. Media advocacy generally targets a specific population and involves carefully planned out media campaign strategies.

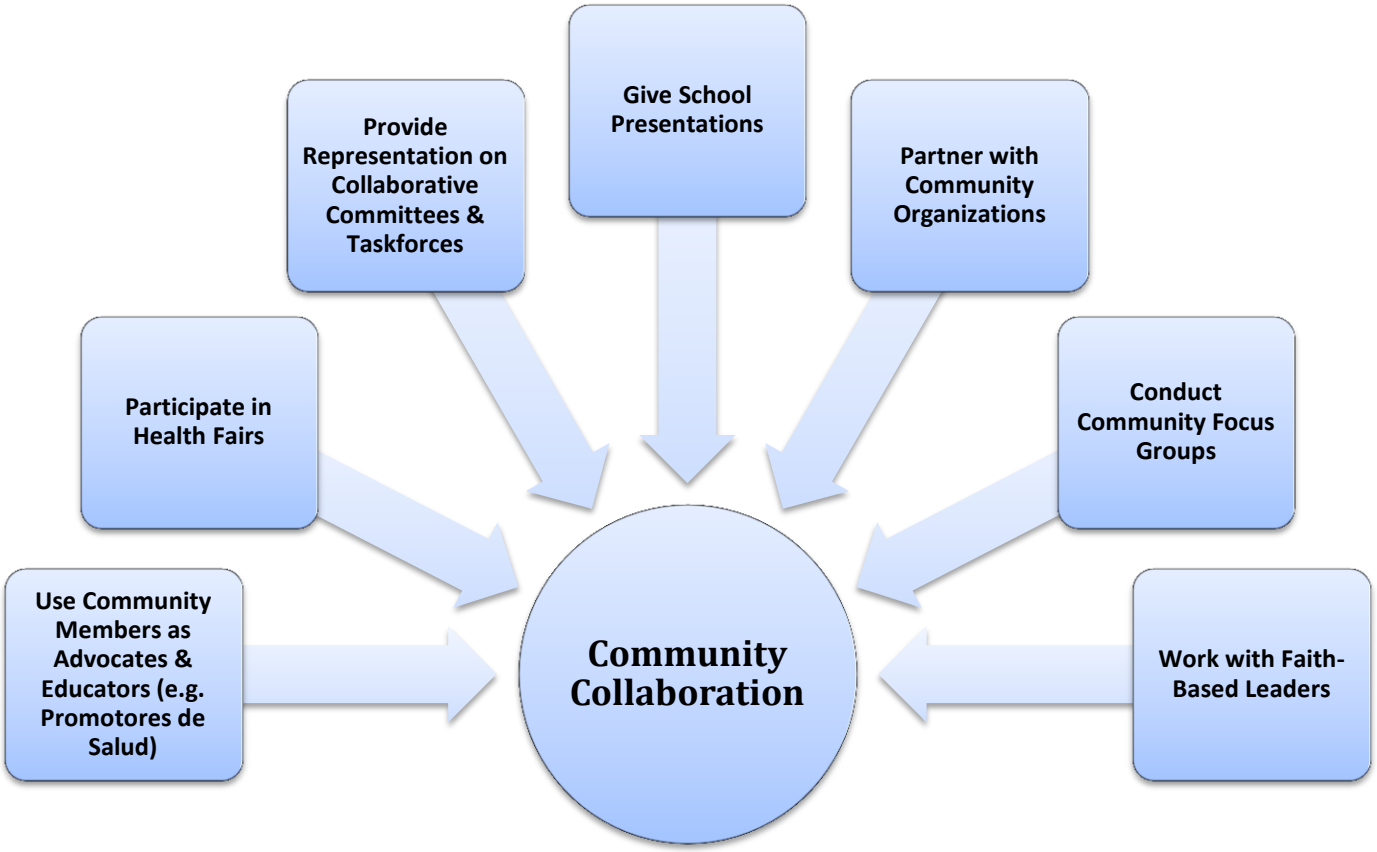
When deciding to launch a media campaign, there are several factors to take into consideration. First and foremost, you must take your target audience into consideration. Listen to what they need; what they want is more important than what you think they need. Use culturally relevant (not always traditional) creative elements (e.g., colors, images, formats, etc.), and tell familiar and relatable stories. You also need to be clear and specific about the call to action, i.e. what you want people to do. Another consideration is partnering with an outside agency to help develop and implement a campaign.

For example, the County of San Diego Health and Human Services Agency's Behavioral Health Services (BHS) partnered with the Metropolitan Group (www.metgroup.com) to create a bilingual Spanish and English "Fotonovela" to target San Diego's Hispanic population. The Fotonovela narrates in print a Hispanic family's experience with depression, and depicts in a culturally sensitive and appropriate manner how the family begins to understand what depression is and where to get help. Because of their format and popularity, the Fotonovela is particularly effective in engaging and educating Spanish-speakers and bilingual readers. Due to their success, other counties in California have requested copies for use in their own efforts to engage the Hispanic population. For more information and to download the Fotonovela, please visit: http://sandiego.camhsa.org/fotonovela.aspx.

Community Collaboration

Community collaboration entails outreach and meaningful engagement of communities experiencing disparities in order to meet the needs of the community. "Community engagement" refers to developing relationships over time that are rooted in trust, common goals that yield mutual solutions to create significant and positive change.

The diagram on the following page gives some examples identified from presentations at the CCMH Summit XVIII to enhance community collaboration.



Additional examples of community collaborations identified from Summit presentations include implementing Promotoras de Salud, and developing relationships and partnerships with faith-based leaders and congregations.

Promotores de Salud

The Promotores de Salud (Health Promoters) program utilizes community members as advocates and educators. Promotores de Salud are individuals who live in the community, speak the same language as the community, and possess leadership and advocacy skills. They have existing social networks, are willing to learn, are potential agents of change, and are sensitive to sociocultural aspects of the acculturation process. As members of the community they are better able to share knowledge about mental illness with members of their community, which in turn reduces stigma about mental illness and allows them to provide community members information about appropriate mental health services and other relevant services.

Working with Faith-Based Leaders

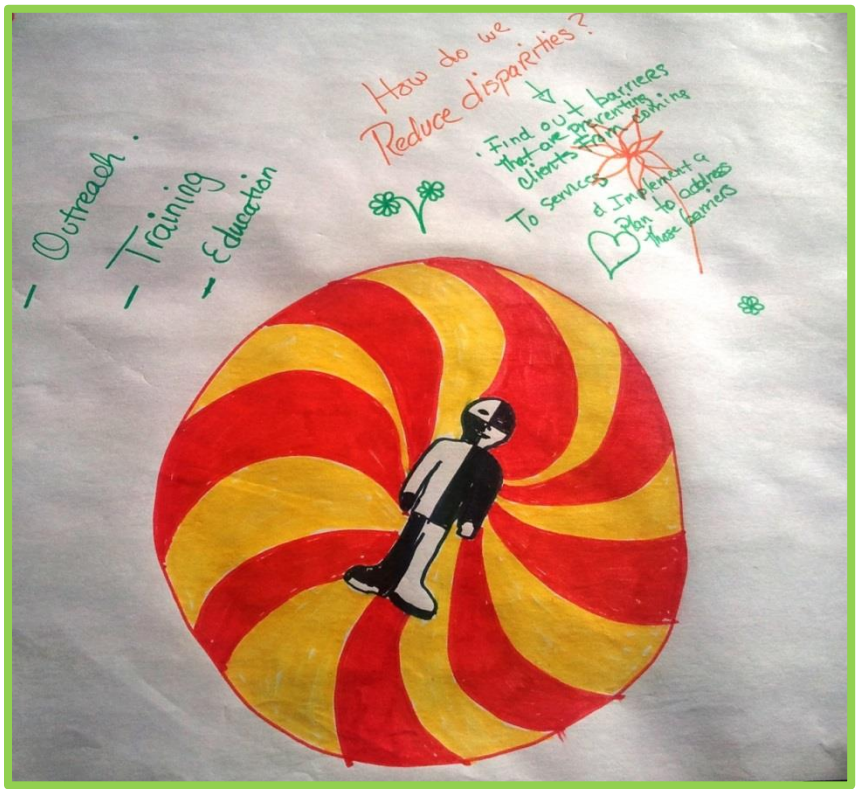
It is important to collaborate with faith-based and spiritual communities, as these are cultural institutions and natural places for clients and families to seek out support. Some cultures that tend to not seek formal mental health services will turn to their spiritual leader in times of need. When working with faith communities it is important to: provide education to faith leaders on mental health issues and resources, invite pastors and spiritual leaders to mental health conferences and workshops (have leaders from various denominations in your community); ask questions such as: "What are the issues?" and "How can we mutually solve them and what do we need to do to achieve a solution?"; and finally provide options and tools that can be carried out.

The Right to Mental Health

The World Health Organization (WHO) has established a concept of "The Right to Health". According to the WHO, the right to health entails: availability, accessibility, acceptability, and quality. The table below gives the WHO's definitions of these components for health and examples of how these can be adapted to mental health (World Health Organization, 2012).

	Health	Mental Health
Availability	A sufficient quantity of functioning public health and health care facilities, goods and services, as well as programs.	A sufficient quantity of mental health facilities, general practitioners, and specialized providers without long waits for appointments.
Accessibility	Health facilities, goods and services accessible to everyone. Accessibility has four overlapping dimensions: non-discrimination, physical accessibility, economical accessibility (affordability), and information accessibility.	Mental health facilities and specialized services accessible to everyone. The same four overlapping dimensions for the right to health apply to mental health.
Acceptability	All health facilities, goods and services must be respectful of medical ethics and culturally appropriate as well as sensitive to gender and life-cycle requirements.	All mental health facilities and services must be culturally relevant and respectful, taking into consideration: race, culture, gender identity, and age.
Quality	Health facilities, goods and services must be scientifically and medically appropriate and of good quality.	Mental health facilities and services must be culturally appropriate and of good quality.

Although not cited directly, the above mentioned components are reflected in the five CRDP reports as critical to reducing disparities in mental health.



IV. Practicing the Walk

"Practicing the walk" is a widely used expression to encourage a match between rhetoric and action. The "walk" in this case, is the actual practice, or doing what is suggested in the paths to bridge cultural gaps.

Recommendations Across Populations

Although numerous recommendations were given in the CRDP reports, for the purposes of this toolkit we have identified seven overarching recommendations that were common to the five reports. The seven are:

1. Increase Collaboration between Counties and Community-Based Organizations
2. Develop a Culturally and Linguistically Competent Workforce
3. Adapt or Develop Treatment Modalities that are Culturally and Linguistically Appropriate
4. Remove Barriers to Increase Access to Services
5. Collect Inclusive Demographic Data to Increase Accuracy and Efficacy of Data
6. Build Community Capacity through Training and Support
7. Use Media to Reduce Stigma and Promote Resources

The following pages outline individual recommendations from each CRDP report that fall under the recommendations across populations listed above. These seven areas were chosen because they support the recommendations cited in the CRDP reports.

For a full listing of recommendations within each of the CRDP reports please visit: http://www.dmh.ca.gov/Multicultural_Services/CRDP.asp.

1. Increase Collaboration between Counties and Community-Based Organizations

African American CRDP Report

- Use state provided funds to directly support Black led community-based organizations who provide meaningful programs, interventions, and activities for long-term wellness and progress.
- The Mental Health Services Oversight and Accountability Commission (MHSOAC) should establish culturally congruent community commissions.
- Establish community-county partnerships.

API CRDP Report

- Use existing relationships that community-based organizations have within the community, leverage these relationships and resources to work with communities.
- Integrate existing community resources into outreach and engagement to maximize effectiveness and efficiency.
- Support programs that complement county MHSA/PEI plans, preferably models that have significant community involvement, design and implementation.

LGBTQ CRDP Report

- Programming funded by the state or county, which takes place in a faith-based or church – affiliated organization should be required to have LGBTQ-relevant anti-discrimination policies.
- State and county requests for proposals should support innovative community-based efforts and require providers that claim to work with LGBTQ communities to provide a historical record of such work.
- Health care agencies need to create linkages with local LGBTQ communities and use appropriate referral sources and resources for their LGBTQ clients

Native American CRDP Report

- Respect the nature of Native Communities and engage the community leaders to ensure work is in alignment with community priorities.
- Develop a community advisory board to ensure evaluation integrates traditional and culturally based services and ensures appropriate community involvement.

Latino CRDP Report

- Increase county-community collaboration by coordinating and maximizing community resources to achieve an increase in access to treatment among Latinos.
- Engage faith-based organizations to develop and implement strategies to promote pathways to wellness, reduce stigma, promote social inclusion, and advocate for the importance of spirituality to one's being.

2. Develop a Culturally and Linguistically Competent Workforce

African American CRDP Report

- Create a continuum of systems for education institutions, sustained by culturally congruent workforce education training to employment program.
- Licensed mental health providers should be certified by the Association of Black Psychologists in order to provide culturally competent services to African Americans.
- Create a continuum of systems for education institutions, sustained by culturally congruent workforce education training to employment program.

API CRDP Report

- Increase availability and quality of care by supporting the development and retention of a culturally competent workforce.
- Promote mental health careers through outreach to API youth and their parents.
- Ongoing training and technical assistance for providers, both in mental health and other fields, serving the API community.

LGBTQ CRDP Report

- Require statewide workforce training and technical assistance in order to increase culturally competent mental, behavioral, and physical health services.
- Require statewide workforce training and technical assistance for all California public school staff and administrators in order to increase culturally competent and sensitive treatment of all students who are, or are perceived to be, LGBTQ.

Native American CRDP Report

- Ensure the Native American specific grant program includes a strong linkage to technical assistance and training for every participating California Native American organization/tribe.
- There should be funding for all operational needs, including suitably trained staff.

Latino CRDP Report

- Invest in training opportunities for primary health care and mental health care providers to coordinate and manage the care of mental health illnesses.
- Develop and sustain a culturally and linguistically competent mental health workforce consistent with the culture and language of Latino communities.
- Support career pathways that lead to certification programs and advanced degrees with a focus on bicultural and bilingual training and other population-specific subject matter.

3. Adapt or Develop Treatment Modalities that are Culturally and Linguistically Appropriate

African American CRDP Report

- Implement culturally focused short-term population-based crises care.
- The mental health system needs to be redesigned to be more responsive to ethnic population needs.
- Create and provide opportunities for adoption and inclusion of culturally competent curricula developed by African Americans based on community-defined evidence in a way that better serves diverse African Americans.

API CRDP Report

- Increase availability and quality of care by supporting services that meet the core competencies and program criteria as defined by the API-SPW.
- Support existing culturally competent programs to continue serving the community.
- Support the development of new culturally competent programs to respond to the needs of the community.

LGBTQ CRDP Report

- Agency policies and procedures should be inclusive of LGBTQ staff, clients and communities.
- Written forms and documents, and oral language used in assessment and interventions should be inclusive and respectful of LGBTQ people.

Native American CRDP Report

- Ensure oversight of services is culturally competent for Native Americans.
- Funded projects should be managed through the Office of Multicultural Services or other culturally competent entity at the state level.
- Utilize a Native American advisory council that convenes on a regular basis to advise the management of the CRDP to address mental health disparities in the community.

Latino CRDP Report

- Form accountability panels to develop culturally attuned evaluation instruments that would measure the impact of the services Latinos receive.
- Mental health providers and support staff need to understand the importance of communicating with each consumer in a way that acknowledges the consumer's beliefs about mental health.
- Develop a "Latino cultural and linguistic assessment tool" to assess how well providers and support staff comply with CRDP recommended community-defined evidence practices.

4. Remove Barriers to Increase Access to Services

African American CRDP Report

- Shift emphasis of service delivery away from diagnoses and prescriptions to screening, accurate assessment and identification of immediate needs. Shift emphasis of service delivery away from diagnoses and prescriptions to screening, accurate assessment and identification of immediate needs
- Provide services to community program partners (CPP), and work with them to plan and implement distributions and activities in their communities, which help reduce the immediate need.

API CRDP Report

- Support for more flexibility in establishing eligibility for services such as modifying the requirement to meet medical necessity.
- Support for inclusion of ancillary services as part of the service plan, such as interpretation and transportation.

LGBTQ CRDP Report

- All locations where state and county funded mental/behavioral and physical health care services are offered should be required to be safe, welcoming and affirming of LGBTQ individuals and families.
- State and county mental/behavioral health and physical health care departments should create an environment of safety and affirmation for their LGBTQ employees
- Mental, behavioral and physical health care and educational materials provided to LGBTQ clients should be made available in client's primary language, particularly if the client speaks a threshold language.

Native American CRDP Report

- To maximize access to grant funds, a simple application from each interested California Native American organization/tribe participating should suffice.
- Native American organizations/tribes in California should use funds towards having streamlined access and input into resource dissemination and program responsiveness.

Latino CRDP Report

- Mental health programs receiving funding to serve Latinos and improve mental health disparities for Latinos should be required to produce outcomes that demonstrate increases in access to services, improved retention rates, reduced dropout rates and increased quality of care.
- Counties should adopt the recommendations from the Latino CRDP Report to ensure that Latinos and other diverse underserved communities gain proportional access to MHSA programs.

5. Collect Inclusive Demographic Data to Increase Accuracy and Efficacy of Data

African American CRDP Report

- The MHSOAC should immediately develop and implement a due diligence process of examination and evaluation to determine the utility and effectiveness of programs services' ability and/or capability in working with people of African heritage.
- Mandate culturally congruent methods that document individual and community positive actions for what is working well toward personal improvement, progress toward independence, and toward becoming a contributor. Progress reports and data outcomes must be reported on a regular basis to ensure program fidelity and return on MHSA financial investment.
- Mandatory analysis of all assessment and screening tools used on African Americans for all mental health issues and standardized culturally adapted screening instruments and tools.

API CRDP Report

- Mandate the collection of disaggregated data to accurately capture the needs of various API communities.
- Support developing culturally appropriate outcome measures.

LGBTQ CRDP Report

- Demographic information should be collected for LGBTQ people across the lifespan, and across all demographic variations.
- All domestic violence programs in California should be required to include information about the gender and sexual orientation of clients in their statistical documentation and recognize the partnerships of LGBTQ persons as "domestic".

Native American CRDP Report

- Apply an adjustment factor to census data or an alternative means of population counts should be used to develop a more accurate count of Native Americans as many tribes have such data sources.
- Require the use of community based participatory research methods within each community.Use mixed method evaluation to ensure the strongest reflection of successes and challenges.

Latino CRDP Report

- Design and incorporate a survey that measures skills, knowledge and attitudes, and reflects evidence-based "best practices" and treatment management.
- Evaluate implemented programs and best practices to determine if the integration leads to reduction of health and mental health disparities, accompanied by improvements in treatment outcomes and quality of life.

6. Build Community Capacity through Training and Support

African American CRDP Report

- Establish a statewide network of community healers & indigenous/traditional healers, in order to deliver culturally grounded mental health services.
- Train clergy and lay persons in African American communities and educate parents with school-based interventions.
- Identify what is "meaningful" for Black people to experience good mental health intervention from first responders.

API CRDP Report

- Establish a statewide network of community healers & indigenous/traditional healers, in order to deliver culturally grounded mental health services.
- Train clergy and lay persons in African American communities and educate parents with school-based interventions.
- Identify what is "meaningful" for Black people to experience good mental health intervention from first responders.

LGBTQ CRDP Report

- Funding should be made available to support LGBTQ researchers of color and research organizations with demonstrated access to these populations in order to close the gap in information about these populations.
- Funding should be allocated to develop statewide resource guide listing agencies, programs and services which have been determined to be LGBTQ-sensitive, affirming and culturally competent.

Native American CRDP Report

- Staff and workgroups should advise the state, reengage communities and educate other communities not reached by the Native American CRDP to promote the CRDP next phase implementation
- Support cultural revival for tribal, rural and urban communities.

Latino CRDP Report

- Provide resources for development of grassroots community capacity-building strategies.
- Capacity-building strategies should focus on convening and developing partnerships amongst mental health professionals and the indigenous community leaders to develop and strengthen their relationship.

7. Use Media to Reduce Stigma and Promote Resources

African American CRDP Report

- Deliver a public education campaign on mental illness, recognizing early warning signs, and how to take action and access resources to prevent a major episode.
- Utilize the Black media to promote a public education campaign designed like the national heart attack or stroke campaign.
- Develop social marketing plans and outreach with Black media to expand and enhance understanding of Black culture with an emphasis on positive imagery for improved mental health and to destroy erroneous ideologies about the population.

API CRDP Report

- Support computer technology, such as social networks, podcasts and web-based blogging to be used for outreach to younger generations.
- Support for establishing or maintaining community infrastructure so resources can be shared and leveraged.

LGBTQ CRDP Report

- Implement a statewide social marketing campaign that is informed and endorsed by LGBTQ communities to: (1) address and eliminate stigma directed towards LGBTQ individuals and families, and (2) decrease the stigma surrounding the seeking of mental and behavioral health services by LGBTQ individuals and families.

Latino CRDP Report

- Engage Latino news media and the entertainment industry in supporting educational programs that promote balanced and informed portrayals of mental health problems, LGBTQ issues and mental health services.
- Create and disseminate fotonovelas.
- Create recordings of meaningful conversations, or Platicas, in which Latino families with individuals who are successfully recovering from a mental illness share their stories and unique perspectives.
- Convene youth workgroups to design thoughtful messages relevant to youth and mental health stigma, and disseminate these messages using Facebook, Twitter, YouTube, blogs, and other social media outlets.

Reducing mental health disparities and promoting equitable access to services requires collaboration at every level. No one organization, network, or community can accomplish this task on their own. It is particularly critical that counties work with their non-profit partners in the context of community. Part of the focus of cross-system collaboration is partnership in developing a culturally competent workforce through shared human resources and training. Capacity is expanded when training is also offered to the community at large.

From the community perspective, mental health services are too often unavailable or inappropriate. Partners must work together to adapt or develop treatment approaches that are culturally and linguistically appropriate. A concerted effort must also be made to address barriers to service such as stigma, and more concretely cost, location, and transportation. The media can be a key partner in helping to reduce stigma and promote access to services.

Recommendations Identified in CRDPs by Population

The tables on the following pages lay out specific recommendations for each population given in the CRDP Reports that pertain to support from the field. "The field" refers to the keynote presentations, plenary panel, workshops, institute, media advocacy showcases, and Conversation Café at the CCMH Summit XVIII. These recommendations were randomly chosen because they were reflected at the CCMH Summit XVIII, not because they are perceived to be of greater importance than others.

For a full listing of recommendations with each of the CRDP reports please visit: http://www.dmh.ca.gov/Multicultural_Services/CRDP.asp.

African American Population

CRDP Recommendation

The state should provide significant financial resources directly to Black-led community-based organizations to continue providing meaningful programs, interventions and activities for long-term, positive community wellness and growth.

Summit Reflections

Workshop: Africancentric Rites of Passage, Cultural Competency and PEI Intervention

The DuBois Institute and the MAAT Center Program empower black male adolescents through a nine months rites of passage program. They are introduced to the major principles of Nguzo Saba, the 10 virtues of MAAT (Truth and Justice, a moral standard between right and wrong), the RIPSO principles and the DuBois Institutes Class Creed, as well as lessons in nutrition and food.

For more information please visit: http://duboisscholars.org/

Workshop: California Reducing Disparities Project (CRDP): African American Populations Report

Using an ecological approach focusing on individuals, community and systems – 1) shift service delivery to screening, accurate assessment and identification of immediate needs, 2) establish a "black care paradigm" based on African-centered behavioral change model, 3) fund and establish community healers support, 4) fund for the sustainability of neighborhood health efforts.

For more information please visit: http://www.aahi-sbc.org/

CRDP Recommendation

Counties should establish culturally congruent community commissions, in order to ensure that African American issues related to total health and wellbeing are appropriately addressed using culturally appropriate approaches as valued by local county residents.

Summit Reflections

Workshop: Evidence-Based Prevention and Early Intervention Services for African American, Latino, and Vietnamese Older Adults

Program to Encourage Active and Rewarding LiveS (PEARLS) – Implementation in the African American community includes maintaining a connection with family, utilizing strong religious beliefs as a strength (partnership with religious beliefs), building trust by explaining services in detail and how things work, framing the acceptance of help as a strength and an opportunity to allow others to serve and tapping into what client's desires are when providing resources/access to other care.

For more information please visit: http://www.pearlsprogram.org/

Institute: Alameda County – From Dialogue to Action; "Stepping" Toward Improving MH Outcomes for the African American Community

Incorporate the illumination of culturally congruent well-being and wholeness with the Sakhu Project – a curriculum and treatment plan grounded in black psychology, African-centered thought designed to serve as a tool used to provide training to improve the "culturally grounded services" for service providers

For more information please visit: http://www.acbhcs.org/

CRDP Recommendation

All mental health service providers should be provided cultural competency training in African American cultural orientation by African American trainers and providers in order to improve the delivery of services to African American clients.

Summit Reflections

Workshop: Institute: Removing Barriers to the Elimination of Disparities: Is Cultural Competence Enough?

Redefine and re-conceptualize "cultural competence" to reflect structural issues in policies and laws. King Davis' working definition that he developed and uses in his work, research and teaching: "Cultural competence is the integration and transformation of knowledge, information, history, and data about individuals, groups of people, communities, and neighborhoods into specific clinical standards, practices, skills, service approaches, techniques, policies, advocacy, participation, organizing, and health care marketing programs that match the culture and increase the quality of health care, well-being, recovery, and life."

Institute: Alameda County – From Dialogue to Action; "Stepping" Toward Improving MH Outcomes for the African American Community

Understanding the positive power of peer-to-peer counseling programs, Behavioral Health Care Services (BHCS) has been leading the directive to enlist more African American consumers in these efforts. There is also a need more African American clinicians and physicians within the system, and Alameda County is working with HR and recruiters to make this an important imperative.

For more information please visit: http://www.acbhcs.org/

Asian Pacific Islander Population

CRDP Recommendation

Support the development and retention of a culturally competent workforce, with a keen understanding of the culture and history of the community.

Summit Reflections

Workshop: Filipino Americans: Cultural Awareness and Clinical Applications

Utilize traditional Filipino traditions in treatment, including 1) "pakikiramdam", which is the ability to interpret nonverbal cues, or use indirect communication, which allows you to feel empathy, and 2) "pakikisama", in which direct conflict is avoided.

Plenary Panel: C. Rocco Cheng, API CRDP

It is important to integrate community resources and strengths, including consideration of traditional healing and the spiritual framework.

For more information please visit: http://crdp.pacificclinics.org

CRDP Recommendation

Increase availability and quality of care by supporting the development of culturally competent programs that serve the API community.

Summit Reflections

Workshop: Evidence-Based Prevention and Early Intervention Services for African American, Latino, and Vietnamese Older Adults

Implementation of evidence-based prevention and early intervention services in the Vietnamese community includes using visual aids, creating tangible goals, providing verbal instructions, food offering, prompting, clinicians taking the initiative to facilitate the action plan and allowing the client to talk about their accomplishments and use them as strengths for problem solving.

Workshop: From Mental Health Disparity to Health Care Reform Equity: Lessons Learned from the California Reducing Disparities Project API Workgroup

Examples of promising strategies serving the community – 1) IMPACT, for youth leadership, 2) SITIF, for parenting, 3) Sisterhood, for gender-specific outreach, 4) Saving Earth & Healing Hearts, which is a faith-based program, 5) Fu Yau, for 0-5 school consultation, and 6) From Killing Fields to Growing Gardens, which is a community garden program.

For more information please visit: http://crdp.pacificclinics.org

CRDP Recommendation

Support inclusion of community participation in the decision-making process as the community understands its own needs and such inclusion can also empower the community to find its own solutions.

Summit Reflections

Workshop: Filipino Americans: Cultural Awareness and Clinical Applications

Invite family members/older family members to participate in the initial interview, which reflects the collectivist approach and recognizes strong familial obligation.

Workshop: Multicultural Preventative Approach to Geriatric Mental Health Services for Refugees and Immigrants

Foster leadership within the community.

LGBTQ Population

CRDP Recommendation

Demographic information should be collected for LGBTQ people across the lifespan, and across all demographic variations (race, ethnicity, age, geography) at the state and county levels.

Summit Reflections

Conversation Café

Disaggregate data, look at how it is reported, and look at seriously.

Workshop: First, Do No Harm: An Introduction to Reducing Disparities for LGBTQ Communities

Only 29% of mental/behavioral/medical health providers ask about sexual orientation, and only 26% ask about gender identity.

CRDP Recommendation

All locations where state or county funded mental/behavioral and physical health care services are offered should be required to be safe, welcoming and affirming of LGBTQ individuals and their families across all races, ethnicities, cultures and across the lifespan.

Summit Reflections

Workshop: First, Do No Harm: An Introduction to Reducing Disparities for LGBTQ Communities

LGBTQ individuals need to be provided with LGBTQ competent providers, providers they are comfortable with who are also LGBTQ knowledgeable, providers that are supportive of their LGBTQ identity, LGBTQ specific services in their area, and competent LGBTQ providers who are not in their same social circle.

Media Advocacy Campaign Showcase: OC LGBTIQ ACCEPT, Orange County Health Care Agency/Behavioral Health Services

Orange County program specifically geared towards providing access and resources to mental health services for the LGBTQ population.

For more information please visit: http://ocequality.com/page/oc-accept

CRDP Recommendation

Statewide workforce training and technical assistance should be required in order to increase culturally competent mental, behavioral and physical health services, including outreach and engagement, for all LGBTQ populations across the lifespan, racial and ethnic diversity and geographic locations.

Summit Reflections

Workshop: First, Do No Harm: An Introduction to Reducing Disparities for LGBTQ Communities

Training of service providers in public mental/behavioral and physical health systems should focus on the distinctiveness of each sector – lesbians, gay men, bisexual, transgender, queer and questioning – with the overarching approach to mental health throughout the lifespan for the racial, ethnic and cultural diversity of LGBTQ communities. Cultural competency training cannot only be a general training on LGBTQ as a whole, but also needs to include separate subgroup-specific training sessions.

Workshop: The Process of LGBTQ Acceptance in the Latino Family

Bring LGBTQ presentations to staff to assist taking away the fear of working with gays and lesbians.

For information on trainings please visit: www.genderspectrum.org

Native American Population

CRDP Recommendation

Empower Native communities. Support cultural revival for tribal, rural and urban communities. Strengthening cultural identity is a core value in promoting wellness for Native communities.

Summit Reflections

Workshop: Native Vision: A Focus on Improving Behavioral Health and Wellness for California Native Americans

Empower Native communities – direct from the source with no middle "overseer".

For more information please visit: http://www.nativehealth.org/

Workshop: Cultural Traits: Bridges to Serving Clients Effectively

Cultural traits are important to mental health providers because they: reveal values, cognitive styles, and behavioral characteristics of clients, as well as help providers understand, motivate, teach, and reward clients effectively.

CRDP Recommendation

Structure funding and implementation to ensure success for Native Americans, by distributing funds through a grant mechanism and supporting the communities that receive the funds.

Summit Reflections

Workshop: Native Vision: A Focus on Improving Behavioral Health and Wellness for California Native Americans

Coordinate funding streams in order to maintain continuity of care and increase provider longevity in their positions.

Workshop: Historical Trauma in Context

Create a Children's Mental Health Awareness Carnival for schools and communities, with prevention presentations about healthy relationships, bullying, depression, suicide, career interests, etc.

CRDP Recommendation

Respect the nature of Native communities and engage the community leaders to ensure work is in alignment with community priorities. Ensure that each local community is reflected uniquely in its own evaluation process.

Summit Reflections

Workshop: Native Vision: A Focus on Improving Behavioral Health and Wellness for California Native Americans

Understanding the frame of reference for the community is that of a collective. Mental health healing for this population is an issue that works as a collective process more than on an individual level.

For more information please visit: http://www.nativehealth.org/

Workshop: Historical Trauma in Context

Well Parent Program/Healthy Families – Continue to increase parent participation and continue to bridge the elder-youth gap.

Latino Population

CRDP Recommendation

Increase county collaboration with schools to identify mental health problems among Latino adolescents and provide interventions aimed to decrease the risk of incarceration, drug use and mental illness. Stress that early detection and identification translate into reductions in cost of care.

Summit Reflections

Plenary Panel: Sergio Aguilar-Gaxiola, Latin American CRDP

Focused on the importance of building partnerships with schools and noted that schools are easily accessible and convenient for both mental health treatment and prevention programs. Also, the presentation focused on the importance of family support and involvement in a school context as a strategy to educate Latino families and communities about mental health services.

Conversation Café

In order to reduce disparities, counties should collaborate with schools (high schools and community colleges) regarding the mental health profession.

CRDP Recommendation

In order to provide culturally and linguistically appropriate treatment to Latino communities, mental health providers should recognize the importance of communicating with consumers in a way that acknowledges their beliefs, culture and language.

Summit Reflections

Workshop: Sharing Knowledge, Improving Lives: Community-Defined Solutions for Latino Mental Health Disparities

Interventions conducted in the consumer's native language were twice as effective as other interventions in English.

Workshop: Promotores de Salud

Promotores de Salud: live in the community, speak the same language as the community, understand "familiarismo" and "personalismo", possess leadership and advocacy skills, have existing social networks, have a willingness to learn, have no personal interest in personal gain, are agents of change and are sensitive to social cultural aspects of the acculturation process.

For more information please visit: http://www.elsolnec.org/history.html

CRDP Recommendation

Engage a consortium of faith-based organizations to develop and implement strategies to promote pathways to wellness, reduce mental health stigma, promote social inclusion and advocate for the importance of spirituality to one's well-being.

Summit Reflections

Workshop: Evidence-Based Prevention and Early Intervention Services for African Americans, Latino, and Vietnamese Older Adults

Implementation of evidence-based prevention and early intervention services in the Latino community includes utilizing religion as strength.

Conversation Café

In order to reduce disparities, counties should collaborate with interfaith organizations - offer volunteer opportunities, strategy sessions to implement reports, outreach, and community representative should engage with their churches.

View from the Field Recommendations

In addition to recommendations identified in the CRDP Reports, recommendations were also identified and presented during the CCMH Summit XVIII. These additional recommendations came from Conversation Café, presentations (institutes, workshops, plenaries, and keynotes), and the media advocacy showcases.

Conversation Café

As part of the Cultural Competence and Mental Health Southern Region Summit XVIII, participants were engaged in a Conversation Café. The purpose was to help discern strategies to reduce disparities and bridge the cultural gap. Conversation Cafés are structured small-group conversations to engage individuals in fun, inviting, and open dialogues and serve to generate new ideas with broader solutions and share best practices and strategies to overcome challenges. Facilitators, known as "hosts" in Conversation Cafes, lead the discussions, providing guidance and assistance with generating new ideas.

The questions that guided the conversation were divided into three topic areas; each section had three questions. The CCMH Summit Planning Committee comprised of Southern California Ethnic Services Managers and other key stakeholders came together to draft the following questions:

Topic 1: Beyond the Talk

1. Based on the keynote and plenary presentations, what are focus areas where you see a need in the county to address how to reduce disparities?
2. Of those actions or changes you have identified, which are priorities?
3. Who will you need to collaborate/partner with to make this happen in your respective community?

Topic 2: Practicing the Walk

1. Based on the learning you have experienced from this Summit, what is the most important insight you have gained?
2. How can you apply this new learning back in your community?
3. What new behaviors or actions are you personally committed to?

Topic 3: A Path to Bridge the Cultural Gap

1. Who will you build/construct your bridge to reach?
2. What do you need to build/construct your bridge?
3. What measures will need to be put into place to know that your bridge is solid?

In response to these questions, the following themes arose through dialogues at Conversation Café on how to increase cultural competency:

Culturally Competent vs. Culturally Responsive	• It may not be possible for providers to be culturally competent in all respects but it is possible for them to be culturally responsive; meaning although they may not have the knowledge they can still be culturally open-minded and sensitive.
What You Say Matters	• When addressing consumers it is very important to be aware of the words one uses and to acknowledge that something said by one person can be interpreted differently by someone belonging to a different culture.
Respect the Uniqueness of Each Culture	• A community cannot be addressed with a "one size fits all" approach. Providers need to be cognizant of the cultural uniqueness of a community and respect that by not trying to fit it into the mold of another.
Diverse Workforce	• The workforce needs to reflect the diversity of the community being served. If the workforce reflects the community it serves, there is more cultural awareness and competency.
Cultural Competency Training	• Across the board participants noted the need for cultural competency training. They felt this would obviously lead to more culturally competent practices taking place.

The group also identified three effective practices that they felt should be implemented.

Modeling & Adapting	• Look at another county's program that has been effective with a community similar to yours, and adapt it to fit your community.
Reminders	• Set up reminders of what needs to be done to build cultural competence and make sure to put it on your agency's agenda as an ongoing task (i.e. dedicating time to learn about cultural competency).
Meet People Where They Are	• Meet people where they are at by setting up satellite offices, providing transportation, or using mobile technology.

Summit Presentations

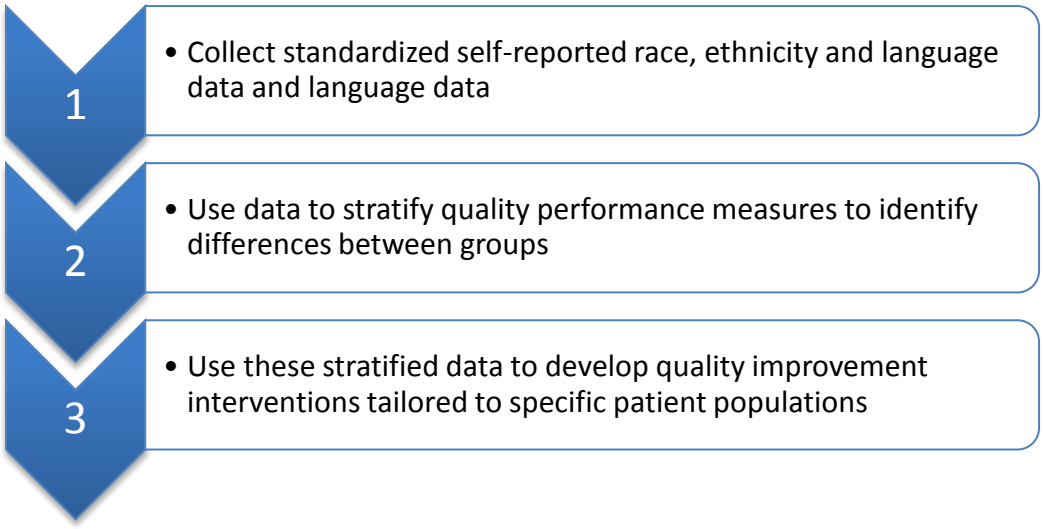
Throughout the CCMH Summit XVIII presenters spoke about "practicing the walk" in terms of increasing one's cultural understanding by striving to be more culturally sensitive. From all of the presentations at the Summit, the following table reflects a synthesis of "tips", or recommendations for obtaining better cultural understanding and for spreading effective practices.

Tips for Understanding Client Culture	
Find Out	About a client's cultural background and how it influences them, such as: • Generational immigration history and current status of client/family • Level of cultural assimilation (monocultural, bicultural, unicultural) • Level of integration within cultural assimilation – isolated, marginal, acculturated • Religious beliefs • Socio-economic status • Reactions to racial oppression • Influence of majority culture • Influence of own culture
Be Self-Reflective	Be aware of your own cultural values and biases. This is the prerequisite for being able to accept and embrace similarities and differences of a client's worldview. Pay constant attention to our own reactions, how you attempt to understand and support your client will affect how he/she will respond to you.
Learn	As much as we can about various cultures, but never make assumptions that what we come to know is all that is relevant.
Bilingual Staff	Depending on the demographics of your community, it may be necessary to develop bilingual staff in order to properly understand your clients.
Holistic Understanding	Gain an understanding of your client's experiences, life changing events, spirituality and worldview, cultural and family systems leads to a more comprehensive understanding of a client's development, emotional, functional and cognitive processes and behaviors. Work to understand a person's perspective on their own mental health and/or substance abuse issues.

Several of the CCMH Summit XVIII presentations also indicated that a key way to "practice the walk" of reducing disparities is to focus in on data and use it differently to inform actions. In particular, data fields are often limited and inaccurate, thus do not reflect the range of diverse needs to be served by mental health systems. Accuracy can be increased by collecting standardized data that allows a respondent to self-report their race, ethnicity, language preference and sexual orientation. Data may also be used more effectively to examine differential impacts of services between identified groups. Finally, the specificity of the data allows for mental health treatment to be tailored to the unique needs of a given population and thus increase treatment efficacy. The Institute of Medicine has done extensive work in

this area. Their three step framework provides key steps for the identification of data needed to inform reduction in disparities.

Institute of Medicine's Three-Step Framework to Identify and Address Disparities



More information regarding this framework can be found in *Reform in Action: Equity in the Context of Health Reform*, a publication by the Robert Wood Johnson Foundation (2012). The publication promotes the framework to identify and address disparities as a method for collecting and using data on race, ethnicity, and language to improve equity in health care. This data is a powerful analytical tool that gives providers the ability to look for disparities within any subgroup or condition. Collecting this data is a critical first step in identifying disparities and the health care needs of specific populations and planning customized interventions to address inequalities in care. *Reform in Action: Equity in the Context of Health Reform* also gives examples of how some health care providers are using data to address disparities in their communities.

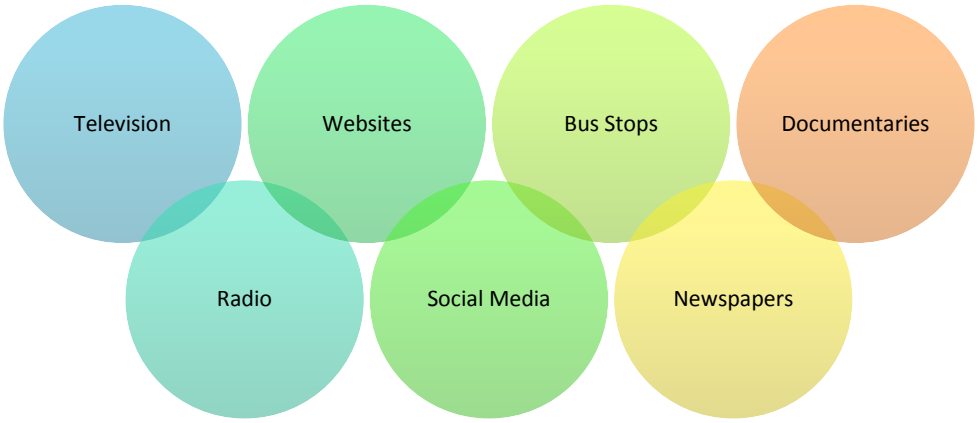
This publication is available for download at:
http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2012/rwjf402390.

Media Advocacy

During the CCMH Summit XVIII, eight Southern California Media Advocacy Showcases were highlighted. These campaigns were sponsored by MHSA funds. The purpose of these showcases was to highlight Media Advocacy Campaigns designed to reduce stigma and raise awareness around mental health. In addition to the Media Advocacy Showcases, some of the presentations given at the Summit also emphasized the importance of Media Advocacy.

The highlighted media advocacy campaigns used several different types of outlets to distribute their messages. These included: televised public service announcements (PSAs), radio PSAs, websites, social media, bus stop advertisements, and print (mostly newspapers).

Frequently Used Media Outlets

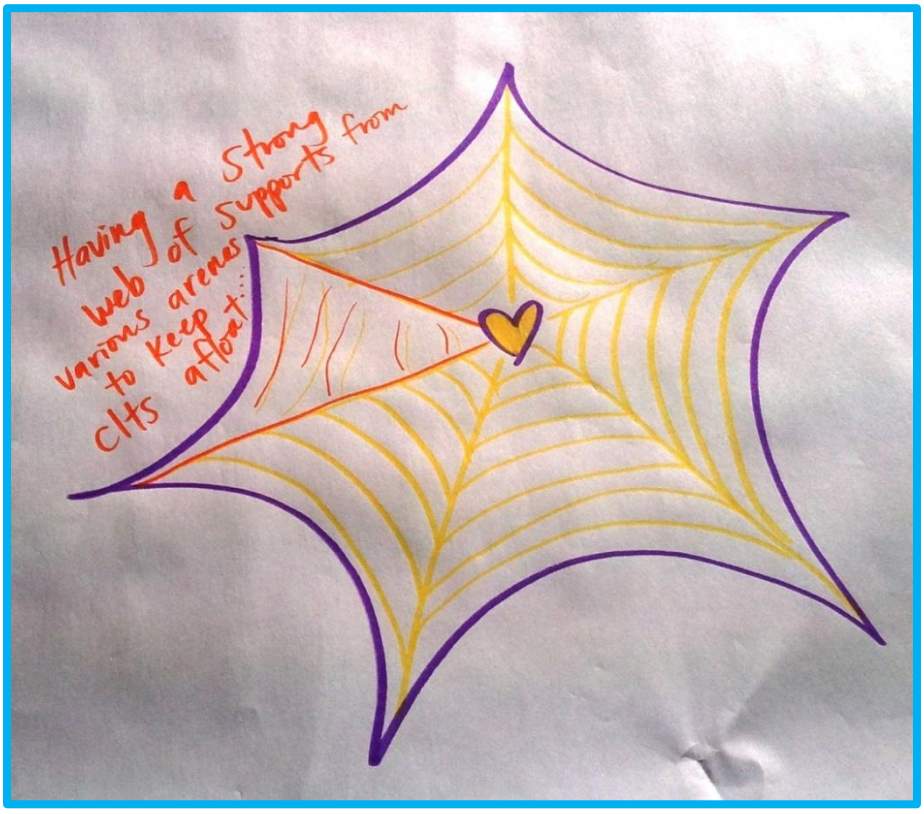


In addition to these media outlets, some communities respond when information is provided in their churches, clubs, beauty shops, grocery stores, and restaurants. Media campaigns are often multifaceted with several different issues being addressed within an individual campaign. The messaging was often aimed at reducing stigma, increasing awareness, giving hope, identifying resources, and showing the positive outcomes of services for viewers. Depending on the established purpose, media campaigns can be tailored to address a specific issue such as eating disorders and bullying, or for a specific group such as college students.

The table on the following page is a compilation of media advocacy campaigns presented at the CCMH Summit XVIII; each is an excellent example of how a campaign can be executed.

Housing Matters (San Diego County)	http://housingmatterssd.org/
Highlights:	Targets a specific topic (housing). Raises awareness and shows the positive outcome of obtaining housing services. PSAs are available for viewing on the website and were televised in San Diego.
It's Up to Us (San Diego & Riverside Counties)	http://www.up2riverside.org/ • http://www.up2sd.org/
Highlights:	Utilizes televised PSA to: identify resources, tailor different ads to specific populations (men, women, older adults, children's issues, and service members), increase awareness, and reduce stigma.
Center of Excellence (Orange County)	http://ochealthinfo.com/bhs/about/pi/coe
Highlights:	A video clip was developed that features the resilience and recovery journeys of six Orange County community champions. They share their lived experience with behavioral health conditions and the community-centered meanings they have made through their journeys. The video clip was created to raise awareness that people with mental health conditions and substance abuse issues can recover and make important and meaningful contributions to their community.
SLO the Stigma (San Luis Obispo County)	http://www.slothestigma.org/
Highlights:	This website features short videos documenting several people's stories about mental illness. The efforts of this website are aimed at reducing stigma and raising public awareness about mental illness.
TEAM Up (California Statewide)	http://www.eiconline.org/
Highlights:	TEAM Up: Tools for Entertainment & Media campaign is about bringing together the entertainment community, news media, and mental health stakeholders throughout California and across diverse populations to reduce negative public attitudes about people experiencing mental health challenges. Entertainment Industry Council (EIC) provides free resources and assistance to journalists and the creative community.
Online Diverse Community Expansion (San Bernardino County)	http://www.facebook.com/sbdbh • http://www.facebook.com/sbdbhespanol • http://www.twitter.com/sbdbh
Highlights:	The Online Diverse Community Expansion project uses social networking sites on behalf of the County of San Bernardino, Department of Behavioral Health to provide information about mental health and drug/alcohol services, events, research, meetings, websites, and more. With the aim of reducing stigma, providing access to those that are socially or geographically isolated, provide opportunities for interaction, and promoting wellness and recovery.
Wellness Everyday (Ventura County)	http://www.wellnesseveryday.org/ • http://www.wellnesseveryday.org/ • www.saludsiemprevc.org
	Highlights: This campaign addresses mental health as a part of overall wellness. It targets different demographics (e.g. a website in Spanish) and addressed specific topics such as eating disorders and bullying.

The overarching recommendations from the CRDP Reports; the specific recommendations by CRDP population; and recommendations from the Summit that reflect the "view from the field" (from presentations and the Conversation café)—all set the stage for a thoughtful consideration of how one can move beyond the talk, to practice the walk of reducing disparities.



V. Beyond the Talk: A Call to Action

Moving "beyond the talk" is much easier to say than to carry out the actual deeds. Much of the rich detail contained in the CRDP Reports was derived from focus groups, dialogs among stakeholders, professionals, and community members. Going forward, strategic actions must move beyond the talk, yet maintain the momentum and cohesion the CRDP Strategic Planning Workgroups (SPW) inspired.

From its inception, the Cultural Competence and Mental Health Southern Region Summit XVIII (CCMH Summit XVIII) was focused on collective actions that can lead to real results. In "How Teachers Learn", (February 2009, Volume 66, Number 5, pg. 20 - 25) Debra Smith, Bruce Wilson and Dick Corbett identified six conditions that helped urban school districts to launch—and sustain—strong learning communities that are able to move beyond the talk to strategic action. The conditions that heightened the quality of learning in collaborative communities are: a preexisting supportive culture, time to meet, satisfying processes, voluntary participation, support from leadership, and a cadre of trained facilitators. These same six conditions may serve as a catalyst for the kinds of actions required to reduce mental health disparities.

When professionals and community members view each other as caring, cooperative, and intellectually curious, the foundation for meaningful change is laid. In some cases a supportive culture must be "grown" to change the conditions that contribute to disparities. It is critical to create opportunities for open communication to encourage collaboration and truly engage the community.

Going forward partners for change need a defined focus or common purpose. In such circumstances, participants will do more than bide their time, because they perceive the task at hand as relevant rather than perfunctory. Also, participants need equal opportunities to talk and practice active listening in order to hear diverse perspectives. Leadership and skilled facilitation are also critical. Both can keep partners focused and moving towards action. Leaders bring relevant strategies and provoke critical thinking.

Call to Action

King Davis, Ph.D. is a renowned leader and advocate for change in the mental health field. He calls not only on participants of the CCMH Summit XVIII to action, but the reader of this publication as well. Dr. Davis suggests the following nine steps are critical components of collective action:

1. White House Conference 2014 – Race, Culture, Ethnicity
2. Rescue and Revive Mental Health Coalitions like NAMBHA
3. Redefine and Re-conceptualize Cultural Competence
4. Field Test Cultural Competence/Instruments
5. Federal Funding for Research on Practice Based Evidence
6. Participation on Federal Panels
7. Key Roles of Leadership in Mental Health Systems and Organizations
8. Activism in Legislation and Elections
9. Explore Concept of Social Determinants as Cause of Disparities

1. White House Conference 2014

In 1902, President Teddy Roosevelt was approached by groups of advocates for the poor. They provided data and information showing the relationships between 15 race, class, gender, and childhood poverty and health risks. The groups convinced the president to sponsor the first White House Conference on Children. As a result, a variety of new policies and agencies were established to improve the lives of children. Dr. Davis calls for partners to petition the Obama administration to sponsor the next White House Conference in 2014. The focus of the conference should be on health and mental health needs and services for children but also cover other issues vital to the health and well-being of children. The recent incidences of gun violence that include persons with mental illness have resulted in a national dialogue about expanded services. The time seems ideal for a national dialogue on mental health led by the president.

2. Rescue and Revive Mental Health Coalitions like NAMBHA

The National Alliance of Multi-Ethnic Behavioral Health Associations …NAMBHA was developed from discussions and planning in 1985. And, it was the first national organization to include African Americans, Asian Pacific Islanders, Latinos, and Native Americans. The groups formed a powerful collaboration that sought to advocate collectively for quality mental health care of populations of color through the United States. Members participated in federal policy discussions, state level service design, and local services. The level of collaboration between these groups was and remains unprecedented and demonstrated the effectiveness of cross-racial and ethnic participation as a means of improving quality of services.

In the past 3 years, NAMBHA has been unable to find the resources to sustain its collaboration. There is a dire need to re-energize this first national effort to pull all groups of color together in a coordinated policy and advocacy effort.

3. Redefine and Re-Conceptualize Cultural Competence

Dr. Davis has suggested that we need to redefine and re-conceptualize cultural competence to reflect structural issues in policies and laws. Accordingly, he developed the following working definition that he uses in his work, research, and teaching:

> "Cultural competence is the integration and transformation of knowledge, information, history, and data about individuals, groups of people, communities, and neighborhoods into specific clinical standards, practices, skills, service approaches, techniques, policies, advocacy, participation, organizing, and health care marketing programs that matches the cultural group and increases the quality of health care, well-being, recovery, and quality of life (Davis, 2012)."

4. Field Test Cultural Competence/Instruments

Consistent with the recommendation to field test cultural competence instruments, Rachel Guerrero, LCSW and retired Chief of the Office of Multicultural Services for the California State Department of Mental Health, recommends the Institute of Medicine's 3-step framework (as referenced in section IV. Practicing the Walk) to identify and address disparities should be utilized whenever possible. It calls for the collection of standardized self-reported race, ethnicity and language data; the use of data to arrange quality performance measures to identify differences between groups; and using stratified data to develop quality improvement interventions tailored to specific patient populations.

5. Seek Federal Funding for Research on Practice Based Evidence

Research suggests that culturally-oriented interventions are more effective than usual care at reducing dropout rates for underserved populations receiving mental health services. For example, interventions conducted in the consumer's native language have been demonstrated to be twice as effective. Dr. Sergio Aguilar-Gaxiola, Director of the Center for Reducing Health Disparities at the University of California, Davis, gave the following definitions regarding practice based evidence in his workshop at the CCMH Summit XVIII:

- **Research Validated Best Practice** is a program, activity or strategy that has the highest degree of proven effectiveness supported by objective and comprehensive research and evaluation.

- **Field-Tested Best Practice** is a program, activity or strategy that has been shown to work effectively and produce successful outcomes and is supported to some degree by subjective and objective data sources.
- **Promising Practice** is a program, activity or strategy that has worked within one organization and shows promise during its early stages for becoming a best practice with long term sustainable impact. A promising practice must have some objective basis for claiming effectiveness and must have the potential for replication among other organizations.

The CRDP Reports described how various populations identified culturally grounded recommendations that can be helpful in redesigning a mental health system, programs and interventions. Each report also identifies culturally grounded community practices for prevention and early intervention of mental health issues. These practical community-identified solutions for eliminating health disparities were expressed by populations often using community-based participatory research methods (CBPR) to collect qualitative and quantitative data to better understand the perspective of the population.

Adaptation

Many leaders feel that conventional assessment tools and interventions do not effectively serve all populations, particularly the five unserved and underserved populations. All of the CRDP reports noted that adapting strategies to meet the specific needs of a population would be more effective than using conventional assessment tools and interventions.

Treatment adaptations are changes to treatment content or process that include additions, enhancements, or deletions. Culturally competent adaptations are a balancing act between maintaining fidelity to an evidence-based practice, while adapting and tailoring the practice to increase engagement, receptivity, efficacy and value to the recipients (in other words, cultural responsiveness).

Community Defined Evidence

Dr. Sergio Aguilar-Gaxiola notes that between cultures there are different ways of knowing, and what counts as "evidence" is defined differently from group to group. He also gives the definition of Community Defined Evidence as 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. The National Latino Behavioral Health Association (NLBHA) and National Network to Eliminate Disparities in Behavioral Health (NNED) in association with the Department of Child and Family Studies in the Louis de la Parte Florida Mental Health Institute, University of

South Florida have initiated the Community Defined Evidence Project (CDEP) in order to advance the current body of knowledge on community based practices "that work" for Latino populations. For more information on the CDEP please visit: http://nlbha.org/index.php/programs/cdep.

6. Participate on Federal Research & Policy Panels

Members of the five unserved and underserved groups must participate on federal research and advisory panels. These panels make critical decisions about grant funding, policy direction, and agency performance. However, in numerous instances few members of these federal panels represent the 5 constituency groups. There is a similar need for participation at the state and local levels where key decisions on funding, services, workforce, and policy are made.

7. Key Roles of Leadership in Mental Health Systems and Organizations

It takes a concerted effort to enact change, for example seeking key leadership roles that influence policy and funding. Representatives from the five unserved and underserved populations are encouraged to seek high level elected positions and/or identify others who are willing to fill those seats. Once there, one must actively raise the issues and push for change. Representatives are encouraged to take advantage of all opportunities, such as officials retiring from their positions or moving into new positions. Communities must constantly connect with leaders in government, business and organizations who have the ability to influence policy direction.

The five unserved and underserved groups must identify and respond to opportunities to fill strategic positions in federal, state, and local mental health systems. Few representatives of these groups occupy positions as directors of state or local mental health programs making the application of culturally competent services more difficult. To obtain these key positions requires a combination of education, experience, and linkages to legislative decision-makers.

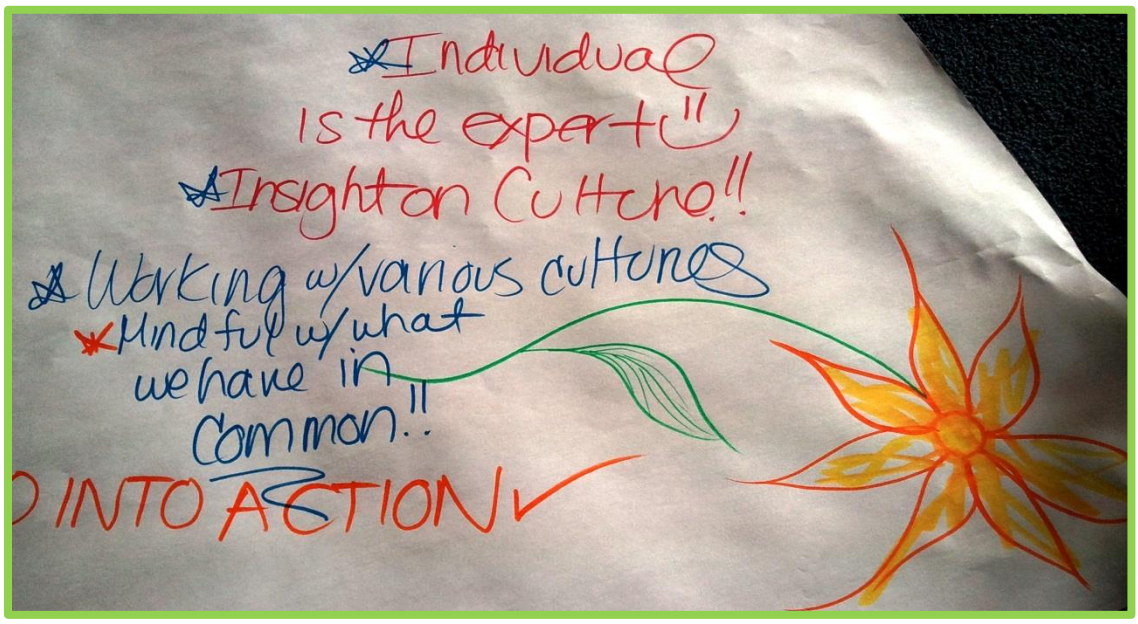
8. Activism in Legislation and Elections

Electing representatives from minority groups to positions in government increases the opportunity to push for change at a legislative level. We can only create lasting change by being active in government. An example of successful activism in legislation was with the 2012 mid-term U.S. Senate and House of Representatives elections.

9. Explore Concept of Social Determinants as Cause of Disparities

The World Health Organization (WHO) defines social determinants of health as: the conditions in which people are born, grow, live, work and age, including the health system. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels. The social determinants of health are mostly responsible for health inequities - the unfair and avoidable

differences in health status seen within and between countries (World Health Organization, 2008). We need to explore social determinants as the cause of disparities in mental health care.



View from the Field

Cultural Competence Summit XVIII Presenters & Conversation Café

Summit presenters and participants at Conversation Café touched upon several items that are key to bringing action into place and moving "beyond the talk". Their recommendations for "a call to action" are outlined below. Note that many of them echoed the call to action by Dr. King Davis!

Contagious Passion

It was often highlighted that the passion that is ignited at conferences such as the CCMH Summit XVIII sometimes dwindles after attendees return back to work. In order to move "beyond the talk" the fiery passion for reducing disparities needs to be kept and this means actively making it a part of our daily routines. This includes keeping our own passion alive, while spreading that passion to others; being so passionate that others can't help but become impassioned as well. This is how a wave of change is created.

Consistent Follow-Up and Outreach to Unserved/Underserved Communities

Building upon the passion for reducing disparities, presenters and participants noted that this passion would build action. A key action item that this passion should build is consistent follow-up and outreach to unserved and underserved communities. It is necessary to make follow-up and outreach to these communities a part of your an agenda and mission.

Meet People Where They Are

When doing follow-up and outreach it needs to be done where the people who need services are located. Many presenters and participants noted that offering services and doing outreach is key, but if you are not meeting people where they are at (both figuratively and literally) you cannot make the needed change.

Willingness to Learn from Others

In order to move from talking to action, we can take heed from those who already have. Reach out and explore practices by counties or agencies that have been effective at reducing disparities and use that model as a starting point for yours. Two examples that were given as being effective within a population were Imperial County and Alameda County. The former having shown great progress with the Latino population in Southern California, and the latter with the African American population in Northern California.

White House Conference

Presenters and participants alike were enthusiastic about the idea of a White House Conference.

Pulling it All Together

This section concludes with an acknowledgement that, although this publication is a form of the kind of talk we need to move beyond, the hope is that it inspires action fueled by contagious passion. The most important actions begin with a personal commitment.

Take Personal Action to Eliminate Disparities

The following are a few beginning steps from Rachel Guerrero to translate personal commitment into action:

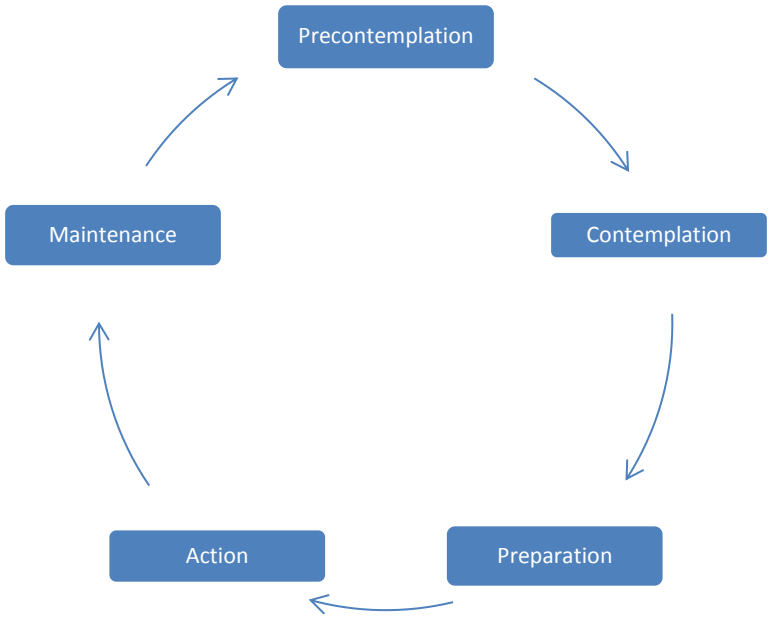
1. Support your "edgewalker" (others who are taking risks); stop marginalizing them
2. Do your homework on equity, disparities, and related issues
3. Value communities as true partners in change
4. Learn how to authentically engage and include "Networks of Collaboration"
5. Stop working from a color blind viewpoint
6. Really grow a diverse workforce to match your community; all communities are looking for authentic engagement
7. Understand the diversity within communities
8. Grow your fearlessness

Readiness to Move Beyond the Talk (Stages of Change Model)

Readiness for change or readiness to take action does not usually happen in one step. Rather, people tend to progress through different stages on their way to successful change. Also, each of us progresses through the stages at our own rate. These findings are embedded in the Stages of Change Model which was originally developed in the late 1970's and early 1980's by James Prochaska and Carlo DiClemente at the University of Rhode Island. The basic premise is that to change, or to take decisive action, a person must be ready. Their degree of readiness is defined in the following stages:

- **Precontemplation** involves not yet acknowledging that there is a problem and/or action that needs to be taken
- **Contemplation** is reflected in acknowledging that there is a problem but not yet ready or sure of wanting to take action
- **Preparation** is getting ready to take action
- **Action** means decisively acting in new ways
- **Maintenance** is when one maintains action as a pattern over time, a lifestyle

Stages of Change Model



Moving Beyond the Talk: Where are you?

The checklist below identifies a statement that corresponds with each of the aforementioned stages of change. Use this checklist to help you identify where you are at in regards to taking action. Once you understand where you are, take a moment to reflect on how you can move yourself into the next stage of change.

Readiness to Move Beyond the Talk Checklist: Where are you?

☐	1. Reducing disparities is important work, but it's not part of my job description, not my calling. Someone else will do it, besides, it's not as big an issue as people make it out to be. (Precontemplation)
☐	2. I have been curious about what it takes to reduce disparities. I'm wondering what I can do to make a difference. (Contemplation)
☐	3. Recently I've learned a lot about the importance of working to reduce disparities. I am making plans to act on one or more recommendations in the CRDP Reports. (Preparation)
☐	4. I am actively taking steps to help reduce disparities. (Action)
☐	5. One of my life's commitments is to promote fairness and equity for every person. I take steps to connect with others to sustain momentum in this direction. (Maintenance)

Take the Crucial Next Step

Despite the motivational talk, and even when optimal conditions in place, it is tempting for partners to settle for "improved talk"—what Rick DuFour (2003) calls "collaboration lite." The factors outlined in this publication can pave the way for partner education, but do not necessarily push participants to act on what they learn. In other words, one can become stuck in contemplation, or preparation.

The critical factor in making collaboration a vital vehicle for reducing mental health disparities is a shared commitment to risking something different. The crucial next step is a commitment to action. Take a moment to assess when you are personally with respect to readiness to take action. Use this toolkit for ideas on how you can move to the next stage and take the crucial next step.

VI. Tools to Reduce Disparities

The California Reducing Disparities Projects (CRDP Reports) described cultural gaps encountered by populations who experience disparities, and made recommendations regarding the use of tools to reduce disparities. Although the CRDP Reports contain a number of useful ways to address these disparities, the following tools were pulled from each CRDP Report to be included in this Toolkit:

Name of Tool	Source
SMART Recommendations/ Action Criteria	*"We Ain't Crazy! Just Coping With a Crazy System" Pathways into the Black Population for Eliminating Mental Health Disparities*, Editors: V. Diane Woods, Dr. P.H., Nicelma J. King, Ph.D., Suzanne Midori Hanna, Ph.D., and Carolyn Murray, Ph.D.
8 Core Components of Cultural Competency	*The Asian Pacific Islander Report: In Our Own Words*, Pacific Clinics on behalf of the API-SPW, Project Director: C. Rocco Cheng, Ph.D.
Selection Criteria for Promising Programs and Strategies	
LGBTQ Competency Considerations	*First, Do No Harm: Reducing Disparities for Lesbian, Gay, Bisexual, Transgender, Queer and Questioning Populations in California*, Pasha Mikalson, M.S.W., Seth Pardo, Ph.D., and Jamison Green, Ph.D.
Two Spirits	
The Learning Collaborative	*Native Vision: A Focus on Improving Behavioral Health Wellness for California Native Americans*, Native American Health Center, Project Director: Kurt Schweigman
Medicine Wheel Tool	
The Five A's for Reducing Disparities in Latino Populations	*Community-Defined Solutions for Latino Mental Health Care Disparities*, UC Davis Center for Reducing Health Disparities

Although each of the tools listed above was developed with a specific population in mind, the concepts may be applicable to other populations. Each of the tools are explained in greater detail on the following 13 pages.

SMART Recommendations/Action Criteria

The African American CRDP Population Report recommends that pathways for eliminating mental health disparities in the Black population be bold, different, and culturally grounded. The African American Prevention and Early Intervention ***SMART*** recommendations are designed to clearly and concisely position the State of California as the leader in national actions to reduce disparities for the African American population. The ***SMART*** design for these recommendations was intended to promote permanent, long-term solutions that generate immediate positive impact on individual, community and system-wide investment. In order to do this the report offers the following criteria for specific recommendations and actions:

Excerpt from: "WE AIN'T CRAZY! Just Coping With a Crazy System" - Pathways into the Black Population for Eliminating Mental Health Disparities, page 250.

Eight Core Components of Cultural Competency

The Asian Pacific Islander Strategic Planning Workgroup (API-SPW) set out to define core components of cultural competence and agreed on common elements from which they developed a list of core competencies. The core competencies reflected in the tables below are divided into eight categories with each category reflected across three levels. The three levels were devised to conceptualize cultural competence beyond the individual level, and to encourage recognition and support from organizations and systems to make cultural competence possible and meaningful.

Professional Skills	
Provider Level	• Must have training to provide culturally appropriate services and interventions. • Ability to effectively work with other agencies and engage with community. • Clear understanding of PEI strategies and relevant clinical issues. • Knowledge about community resources and ability to provide proper linkage.
Agency Level	• Employ, train, and support staff that possess the necessary professional skills. • Capacity to provide needed linkage to other agencies.
Systems Level	• Recognize the importance and provide support for the development and retention of professionally qualified and culturally competent workforce. • Support the capacity to provide linkage.

Linguistic Capacity	
Provider Level	• Proficiency in the language preferred by the consumer OR • Ability to work effectively with properly trained interpreter.
Agency Level	• Employ, train, and support staff that possesses proficiency in the language preferred by the consumers. • Provide language appropriate materials. • Provide resources to train interpreters to work in mental health setting.
Systems Level	• Recognize the importance and provide support for the development and retention of linguistically qualified workforce. • Provide resources to support bilingual staff and reimbursement for the service, including interpreters. • Provide resources for preparing and printing bilingual materials.

Community Relations & Advocacy	
Provider Level	• Ability to effectively engage community leaders and members. • Ability to form effective partnerships with family. • Willingness and ability to advocate for needs of the consumers.
Agency Level	• Capacity to effectively engage the community. • Credibility in the community. • Capacity and willingness to advocate for systems change aiming to better meet community needs.
Systems Level	• Encourage and support culturally appropriate efforts for community outreach and community relationship- building. • Recognize the importance and provide support for collaboration with community leaders. • Promote cultural competency.

Flexibility in Program Design & Service Delivery	
Provider Level	• Flexibility in service delivery in terms of method, hours, and location. • Understand and accommodate the need to take more time for AANHPIs to build rapport and trust.
Agency Level	• Capacity to allow flexibility in service delivery (e.g.: more time allowed for engagement and trust building for consumers/ family members; provide essential services to ensure access to services, such as transportation, available hours of operation, and convenient location). • Program design should consider community-based research, culture, and traditional values so it will make sense to the consumers. • Willingness to look for innovative venue for outreach, such as ESL (English as a Second Language) classes.
Systems Level	• Recognize the importance and support more time needed for engagement and trust building. • Recognize the importance and support essential ancillary services needed to ensure access to services. • Recognize the importance and support flexibility in service delivery. • Encourage and support programs that include community-based research and/or community-designed practices. • Flexibility in diagnostic criteria to accommodate cultural differences. • Provide support for innovative outreach.

Capacity Building	
Provider Level	• Ability to empower consumers, family members, and community. • Capacity to collaborate with other disciplines outside mental health.
Agency Level	• Capacity to educate the community on mental health issues. • Capacity to collaborate with other sectors outside mental health, such as primary care and schools. • Plan in place to groom the next generation leaders and staff for the future. • Capacity to provide cultural competence training to mental health professionals and professionals from other fields.
Systems Level	• Provide support for capacity building within the agency and within the community. • Provide support for future workforce development. • Encourage and support outreaching and educating the community on mental health issues. • Provide support for cultural competency training. • More involvement of the community in the policy- making process. • Provide support for a central resource center.

Use of Media	
Agency Level	• Capacity to utilize ethnic media and social media for outreach.
Systems Level	• Encourage and support the use of ethnic media and technology for outreach.

Data Collection & Research	
Agency Level	• Collect disaggregated data. • Work with researchers and evaluators to assess effectiveness of programs and services.
Systems Level	• Provide support for disaggregated data collection. • Support ethnic/cultural specific program evaluation and research. • Support research to develop evidence-based programs (EBPs) for AANHPI communities.

Excerpt from: The Asian Pacific Islander Report: In Our Own Words, page 49

Selection Criteria for Promising Programs and Strategies

The Asian Pacific Islander Strategic Planning Workgroup (API-SPW) identified community-defined promising programs and strategies to reduce existing disparities in the Asian American, Native Hawaiian and Pacific Islander (AANHPI) community and established criteria to be used as the parameters for selecting culturally competent promising programs and strategies to serve the AANHPI populations. This list served as a guideline for the API-SPW to identify and collect community-defined promising programs and strategies. Additionally, this list is intended to be used for determining whether a program or a strategy is culturally appropriate for the intended population.

Selection Criteria for Promising Programs and Strategies	
Goals/Objectives	• Does the program have clearly stated goals and objectives?
PEI-Specific	• Is the focus of the program primarily on prevention and early intervention (PEI)?
Focus on Addressing API Community-Defined Needs	• How well does the program clearly identify and address needs in the API community (as voiced by community members, leaders, and stakeholders)? • Did the program have input from the community in the design and evaluation of the program? • Does the program have relevance in supporting the overall wellness in the community
Addressing Culture/ Population-Specific Issues	• Is the program designed for a specific target population such as gender, ethnic group, cultural group, and age group? • How well does the program integrate key cultural elements into its design (e.g.: oral history, spiritual healers, other cultural components or practices)? • How well does the program demonstrate sensitivity to cultural/linguistic/historical issues (e.g.: immigration, level of acculturation, spirituality, historical trauma, cultural identity, etc.)
Community Outreach & Engagement	• How well does the program outreach to the community in a culturally appropriate manner (e.g.: staff who are sensitive to working with the community, use of bilingual materials, use of ethnic/mainstream media and social media, etc.)? • How well does the program promote wellness through outreach, education, consultation, and training? • How well does the program use consumers, family members, and community members in their outreach efforts?

Selection Criteria for Promising Programs and Strategies	
Model	• How well does the program promote wellness and follow a strength-based model (e.g. increase life management skills, increase ability to cope and make healthy decisions, improve communication between family members, etc.)? • How well does the program strengthen and empower the consumers and community members? • Is the program design based on a theory of change that reflects cultural values or has some cultural relevance? • Does the program provide a reasonable logic model? • How well does the program describe its various components and are they related to the stated goals and objectives?
Replicability	• Can the program demonstrate how it can be replicated (across communities that are ethnically and geographically diverse)? • Does the program have the capacity to offer training and development to other agencies if resources are made available? • Does the program have the capacity to offer culturally and linguistically appropriate PEI strategies?

Excerpt from: The Asian Pacific Islander Report: In Our Own Words, page xvi

LGBTQ Competency Considerations

"I think that when you are seeking services…providers need to not expect us to educate them about our gender identity and sexual orientation."

-Bisexual CRDP Advisory Group Member

The chart below outlines considerations that must be taken into account to reduce disparities in mental health services for the LGBTQ population.

Harm
Harm may be caused through well-meaning albeit detrimental actions, due to lack of education, lack of adequate supervision, heterosexist ideology, firmly held religious beliefs, or a combination of any of the above.
Commitment
Service providers of all types must be committed to preventing the harm LGBTQ individuals are exposed to by society-at-large.
Diversity
LGBTQ individuals do not have only LGBTQ identities but are influenced by racial, ethnic and/or cultural identities, traditions and norms. Therefore the recommendations from all five reports should be viewed as an intersecting body of work, with the LGBTQ recommendations as an important addition to achieving culturally competent services and equitable treatment for all California populations.
Know What You Don't Know
Harm may be caused through well-meaning albeit detrimental actions, due to lack of education, lack of adequate supervision, heterosexist ideology, firmly held religious beliefs, or a combination of any of the above.
Detrimental Attitudes
Heterosexist attitudes: • Pity: Practitioners view heterosexuality as preferable to any other sexual orientation. Persons who cannot change their lesbian, gay or bisexual orientation or seem to be born that way should be pitied. • Tolerance: Practitioners tolerate same-sex or bisexual orientations as just a phase of adolescent development that eventually will be outgrown. These practitioners treat those who do not outgrow this "phase" or are "immature" in their development with the protectiveness and indulgence one might apply to a young child. • Acceptance: Practitioners say they accept LGB persons. Thinking that they have to accept them, however, implies that these clients have a "problem." • Liberal: Practitioners are friendly with LGB persons but have not thought beyond this to how they are still biased. They display heterosexist bias, for example, when they take for granted the privilege associated with heterosexual status. Negative Attitudes: Practitioners who are unable or unwilling to change their negative attitudes toward LGBTQ individuals, or who cannot firmly separate their religious beliefs from their mental health practices, should refrain from working with this population.

Developed from: First, Do No Harm: Reducing Disparities for Lesbian, Gay, Bisexual, Transgender, Queer and Questioning Populations in California

Two Spirits

The term two-spirit represents the Native American belief that individuals can carry both masculine and feminine spirits and their identity can therefore result in multifaceted variations of sexuality and gender expressions. From a traditional perspective, most tribes have independent terms to define two-spirit members of their communities such as *nadleh* for the Navajo or *lhamana* for the Zuni (Jacobs, Lang, & Thomas, 1997).The overarching similarity across tribes was that these individuals held revered positions in tribal societies and were often healers or name-givers for their tribal communities. The two-spirit term has been adopted by many lesbian, gay, bisexual, and/or transgender urban Native Americans as an all-encompassing term to define the fluidity of their identities.

Excerpt from: First, Do No Harm: Reducing Disparities for Lesbian, Gay, Bisexual, Transgender, Queer and Questioning Populations in California, page 15

The Learning Collaborative

Each of the CRDP Reports reflect input gathered from members of the communities that are directly impacted by disparities. As learning communities, they came together to problem solve and share information and experiences. Learning Collaboratives, or Learning Communities, engage in a variety of activities (Wenger, 2006). The following table provides a few typical examples:

Problem Solving	"What assessment tools are used to diagnose mental health problems in African Americans?" *-African American CRDP Report*
Requests for Information	"What is needed to improve Native American wellness?" *-Native American CRDP Report*
Seeking Experience	"What in the [city, county, or region] makes it easier to be LGBTQ?" *-LGBTQ CRDP Report*
Reusing Assets	"Multiple sources to obtain information including literature reviews, on-line computer searches, statistical reports, and word-of-mouth…" *-African American CRDP Report*
Coordination and Synergy	"The *Concilio* is a core Latino stakeholder group representing a range of constituencies including…" *-Latino CRDP Report*
Discussing Developments	"Mesas de Trabajo share their time and wisdom…" *-Latino CRDP Report*
Visits	Site visits to Community-defined PEI programs.
Mapping Knowledge and Identifying Gaps	"Who knows what positive services and programs are already in place in your local area? What are we missing? What other groups should we connect with?" *-LGBTQ CRDP Report*

An Example – Native American Learning Collaborative

The Native American Learning Collaborative was a three-phased project. The first phase was funded by the California Institute of Mental Health; the second and third phase were supported through the Los Angeles County Department of Mental Health American Indian/ Alaska Native Under-Represented Ethnic Population Subcommittee and implemented by the Los Angeles County Department of Mental Health. The project aimed to provide a community-informed approach toward integrating traditional-based

healing practices for Native Americans living in Los Angeles County. The project goal was to find and support the community's strengths for supporting mental wellness for its Native American residents.

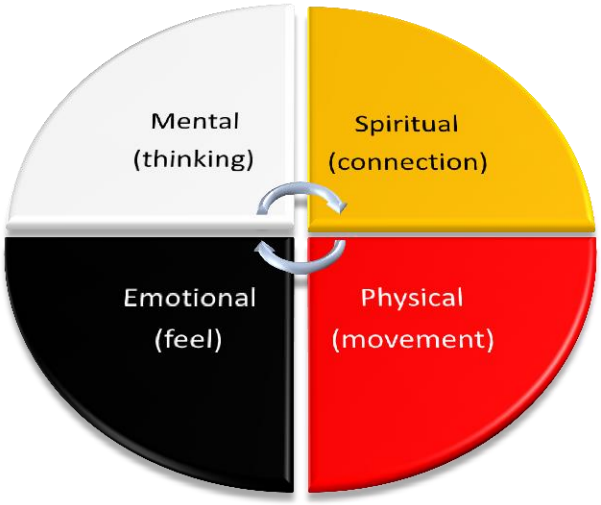
Some of the key findings include the understanding that culture is central to healing and recommendations about how clinicians working with Native American consumers should assume a leadership role in referring them to traditional healing services. Also recommended is that Native American community leaders assume a leadership role to engage and empower community members on mental health, and that county administrators and policy makers integrate Native American traditional healing services into clinical treatment. Traditional healing activities encompass a broad spectrum of cultural activities from drumming, bead making, and attending Pow-wows to full participation in sacred healing ceremonies.

Excerpt from: *Native Vision: A Focus on Improving Behavioral Health Wellness for California Native American,* page 25

Medicine Wheel Tool

The Medicine Wheel curriculum was developed by Tony Cervantes (Chichimeca Tribe) to depict accumulated knowledge, skills, and abilities of Native American cultures to address health and wellness. The Medicine Wheel is a tool to assess, intervene with, treat, and provide recovery support services for mental health, and for alcohol and other drug (AOD) problems. The Medicine Wheel is used in examining depression and providing options for care; post-traumatic stress syndrome and care; traditional healing for suicide prevention; conducting holistic and participatory research/ evaluations; and working with the impact of historical trauma on indigenous populations today.

The framework for the Medicine Wheel is based on systems theory and cognitive mapping. Systems theory states that no individual can be reduced to just parts. No one can exist if any of the parts are taken out. Cognitive mapping is the mental process that we use in acquiring, storing, understanding, and using knowledge to understand and relate to the spatial environment that we live in. Cognitive mapping is most effective when we consider the whole (systems theory) in relationship to ourselves and our behavior. The Medicine Wheel is rooted in tribal cultures and belief systems which provide the resources and tools to address mental health and AOD service delivery.



Excerpt from: *Native Vision: A Focus on Improving Behavioral Health Wellness for California Native American,* page 25

The Five A's for Reducing Disparities in Latino Populations

Disparities in mental health for Latinos have been well documented, showing that they have less access to mental health services than do whites, are less likely to receive needed care, and are more likely to receive poor quality care when treated. The Latino CRDP Report focused on disparities in the Latino population and identified that these barriers can best be understood as problems related to accessibility, availability, appropriateness, affordability, and advocacy, briefly described below. Although the content in the Five A's below reflects the needs of the Latino community, this model can be used as a guide for reviewing and analyzing disparities amongst other unserved and underserved populations.

Accessibility

The physical geographic isolation and dispersion of Latino subgroups such as migrant workers often results in a lack of service opportunities. For example, farmworkers often labor far longer than the eight-hour workday, leaving little time at the end of the day to obtain health care even if badly needed. Migrant workers are reluctant to take time off work for health care because any interruption of the workday decreases their income and consequently their livelihood.

Availability

The critical shortage of mental health facilities and general practitioners and specialized providers, especially in rural (and some urban) areas, has repeatedly been identified as a major problem (Badger et al., 1999; National Advisory Committee on Rural Health, 1992, 1993; Rost, Williams, Wherry and Smith, 1995). The scarcity of professionals in rural areas creates the need for health providers to be self-contained, comprehensive, and capable of managing all the biopsychosocial problems of their patients (Bray and Rogers, 1995). Long waits for appointments with mental health specialists pose additional barriers (Lambert and Hartley, 1998). Equally, Latinos in general and migrant workers in particular need services during non-conventional hours of operation.

Appropriateness

It has been found that availability of culturally relevant services increases Latino's utilization of services and the effectiveness of the treatment. To understand the appropriateness of mental health services for ethnic minorities, special concerns must be considered with regard to compatibility between the patient and therapist, mutual trust, and therapeutic efficacy. Factors such as provider communication style, cultural competence, and the patient-therapist interaction are key to improving treatment outcomes for consumers. Additionally, speaking the language of the client is critical to treatment, however speaking the language of the client does not only mean understanding the words, it includes linguistic competence to understand the sense and tone of the conversation.

Affordability

Statistics show that Mexican-Americans are the least- insured ethnic group in the United States. Although research is inconclusive about the relationship between insurance and mental health care, cost of treatment has been found to be a significant barrier in mental care. Additionally, some studies have found a positive correlation between having health insurance and the likelihood of receiving mental health services. Migrant farmworkers, for example, must apply for Medicaid within the state where they reside, and benefits cannot be transferred between states. Workers often move on to another state in search of employment before eligibility can be established. Even if they have Medicaid coverage, farmworkers have difficulty locating providers who will treat them (Napolitano and Goldberg, 1998).

Advocacy

Many Mexicans and Mexican-Americans do not know where to find these services (Vega et al., 2001). Fortunately, studies have shown that knowing where to find a provider significantly increased the likelihood of using a specialty mental health service. When Latinos obtain services for mental health disorders, they are significantly more likely than other clients to receive them in primary care settings rather than in specialized settings, which is probably related to their underutilization of mental health care (Vega, Kolody, Aguilar-Gaxiola, and Catalano, 1999). The penetration rate is a frequently used measure that provides information about the amount of mental health services used by those eligible, such as those already enrolled in the Medi-Cal program. According to the California Department of Mental Health's report titled Adult Mental Health Needs in California: Findings from the 2007 California Health Interview Survey (CHIS; Grant, Padilla-Frausto, Aydin, Streja, Aguilar-Gaxiola, and Caldwell, 2011), utilization differs by nativity status. The authors found that approximately one quarter (24.2%) of U.S.-born Latinos received minimally adequate treatment for their mental health needs. In contrast, only 10% of Latinos born abroad, 12% of U.S.-born Asians and 14% of Asians born abroad received treatment that met the requirements for minimally adequate treatment, less than half the statewide rate The difference between U.S.-born Latinos and the other three groups were all statistically significant.

Excerpt from: Community-Defined Solutions for Latino Mental Health Care Disparities, page 4

Glossary of Terms

California Reducing Disparities Project (CRDP)	In response to the call for national action to reduce mental health disparities and seek solutions for historically underserved communities in California, the Department of Mental Health (DMH), in partnership with Mental Health Services Oversight and Accountability Commission (MHS OAC), and in coordination with California Mental Health Directors Association (CMHDA) and the California Mental Health Planning Council, have called for a key statewide policy initiative as a means to improve access, quality of care, and increase positive outcomes for racial, ethnic and cultural communities. In 2009, DMH launched this two-year statewide Prevention and Early Intervention effort utilizing $3 million dollars in Mental Health Services Act (MHSA) state administrative funding. (California Department of Mental Health, 2010, p.1)
Cultural Competence	The integration and transformation of knowledge, information, history, and data about individuals, groups of people, communities, and neighborhoods into specific clinical standards, practices, skills, service approaches, techniques, policies, advocacy, participation, organizing, and health care marketing programs that matches the cultural group and increases the quality of health care, well-being, recovery, and quality of life (Davis, 2001).
Community Defined Evidence	A set of practices that communities have used and found to yield positive results as determined by community consensus over time. These practices may or may not have been measured empirically but have reached a level of acceptance by the community. (Community Defined Evidence Project, 2013)
Cultural Sensitivity	Being aware that cultural differences and similarities exist and have an effect on values, learning, and behavior. (Stafford, Bowman, Ewing, Hanna, & Lopez-DeFede, 1997)
Disparity	A state of being different. (Merriam-Webster Online, 2013)
Gaps	A “gap” is the distance between two points, such as (1) positive outcomes, including mental health and wellness, and (2) the disparities in outcomes that exist in many communities. A “gap” can also describe the reasons why the disparities in outcomes exist. Gaps point to what is missing or absent, that would otherwise enable the five historically under-served populations to access affordable, appropriate mental health services. The terms “barrier” and “challenge” are also often used to refer to gaps, and are used interchangeably with the term “gap” in this document.

Health Equity	A particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion. (Healthy People 2020)
Inequity	An instance of injustice or unfairness (Merriam-Webster Online, 2013)
Path	A means or method of addressing the identified cultural gaps. Paths give us direction, point the way, and help us to move forward so that progress can be made in a systematic manner. A path is a course to follow, usually constructed with a particular purpose or destination in mind.
The five unserved and underserved populations/ groups	In this text this phrase refers to the five populations focused on in the California Reducing Disparities Project (CRDP). They are: African Americans, Asian/Pacific Islander, Latinos, Native Americans, and Lesbian, Gay, Bisexual, Transgender, Queer and Questioning (LGBTQ).

References

African American Health Institute of San Bernardino County (2012). *"We Ain't Crazy! Just Coping With a Crazy System" Pathways into the Black Population for Eliminating Mental Health Disparities*. Retrieved from http://www.cdph.ca.gov/programs/Pages/CaliforniaReducingDisparitiesProject%28CRDP%29.aspx

Aguilera, E. (2013, January 31). State becoming equal parts Hispanic and white. *San Diego Union Tribune*. Retrieved from http://www.utsandiego.com/news/2013/jan/31/california-population-hispanic-white/

California Department of Mental Health. (2010, January). *California Reducing Disparities Project* [Fact sheet]. Retrieved from http://www.dmh.ca.gov/Multicultural_Services/CRDP.asp#CRDPDownloads

Community Defined Evidence. (n.d.). *Community Defined Evidence Project*. Retrieved from http://www.nlbha.org/index.php/programs/cdep/111-cde

Davis, King (2001). The intersection of fee for service, managed health care, and cultural competence: Implications for National Health Care Policy and Services to People of Color. In Veeder, Nancy W. & Pebbles Wilkins, Wilma, *Managed Care Services: Policy, Programs, and Research*. New York: Oxford University Press, pp.50-73.

Department of Health and Human Services (1999). *Mental Health: A Report of the Surgeon General.* Rockville, Maryland: U.S. Department of Health and Human Services, SAMHSA and NIMH.

Disparity (n.d.). *Merriam-Webster Online*. Retrieved from http://www.merriam-webster.com/thesaurus/disparity

DuFour, R. (2003). Leading edge: "Collaboration lite" puts student achievement on a starvation diet. *Journal of Staff Development*. Retrieved from http://cusd.capousd.org/edusupport/Articles/DuFour%20Collaboration%20Lite.pdf

Health Equity (n.d.). *Healthy People 2020*. Retrieved from http://www.healthypeople.gov/2020/about/disparitiesAbout.aspx#five

Humes, K. R., Jones, N. A., & Ramirez, R. R. (2011). Overview of Race and Hispanic Origin: 2010. *2010 Census Briefs*. Retrieved from http://www.census.gov/prod/cen2010/briefs/c2010br-02.pdf

Inequity (n.d.). *Merriam-Webster Online*. Retrieved from http://www.merriam-webster.com/dictionary/inequity

Institute of Medicine (1994). *Institute of Medicine (IOM) for Prevention*. Retrieved from http://www.kitsco.com/casupport/WebHelp_Prevention101/Institute_of_Medicine_IOM_for_Prevention.htm

Mental Health America of Northern California & Equity California Institute (2012). *First, Do No Harm: Reducing Disparities for Lesbian, Gay, Bisexual, Transgender, Queer and Questioning Populations in California.* Retrieved from http://www.cdph.ca.gov/programs/Pages/CaliforniaReducingDisparitiesProject%28CRDP%29.aspx

Native Vision Project Native American Health Center, Inc. (2012). *Native Vision: A Focus on Improving Behavioral Health Wellness for California Native Americans*. Retrieved from http://www.cdph.ca.gov/programs/Pages/CaliforniaReducingDisparitiesProject%28CRDP%29.aspx

Pacific Clinics & the Asian Pacific Islander Strategic Planning Workgroup (2013). *The Asian Pacific Islander Report: In Our Own Words*. Retrieved from http://www.cdph.ca.gov/programs/Pages/CaliforniaReducingDisparitiesProject%28CRDP%29.aspx

Robert Wood Johnson Foundation (2012). *Reform in Action: Equity in the Context of Health Reform.* Retrieved from http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2012/rwjf402390

Smith, D., Wilson, B., & Corbett, D. (2009, February). How Teachers Learn. *Educational Leadership*. Volume 66, Number 5, pg. 20 – 25.

Stafford, J.R., Bowman, R., Ewing, T., Hanna, J., & Lopez-DeFede, A. (1997) *Building cultural bridges*. Bloomington, IN: National Education Service

United States Census Bureau (2008). *An Older and More Diverse Nation by Midcentury*. Retrieved from http://www.census.gov/newsroom/releases/archives/population/cb08-123.html

University of California, Davis Center for Reducing Health Disparities & the Latino Mental Health Concilio (2012). *Community-Defined Solutions for Latino Mental Health Care Disparities*. Retrieved from http://www.cdph.ca.gov/programs/Pages/CaliforniaReducingDisparitiesProject%28CRDP%29.aspx

Wenger, E. (2006). *Communities of practice a brief introduction*. Retrieved from http://www.ewenger.com/theory/

World Health Organization (2012). *The right to health*. Retrieved from http://www.who.int/mediacentre/factsheets/fs323/en/index.html#

World Health Organization (2008). *Social determinants of health*. Retrieved from http://www.who.int/social_determinants/en/

Appendices

Appendix A: Presentations

The table below lists the presenters who spoke at the CCMH Summit XVIII. For more information the conference program is available for download at: http://www.culturalcompetencesummit.org/.

	Session	Speaker(s)
A1.	Sharing Knowledge, Improving Lives: Community-Defined Solutions for Latino Mental Health Disparities	Sergio Aguilar-Gaxiola, MD, PhD
A2.	Evidence-Based Prevention and Early Intervention Services for African American, Latino, and Vietnamese Older Adults	Pei Chen Emily Wu, PsyD Evelyn Parada, MSW
A3.	More Opportunities Through the California Reducing Disparities Project	Stacie Hiramoto, MSW Ruben Cantu,
A4.	Promotores de Salud	Myriam Aragon, MSWS Alexander Fajardo
A5.	Increasing Cultural Competence with Minority Service Members and Veterans	Lena Payne, LCSW Rachel Bentley, LCSW
A6.	Through a Cultural Lens: A Different Way to Understand (and Diagnose) Our Clients	Alison Solomon, MSS, LCSW
A7.	A Candid Look at Diversity in the Central Region	Dante Dauz, JD Lisa Covington, MA Ericka Cordero, BA
A8.	Understanding Client Culture and Journeys	Minh Ha Pham, PsyD John (Anonymous) Minni Lucas Nicole Lehman Greg Wright
B1.	First, Do No Harm: An Introduction to Reducing Disparities for LGBTQ Communities	Poshi Mikalson, MSW
B2.	Improved Depression & Diabetes Care Management Among Elderly Latinos: Design, Implementation & Preliminary Outcomes of a Culturally Tailored Strategy	Veronica Cardenas, PhD Elizabeth Lugo, MD Consuelo Razo, RN
B3.	Africancentric Rites of Passage, Cultural Competency and PEI Intervention	E.M. Abdulmumin, PhD Marva Bourne, DMFT Dretona Maddox, RN, MSW Blessing Okoro Rellias, PhD
B4.	Bridging the Cultural Gap in African American & Latino Communities	Edwina Browning-Hayes Georgie Sullivan Angelica Garcia
B5.	Diversity in Dementia	Mario Garrett, PhD Anette Asher

	Session	Speaker(s)
B6.	Mental Health Disorders Resulting From Torture & On Culturally Appropriate Psychosocial, Holistic Treatment Interventions For Torture Survivors & Their Families Within Refugee & Immigrant Communities	Mahvash Alami Rad, PhD, CPRP Patricia Hillard, MSW
B7.	Loud and Clear: Partnering with Journalists for Accurate, Stigma-Free Mental Health Stories	Carlos Alcazar Sally Douglas Arce
B8.	Native Vision: A Focus on Improving Behavioral Health and Wellness for California Native Americans	Kurt Schweigman, MPH Dan Dickerson, PsyD Carrie Johnson, PsyD Karen Kolb Charity White
C1.	California Reducing Disparities Project (CRDP): African American Populations Report	V. Diane Woods, PhD, MSN Suzanne Midori Hanna, PhD Carolyn Murray, PhD
C2.	Effective Strategies to Promote Latino Mental Health and Reduce Stigma	Kevin Kirkpatrick
C3.	Cultural Traits: Bridges to Serving Clients Effectively	Andre Branch, PhD
C4.	Filipino Americans: Cultural Awareness and Clinical Applications	Lorna Pham, PsyD Mary Ann Franco, LMFT, EdD, CP
C5.	Multicultural Preventive Approach to Geriatric Mental Health Services for Refugees and Immigrants	Agnes Hajek, ACSW Dixie Galapon, PhD Salwa Yalda
C6.	The Process of LGBT Acceptance in the Latino Family	Corinne Contreras
C7.	Using Motivational Interviewing (MI) with Latino Populations	James (Diego) Rogers, PsyD
C8.	Cultural and Personal Forgiveness	Sharon Adams, PhD
D1.	From Mental Health Disparity to Health Care Reform Equity: Lessons Learned from the California Reducing Disparities Project API Workgroup	C. Rocco Cheng, PhD
D2.	Mental Health in Schools Building a Continuum of Healthcare and Education Systems	Bruce Wheatley
D3.	Storytelling to Bridge the Cultural Divide	Bobbi Fischer Rubinstein
D4.	Ethnic Beauty and Internalized Oppression: Open Wounds	Barbara Ann White
D5.	African Dance Movement and Drum Combined with Narrative Therapy Techniques on the Mental Health Care and Community Well-Being of African Americans	Suzanne Forbes Vierling, PhD Nana Obrafo Yaw Asiedo Monette Marino
D6.	Promotas de Salud as a New Approach to the African American Community in the County of San Bernardino	Alexander Fajardo Linda Hart
D7.	Communicating is More than Translating	Simon Dixon Luis Tovar, MPA

	Session	Speaker(s)
D8.	Historical Trauma in Context	Leon Altamirano, PsyD
Institute I	African-American Focused Institute- Removing Barriers to the Elimination of Disparities: Is Cultural Competence Enough?	King Davis, PhD
Institute II	Implementation of Evidence-Based Practices in a Rural Community	Michael Horn, MFT
Institute III	Expanding an Authentic Conversation on Evidence Based Practice and the Risk to Latino Communities: Where Do We Go From Here?	Rachel Guerrero, LCSW
Institute IV	Alameda County – From Dialogue to Action; "Stepping" Toward Improving MH Outcomes for the African American Community	Gigi Crowder
Media Advocacy Campaign Showcase I	TEAM Up: Tools for Entertainment and Media	Nedra Weinreich John Hinrichs
Media Advocacy Campaign Showcase II	Using Social Media in a Behavioral Health Environment	Susanne Kulsea
Media Advocacy Campaign Showcase III	Up to Us	Bill Brenneman Jana Sczersputowski
Media Advocacy Campaign Showcase IV	Our Personal Journeys – Mental Health Awareness on Campus: Developing a Multi-media Stigma Reduction Campaign with Transitional Age Youth in a College Setting	Shannon McQuat Dina Mancillas
Media Advocacy Campaign Showcase V	Our Voices: OC LGBTIQ ACCEPT	Hieu Nguyen, LCSW Lamar Smith, PsyD
Media Advocacy Campaign Showcase VI	It Ain't Communication, If They Don't Listen: A Public/Private Partnership Media Marketing & Advocacy Strategy Framework to Deliver Your Message	Luis Tovar, MPA
Media Advocacy Campaign Showcase VII	Understanding Recovery Journeys & Meanings from Client Perspectives	Minh-Ha, Pham, PsyD Jana Sczersputowski
Media Advocacy Campaign Showcase VIII	Housing Matters	Emily Anderson Kalie Standish
CRDP Plenary Panel - African American Report		V. Diane Woods, PhD, MSN
CRDP Plenary Panel - Asian & Pacific Islander Report		C. Rocco Cheng, PhD

Session	Speaker(s)
CRDP Plenary Panel - LGBTQ Report	Poshi Mikalson, MSW
CRDP Plenary Panel - Latino Report	Sergio Aguilar-Gaxiola, MD, PhD
CRDP Plenary Panel - Native American Report	Kurt Schwiegman, MPH

Appendix B: Conversation Café

The following was developed as a standalone document created as an outcome of the Conversation Café held at the CCMH Summit XVIII to allow readers to take advantage of perspectives from individuals working in the field. Some of the content was also utilized in this toolkit.

A Dialogue on Strategies to Reduce Disparities in Mental Health and Increase Cultural Competence

As part of the Cultural Competence & Mental Health Southern Region Summit XVIII (CCMH Summit XVIII), an activity called Conversation Café took place. The purpose was to help discern strategies to reduce disparities and bridge the cultural gap. Conversation Cafés are structured small-group conversations to engage individuals in fun, inviting, and open dialogues and serve to generate new ideas with broader solutions and share best practices and strategies to overcome challenges. Facilitators, known as "hosts" in Conversation Cafés, lead the discussions, providing guidance and assistance in generating new ideas.

Hosts remained at the table while the groups rotated every 15 minutes. Each host was given a pre-determined question for groups to respond to and discuss. Beginning with responses given from group one, the hosts engaged each subsequent group by initiating the conversation and by building upon the key points from the groups prior. Participants rotated from table to table so they had the opportunity to address each set of questions. Each Conversation Café table had butcher paper laid out like a table cloth for participants to doodle freely during conversations.

The questions that guided the conversation were divided into three topic areas, and each area had three questions. The CCMH XVIII Summit Planning Committee, which was comprised of Southern California Ethnic Services Managers and other key stakeholders, came together to draft the following questions:

Topic 1: Beyond the Talk

4. Based on the keynote & plenary presentations, what are focus areas where you see county's need to address to reduce disparities?
5. Of those actions or changes you have identified, which are priorities?
6. Who will you need to collaborate/partner with to make this happen in your respective community?

Topic 2: Practicing the Walk

4. Based on the learning you have experienced from this Summit, what is the most important insight you have gained?
5. How can you apply this new learning back in your community?
6. What new behaviors or actions are you personally committed to?

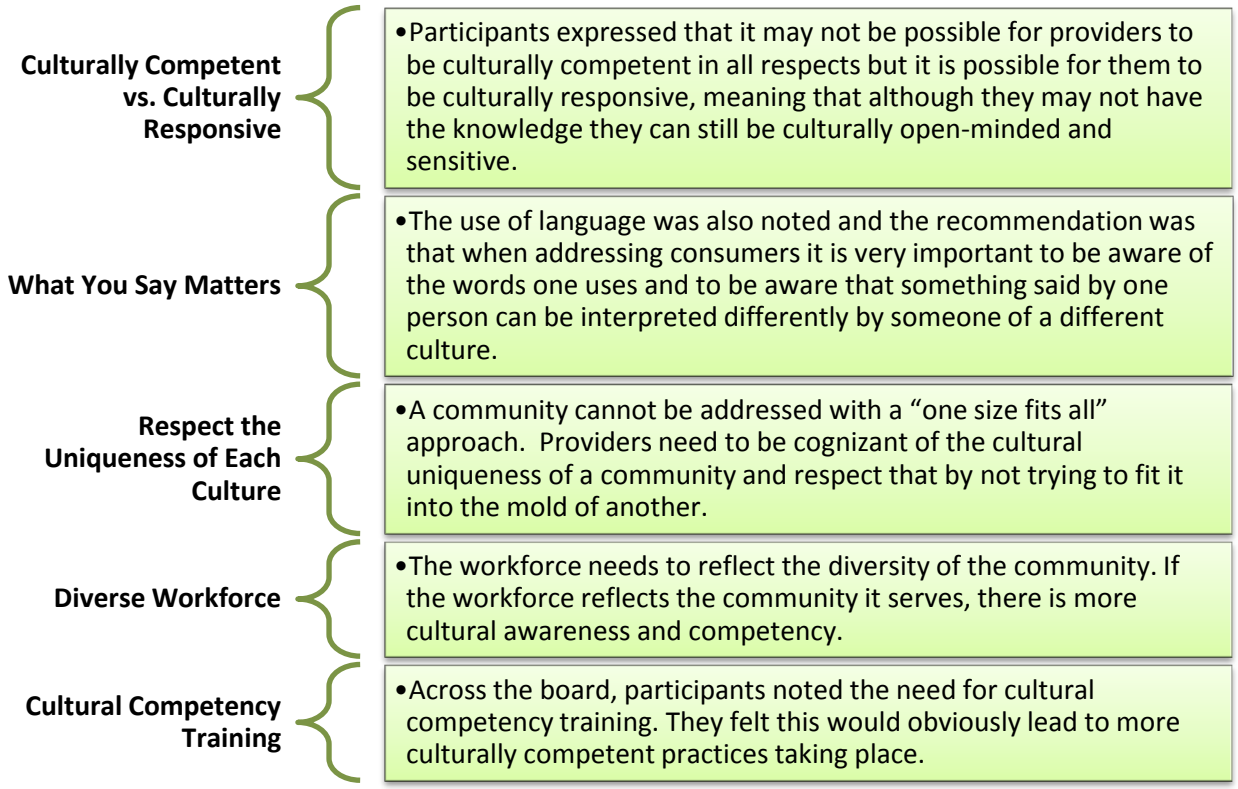
Topic 3: A Path to Bridge the Cultural Gap

4. Who will you build/construct your bridge to?
5. What do you need to build/construct your bridge?
6. What measures will need to be put into place to know that your bridge is solid?

Out of the conversations that transpired resulted in many paths and recommendations to reduce disparities and strengthen cultural competence were uncovered. Overall, the recommendations from Conversation Café fell into four categories: 1) increase cultural competency, 2) spread effective practices, 3) reduce stigma, and 4) data usage. Participants also identified who they could reach out to in order to help facilitate these recommendations. The following is compiled from responses given to questions posed to participants during Conversation Café.

Increase Cultural Competency

The following responses appeared as themes in the recommendations to increase cultural competency:



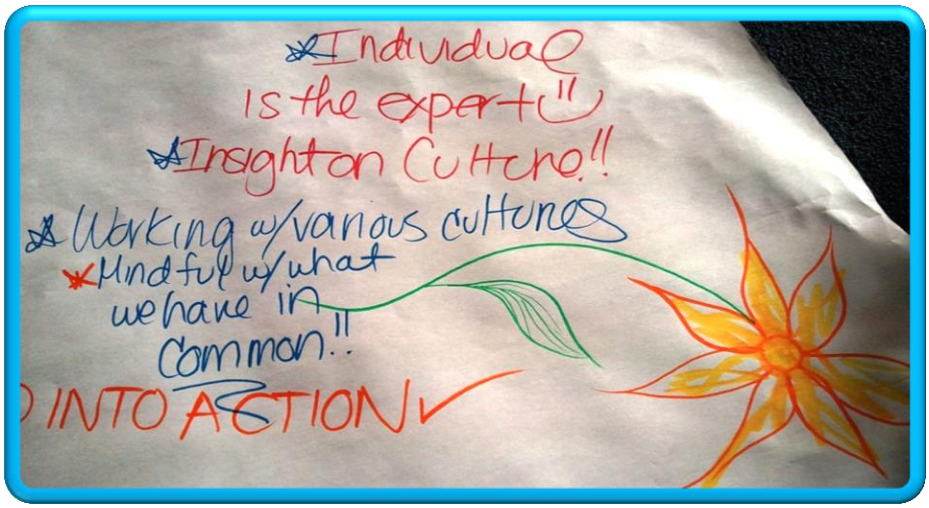
Spread Effective Practices

The group identified three effective practices that they felt should be implemented.

Modeling & Adapting	• Look at another county's program that has been effective with a community similar to yours, and adapt it to fit your community.
Reminders	• Setup reminders of what needs to be done and make sure to put it on your agency's agenda as an ongoing task (i.e., dedicating time to learn about cultural competency).
Meet People Where They Are	• Meet people where they are at by setting up satellite offices, providing transportation, or using mobile technology.

Reduce Stigma

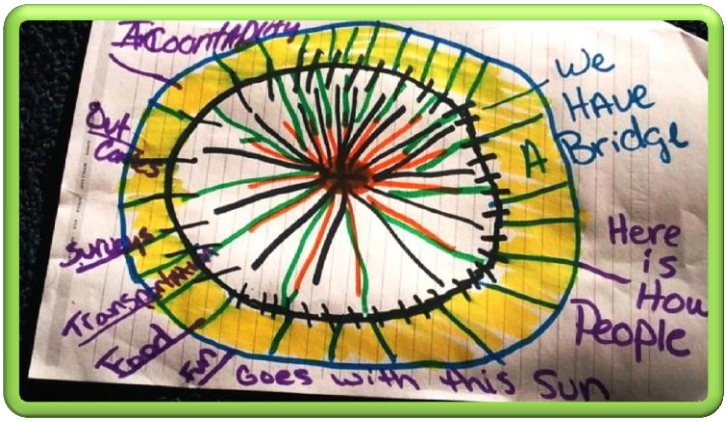
Decreasing stigma was identified as a key issue in addressing cultural competency. Participants felt that this could be accomplished through the use of media, including both traditional ad campaigns and social media.



Data Usage

It is critical to collect data about your community, and necessary to make a point of using this information. Many participants felt that when data is gathered it is often not utilized to create the programs and services for the community being served that it reflects. They noted the importance of looking at the data and tailoring the approach to what it is telling you about the community you are serving.

> "We have data, get the ball rolling, let's see the results."
>
> "Desegregate data to ensure services are more tailored to specific groups (e.g. Hispanics)."
>
> *- CCMH Summit XVIII Conversation Café Participants*



Community Outreach

The group identified the following as persons they felt it necessary to reach out to: community leaders, educators, legislators, faith based leaders, consumers, and family members. They emphasized the importance of community outreach through listening, engaging, and collaborating with these key community stakeholders.

Taking Action

For more information on how to implement these recommendations and others identified at the CCMH Summit XVIII please refer to *Beyond the Talk: A Resource Toolkit to Bridge the Cultural Gap*, available for download in the spring of 2013 at: www.culturalcompetencesummit.org.

Appendix C: CCMH Summit XVIII Planning Committee

Myriam Aragón	*Program Manager, Cultural Competency/Recovery Learning Center*
Patrice Baker	*Community Outreach Coordinator, Harmonious Solutions*
Sandra Chang-Ptasinski	*Ethnic Services Manager, County of Los Angeles Department of Mental Health, Quality Improvement Division, Cultural Competency Unit*
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Celeste Hunter	*Family Partner, Child & Adolescent Services Research Center*
Veronica Kelly	*Deputy Director, Regional Operations & AOD Services, County of San Bernardino Department of Behavioral Health*
Louise Lecklitner	*(Co-Chair), Program Manager, Office of the Clinical Director, Behavioral Health Services Division, County of San Diego Health & Human Services Agency*
Rosa Ana Lozada	*Chief Executive Officer, Harmonium Inc.*
Nancy Mancha-Whitcomb	*Program Supervisor and Ethnic Services Manager, San Luis Obispo County Behavioral Health Department*
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Janine Moore	*Prevention and Early Intervention Coordinator, Riverside County Department of Mental Health*
Will Rhett-Mariscal	*Center for Multicultural Development, California Institute for Mental Health, Sacramento*
Refujio "Cuco" Rodriguez-Rodriguez	*(Co-Chair), Ethnic Services Manager, MHSA Division Chief, ADMHS County of Santa Barbara*
Patricia Tapia	*Program Specialist III, Aging and Independence Services (AIS) County of San Diego Health & Human Services Agency*
Jewel Thompson	*CEO/Executive Director, Inland Multi-Cultural Counseling Agency*
Luis Tovar	*(Co-Chair), Ethnic Services Manager, County of Ventura Behavioral Health Department*
Hanh D. Truong	*Past Cultural Competency Officer, Office of Cultural Competence & Ethnic Services, County of San Bernardino Department of Behavioral Health*

Mental Health
Southern Region Summit XVIII

Prepared by Tracy L. Fried & Associates, Inc.