A Cultural Competency Toolkit:

Ten Grant Sites Share Lessons Learned

National Consumer Supporter Technical Assistance Center
National Mental Health Association

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Key concepts: Asian Americans, consumer involvement, Hispanic/Latino Americans, Russian Americans, translation, warm-line implementation

Introduction: The Cultural Competency Initiative

For organizations providing support to mental health consumers, "cultural competency"—the ability to reach out effectively and appropriately to individuals of different cultural backgrounds — is central to meeting the needs of a diverse community. Recent U.S. census data indicate that nearly 70 million Americans are people of color and that this number is growing. This shift in the U.S. population has a significant impact on the mental health services system. According to the U.S. Surgeon General, language differences, cultural barriers and stigma prevent people of color from receiving necessary or adequate services.

The National Consumer Supporter Technical Assistance Center (NCSTAC) is in a unique position to play a pivotal role in this area. NCSTAC, through its Cultural Competency Initiative, has attempted to increase understanding of ethnic and racial disparities in mental health treatment and to support efforts that address the related barriers to adequate treatment.

The Cultural Competency Initiative, which was launched in 2000, assisted consumer supporter organizations by providing funding and technical assistance as well as by disseminating information about innovative minority outreach programs.

The Cultural Competency Initiative provided funding and disseminated information about innovative programs of minority outreach.

Through a competitive selection process, ten sites across the country were each awarded $5,000 to launch new initiatives or to build upon existing programs over a one-year period. Sites chosen already had proven track records in reaching out to special populations.

The sites that were selected began to address the issues of cultural competency in their communities and to document the lessons learned in carrying out these efforts. With data from these ten organizations, NCSTAC is now able to offer this Cultural Competency Toolkit. Each chapter provides an overview of one of the ten model programs. Project goals and implementation plans are shared, project leaders share their expertise, and program materials are included in each chapter's appendices. NCSTAC hopes that this information will assist other consumer supporter organizations in their efforts to launch similar outreach programs.

NCSTAC's vision is of a just, humane and healthy society in which all people are accorded respect, dignity and the opportunity to achieve their full potential free from stigma and prejudice. It is our hope that organizations providing support to mental health consumers can help to make this vision a reality one project at a time.

Language differences, cultural barriers and stigma continue to prevent many individuals from receiving necessary or adequate services.

Overview of chapters

Chapter one discusses the Mental Health Association in Alaska's (MHAA's) Mentor Project. With NCSTAC funding, MHAA flew five Native Alaskans from the state's most remote regions to Juneau to attend a three-day leadership training to develop advocacy skills.

Prior to this grant proposal, the Mental Health Association of Allegheny County (MHAAC) participated as a founding member in a local Multicultural Outreach and Education Task Force. MHAAC believed that this massive outreach effort was highly replicable, and **chapter two** discusses how this organization used NCSTAC funding to prepare and disseminate a how-to manual for replicating their project.

Chapter three provides an overview of the National Mental Health Association of Georgia's Project HOPE, (Healing, Opportunity, Prevention and Education). Project HOPE aimed to increase awareness in Georgia's African American community of the symptoms of and treatments for depression.

Chapter four describes how the Mental Health Association in Hawaii (MHAH) used its NCSTAC funding to strengthen its existing speakers bureau by recruiting and training mental health consumers of different cultural backgrounds. Over the course of this project, MHAH enlisted eight Native Hawaiians and Asian Americans as consumer advocates.

Chapter five discuses NAMI-New Mexico's (NAMI-NM's) Consumer Involvement Project. NAMI-NM offered a series of workshops at seven different locations across the state to help consumers to launch their own self-help and advocacy programs.

Chapter six explains how the Mental Health Association of South Eastern Pennsylvania (MHASP) built upon its existing Mental Health/Aging Advocacy Project. MHASP trained elderly consumers and their caregivers to advocate for the mental health needs of older Americans in the Philadelphia area.

Aiken County, South Carolina is rated as one of the top 100 places to retire in the United States and accordingly has a large population of older Americans. **Chapter seven** provides an overview of the Mental Health Association in Aiken County's efforts to found an Elder's Task Force to help serve this population's needs.

Despite stereotypes to the contrary, mental illnesses among Asian Americans are actually common. **Chapter eight** describes how Houston's Asian American Family Counseling Center designed and offered a series of brown bag lunches where local mental health professionals could learn more about working with the area's Asian American communities.

Chapter nine explains how the Mental Health Association in Utah organized a two-day conference where 200 mental health professionals could learn about cultural competency. Conference workshops explored working with Utah's various minority populations: Native Americans, Latinos, African Americans, Pacific Islanders and Asian Americans. Additionally, one workshop focused on Deaf culture.

Consumer Voices Are Born (CVAB), a consumer-run drop-in center, established a warm-line where individuals in the Clark County, Washington area facing mental health challenges could call in and discuss their problems with a peer. **Chapter ten** focuses on CVAB's efforts to extend warm-line services to the county's various ethnic communities.

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Cultural Competency Toolkit

CHAPTER 1

The Mentor Project: Fostering Consumer Advocacy Among Native Alaskans

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Executive Summary

The Native population in Alaska experiences high instances of substance abuse and violence and utilizes the state mental health system at a much higher rate than Caucasians. At the same time, there are few Native Alaskan consumers involved in mental health advocacy work. In part, this is due to the remoteness of many Native Alaskan villages, which precludes networking with other consumer groups and consumer leaders. Through the Mentor Project, the Mental Health Association in Alaska (MHAA) proposed to sponsor five Native Alaskans living in remote regions to attend the Bridges 2000 Fly-In. At the Bridges Fly-In, an annual gathering for consumer leaders spearheaded by MHAA, these individuals would have the opportunity to learn about self-advocacy and consumer advocacy skills.

Project Goals

- To involve five Native Alaskans in the Bridges 2000 Fly-In.
- To thereby encourage advocacy among Alaska's native population.

Introduction

There are twelve major native tribes in Alaska, who make up approximately one quarter of the state's population of 600,000 people. Proportionally, the Native Alaskan population utilizes the state mental health system at a much higher rate than Caucasians, with the preponderance of substance abuse, interpersonal violence, sexual abuse and suicide among Native Alaskans having severe, multi-layered social and economic implications for this community.

The preponderance of substance abuse, interpersonal violence, sexual abuse and suicide among Native Alaskans has severe, multi-layered social and economic implications for this community.

Yet the consumer empowerment movement in Alaska sadly lacks Native influence. For example, the Building Bridges Campaign for Mental Health, an initiative aimed at fostering leadership and advocacy skills among Alaskan consumers of mental health services, has involved some 250 consumers and family members since its inception in 1994. Yet of that number, only five Native Alaskans at the time of this proposal had had the opportunity to participate in the program.

Contributing to the lack of involvement by Native Alaskans is the state's expansive, arctic geography and very sparsely developed road system. Many Native Alaskans live in remote areas sometimes accessible only by air.

Program Plan

At the time of this proposal, MHAA had been successfully spearheading the Bridges Fly-In for six years, working with other mental health organizations to organize an annual three-day event providing training in leadership and advocacy skills to mental health consumers, their friends and family members. While MHAA handled primary oversight and coordination for this Fly-In, the Alaska Community Mental Health Services Association provided funding.

Through the Mentor Project, MHAA proposed to sponsor five Native Alaskan consumers to take part in the Bridges Fly-In. These new consumer leaders would be flown to Juneau, would meet and learn the latest methods for impacting public policy, and would be given the opportunity to take part in advocacy activities.

Native Alaskans flew in from the state's most remote regions to participate in the Fly-In.

Organizational Overview

At the time of this proposal, MHAA had been an instrumental leader of the mental health movement in the State of Alaska for almost fifty years. To name a few of its activities, MHAA participated in the development of a state psychiatric hospital; of community mental health centers; of women's shelters, crisis centers, support groups and transitional living programs.

As the only broad-based organization in Alaska advocating for people with mental illness and for the prevention of mental and emotional illnesses, MHAA also monitored legislation and its potential for improvement. MHAA worked diligently towards the resolution of the Mental Health Trust Lands issue, pursuing a twelve-year legal struggle culminating in a new law establishing the Alaska Mental Health Board and a Mental Health Lands Trust Authority designed to protect these funds in perpetuity. MHAA was further involved in the process of negotiation with the State of Alaska over the value of the mental health lands.

MHAA participated in the development of a state psychiatric hospital; of community mental health centers; of women's shelters, crisis centers, support groups and transitional living programs.

MHAA was also an advocate for prevention programs and for a stronger focus on Alaskan youth. The organization advocated for expanded services for the mental health consumer in the form of pre and post hospitalization services, supported employment programs, group and individual sheltered housing projects, respite care programs, and efficient statewide crisis intervention services.

Through an active and ongoing public education process, MHAA also attempted to counteract the stigma that often surrounds mental illness, taking part in the national Mental Health Month campaign in May and in Mental Illness Awareness Week activities in October.

Implementation

In order to contact Native Alaskans to take part in this initiative, project director, Jan McGillivary, networked with other Alaskan mental health organizations including National Alliance for the Mentally Ill, the Alaska Mental Health Board, and community mental health services associations. These various groups reached out to the Native Alaskan communities in their areas to find local consumers interested in participating.

Participants at the March, 2001 Bridges Campaign Fly-In.

The Fly-In took place March 20 through March 22 in the state capitol, Juneau, and five Native Alaskans, sponsored by the Mentor Project, participated. The Fly-In's training agenda included special meetings with mentors, a workshop on how to serve on a board of directors, and a detailed overview of the state government offices. In addition, visits to state legislators, a public hearing before the state senate and a meeting with the governor were also scheduled.

Discussion, Conclusion

Although one-quarter of Alaska's population is made up of Native peoples, McGillivary reports that the state's policy makers are still almost entirely Caucasians: "If you go to the state legislature or any urban community where there's policy-making taking place, you will rarely see a native face."

McGillivary describes it as "her personal mission over the past sixteen years" to attempt to rectify this inequity. She readily acknowledges that as a white person, this is not always easy to do. As with any other cultural group, Native Alaskans tend to be more trusting of individuals from their own communities. "Entering that circle (of the Native Alaskan community) is not always a clear-cut path. It's often very oblique and subtle."

While policy-making occurs year-round, the Native Alaskan life-style still centers around seasonal activities such as hunting and fishing.

Besides the communication barriers that can always exist between individuals of different cultures, there are also other obstacles inherent in trying to invite Native Alaskans to participate in predominantly white mental health delivery systems and policy-making

structures. While policy-making occurs year-round, the Native Alaskan life-style still centers around seasonal activities such as hunting and fishing. During these time periods, fewer Native Alaskans are able to participate in advocacy activities.

Moreover, the pressures imposed by Alaska's harsh climate and sparse population cannot be underestimated. McGillivary describes most villages as "just a pocket full of people," and many village inhabitants may not even have telephones. Local mental health service organizations will serve perhaps ten or eleven villages spread over a wide area. Travel between villages is typically expensive and sometimes, due to extreme weather conditions, simply impossible.

One project participant testified before the State Mental Health Commission. His testimony was so moving that he received a standing ovation.

Nonetheless, McGillivary believes that the Mentor Project and other similar outreach and advocacy training programs are beginning to bear fruit. She reports that "this year at Bridges there were more native faces than ever before. There was a substantial difference in the flavor of the event."

State mental health providers are also becoming more attuned to the importance of working cooperatively with their Native Alaskan constituency. A recent cooperative initiative is teaming the Native Alaskan Tribal Council with the public mental health system to utilize telecommunications to promote mental health.

And following the Fly-In, one project participant testified before the State Mental Health Commission. His testimony was so moving that he received a standing ovation, and shortly thereafter he was invited to apply to become a mental health commissioner.

Alaska's rural geography, with few roadways, makes it difficult for advocates to gather together.

Additional Resources

Publications

Herring, Roger. *Counseling With Native American Indians and Alaska Natives: Strategies for Helping Professionals*. Thousand Oaks, California: Sage Publications, c1999.

Native Outreach: A Report to American Indian, Alaska Native, and Native Hawaiian Communities. Bethesda, Maryland: National Institutes of Health and National Cancer Institute. 1999.

Trimble, Joseph and Bagwell, Weldon (editors). *North American Indians and Alaska Natives: Abstracts of the Psychological and Behavioral Literature, 1967-1994*. Washington, D.C.: American Psychological Association. 1995.

Organizations

Indian Health Service
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Cultural Competency Toolkit

CHAPTER 2

Developing a Multi-Cultural Outreach Manual

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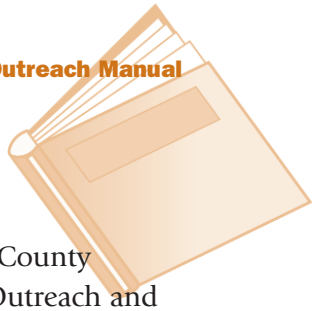


Executive Summary

Prior to this grant proposal, the Mental Health Association of Allegheny County (MHAAC) participated as a founding member in a local Multicultural Outreach and Education Task Force. Designed to reach out to the underserved African American, Hispanic/Latino and elderly populations in Allegheny County, this task force helped to enroll 1,000 people in a newly created managed care system. MHAAC believed that this massive outreach project was highly replicable, and with a NCSTAC grant, they proposed to design and disseminate a how-to manual for other consumer supporter organizations to launch similar programs.

Project Goal

- To produce a manual for starting a minority behavioral health outreach and education program.

Introduction

Allegheny's elderly, Latino and African American communities were not accessing the health care that they needed.

Allegheny County is an urban area in Pennsylvania, home to the City of Pittsburgh. Two years before this grant proposal, MHAAC met with other service providers in the Pittsburgh area to discuss the dearth of information in the minority community concerning the county's new managed care system. At that time, a report issued by the Allegheny County HealthChoices Program indicated that elderly, Hispanic/Latino and African American communities in the area were not accessing the health care that they needed.

The report found that:

- Elderly persons represented only eight percent of the HealthChoices population, and they received authorizations for only two percent of the total authorized services.
- African Americans represented approximately ten percent of the Allegheny County population and almost half of the eligible HealthChoices population. Yet they received only approximately 37 percent of authorizations.
- Because of small numbers of individuals of Hispanic/Latino descent utilizing HealthCare services, this population was most likely also not accessing needed services.
- Caucasian members made up 51 percent of the eligible population but received 62 percent of the authorizations.

To address these disparities, and under MHAAC's leadership, a Multicultural Outreach and Education Task Force was formed. This task force then assisted more than 1,000 individuals to enroll in the existing managed care system over a two year period.

Program Plan

The Multicultural Outreach and Education Task Force's success in enrolling so many new members into the existing managed care system convinced MHAAC that the project should be replicated. MHAAC proposed to NCSTAC to create a manual explaining to health care providers how to conduct multicultural outreach and education.

MHAAC helped to enroll more than 1,000 individuals in Allegheny's managed care system over a two-year period.

Organizational Overview

At the time of this grant proposal, MHAAC had already been providing services to Allegheny County residents for forty years. During this lengthy period, the staff had the opportunity to develop a wide network of connections with direct service providers, with those dispensing educational and informational resources, and with agencies providing ancillary services.

"I went out into the community and held conversations with people so that they could tell me what they needed."
— Delores Burgess, Minority Outreach Coordinator

During the two years directly preceding this grant, MHAAC participated in a variety of collaborative ventures with various agencies including: the Pennsylvania Office of Mental Health and Substance Abuse Services, the Office of Education and Regional Planning of the University of Pittsburgh, and Community College of Allegheny County.

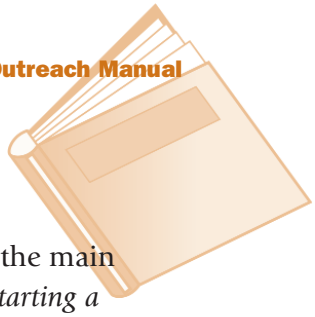
MHAAC also worked together with local social service providers including: Hill House, Peoples Oakland, Renaissance Center, Mon Yough Community Services, Allegheny County Department of Human Services, Project CART (a consumer survey), New Horizons Mental Health Information Center, St. Francis Community Mental Health, Area Agency on Aging, Western Psychiatric Institute and Clinic, Coalition for Leadership, and Mayview State Hospital.

Ongoing projects at MHAAC included a Minority/Community Outreach and Education program, a Services to the Homeless program, a Family Support and Community Advocates initiative, a Substance Abuse and Advocacy program, and an Education Advocacy program.

Many people do not receive health care because:

- They lack information about available care.
- They lack adequate transportation.
- They have difficulty with child care.
- They carry inadequate insurance coverage.
- They are home bound.
- Their jobs limit their ability to keep appointments.
- Lack of cultural sensitivity by professionals keeps them from returning for needed services.

— From the *Step by Step Guide.*



Implementation

Although project director, Brenda Lee, reports that "just finding the time" was the main challenge in completing this project, The *Step by Step Guide and Workbook for Starting a Minority Behavioral Health Outreach and Education Program* was finished in less than a year. (The main body of this workbook is included in the appendix.) Lee and Delores Burgess, the coordinator for MHAAC's Minority/Community Outreach and Education program, worked together on drafting this manual

Burgess, who developed the outreach program on which the manual was based, relied heavily upon her contacts in the field — providers, family members and consumers. She says, "I went out into the community and made the contacts and held conversations with people so that they could tell me what they liked and what they needed."

Organizations and individuals who would ultimately be served by the manual reviewed Burgess's and Lee's drafts and provided comments. The finished manual takes the reader through a series of questions such as "What are the barriers to access in your community?" and "What are the reasonable expectations of the community you will be serving?" that can provide guidance in creating a program appropriate for a particular community.

The finished manual takes readers through a series of questions that can provide guidance in creating an outreach program appropriate for a particular community.

Discussion and Conclusion

Now that the *Step by Step Guide* is complete, it will continue to be a resource for other groups wishing to conduct outreach and education. Burgess has already presented on the outreach program at various counties in the Allegheny area, as well as out of state, and she plans to distribute the manual "to other people who might want to start up a program like our own."

Lee warns anyone wishing to undertake community outreach that "it can be time consuming." But, she adds, "it's well worth it."

Additional Resources

Publications

(African Americans)

Byrd, W. Michael and Clayton, Linda A. *An American Health Dilemma, Volume One: A Medical History of African Americans and the Problem of Race: Beginnings to 1900*. New York: Routledge. 2000.

Cultural Competence Standards in Managed Care Mental Health Services: Four Underserved/Underrepresented Racial/Ethnic Groups. Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services. (Available on the internet at www.samhsa.gov/centers/cmhs/cmhs.html)

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(Hispanic/Latino Americans)

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Tice, Carolyn J. and Perkins, Kathleen R. *Mental Health Issues and Aging: Building on the Strengths of Older Persons*. Pacific Grove, California: Brooks/Cole. 1996.

Zarit, Steven H. and Zarit, Judy M. *Mental Disorders in Older Adults: Fundamentals of Assessment and Treatment.* New York: Guilford Press. 1998.

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Office of Minority Health
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United Seniors Health Cooperative
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Fax. (202) 479-6660
E-mail: ushc@unitedseniorshealth.org
Website: www.unitedseniorshealth.org

Internet Resources

Medicare: The Official U.S. Government Site for Medicare Information. www.medicare.gov

Mental Health Association of Southeastern Pennsylvania: Mental Health and Aging. www.mhaging.org

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CHAPTER 3

Project HOPE: Raising Depression Awareness in Georgia's African American Community

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Executive Summary

With Project HOPE, (Healing, Opportunity, Prevention and Education), the National Mental Health Association of Georgia (NMHAG) aimed to increase awareness in Georgia's African American community of the symptoms of and treatments for depression. NMHAG planned to organize community outreach sessions both in the Atlanta metropolitan area and in rural Georgia—where they would provide information on depression as well as offer depression screenings and referrals. They would build up a referral database and collaborate with other existing organizations serving the African American community to encourage these other groups also to promote depression awareness.

Project Goals

- To offer public education on depression to African American audiences in Atlanta and in rural Georgia.
- To provide depression screenings and, where necessary, referrals.
- To develop a referral database of African American practitioners.
- To enter into collaborative partnerships with existing groups that serve African American people.
- To encourage community leaders to develop clinical services for the African American community that are culturally sound in practice.

Introduction

Any attempts to build cultural competency and to reach minority populations in the State of Georgia must confront some serious challenges. Approximately 27 percent of Georgia's population is African American and 71 percent is Caucasian. In the United States, Georgia is the fifth highest ranked state in African American population. At the same time, low utilization rates by African Americans of hospital and community based care suggests that this population is currently underserved.

Unfortunately, statistics have not historically been kept on depression and African Americans to the extent that statistics on depression and Caucasians have been kept. It is known, however, that among health professionals, there has been a consistent under-diagnosis of depression in the African American community. Clinical bias and underreporting of symptoms may contribute to this trend. The lower rates of diagnosis may also be attributed to socioeconomic factors (e.g., limited access to adequate medical care), mistrust of medical

There has been a consistent under-diagnosis of depression in the African American community. Clinical bias and underreporting of symptoms may contribute to this trend.

health professionals, and a reliance on family and the religious community during periods of emotional distress instead of on the traditional western medical establishment.

In a National Mental Health Association survey, 63 percent of African Americans surveyed believed that depression was a personal weakness, compared to the overall survey average of 54 percent. Only 31 percent of African Americans surveyed said that they believed depression was a health problem and only one-third of African Americans said that they would take medication prescribed by a doctor—compared to over 69 percent of the general population surveyed.

Kristine Medea, project director, realizes that as a Caucasian woman she must rely upon African American leadership for direction and guidance.

Program Plan

In the face of these sobering statistics, NMHAG proposed a grant to continue its year-old Project HOPE campaign of providing public education about depression to the African American community throughout the state of Georgia. In its inaugural year, Project HOPE staff had provided direct training to nearly 100 individuals. In addition, these trainings had lead to further "spin-off" sessions that were implemented by Project HOPE program participants.

NMHAG now wished to expand Project HOPE by offering many more trainings throughout metropolitan Atlanta as well as in rural Georgia. They also aimed to provide depression screenings and, when necessary, referrals to African American practitioners. Finally, Project HOPE leaders intended to collaborate with other existing groups serving the African American community to encourage these groups also to promote depression awareness.

Organizational Overview

In April 1999, the Mental Health Association of Georgia and the Mental Health Association of Metropolitan Atlanta merged to create NMHAG. Together, these two organizations had accrued over 100 years of combined experience in mental health education, training and advocacy in Georgia.

With ample experience and many alliances, NMHAG was well-placed to provide more education on depression to more of Georgia's African Americans.

Over these many years of serving mental health consumers and their family members in Georgia, NMHAG had also developed a broad network of professional alliances. To name only some of these professional connections, NMHAG:

- staffed the Mental Health Services Coalition, with over 50 organizational members;
- co-chaired the Time for Community Coalition;
- co-chaired the Georgia Juvenile Justice Coalition;

- chaired the Mental Health Planning Council;
- served on the board of the Georgia Prevention Network;
- served on the Governor's Blue Ribbon Task Force on Community Based Services;
- served on the Medicaid Long Term Care Advisory committee;
- served on the Department on Human Resources' Hospital Closure Oversight Committee

With this ample experience and these many alliances within the mental health community, NMHAG was well-placed to expand Project HOPE to provide continued education on depression to more of Georgia's African Americans.

Implementation

In Project HOPE's second year, Cassandra Landry, program coordinator, presented on depression to some 1,500 individuals.

In Project HOPE's first year, education efforts focused primarily on African American clergy members and providers. In its second year, Cassandra Landry, the project coordinator, chose to reach out to the broader African American community, and her efforts to this end were enormous. In the program's second year, Landry presented on depression to some 1,500 individuals.

Primarily, Landry spoke at health fairs in Atlanta and across the state. She also presented at churches in some lower income areas, noting that "these are the areas where people are more in need because there are fewer resources."

In addition, Project HOPE arranged for Dr. Alvin Poussaint of the Judge Baker Children's Center in Boston and Faculty Associate Dean for Student Affairs at Harvard Medical School to speak at Georgia's Spellman University on African American women and psychotherapy. The event was a remarkable success, with over 200 individuals attending.

Through Project HOPE, 1,200 African Americans were also able to receive depression screenings. Individuals in need of further assistance were then referred to African American practitioners in their area. A referral database with information on African American mental health practitioners throughout the various regions in Georgia was developed in cooperation with the Primary Care Initiative (see Appendix C).

Project HOPE found that one of the most powerful ways to achieve its goals was through developing collaborative partnerships.

Project HOPE quickly found that one of the most powerful ways to achieve its goals was through developing collaborative partnerships. In its second year of operation, the program entered into various cooperative ventures. For example, depression screenings were offered in collaboration with the Georgia Academy of Family Physicians, the Fuqua Center for Late-Life Depression at Emory University, and NMHAG. Project HOPE also partnered with Delta Sigma Theta, a primarily African American national sorority, to bring depression screenings to the African American community.

In another initiative, Project HOPE worked with the Black Nurses' Association, the American Diabetes Association, the Black Cardiologists' Association of Atlanta, and the American Heart Association in order to train a group of twelve physicians in how to offer depression screenings. And in cooperation with the Primary Care Initiative, Project HOPE developed a referral database with information on African American mental health practitioners throughout the various regions in Georgia.

Project Hope's Strategic Partners

The American Diabetes Association

The American Heart Association

The Black Cardiologists' Association of Atlanta

The Black Nurses' Association

Delta Sigma Theta Sorority

The Fuqua Center for Late-Life Depression

Georgia Academy of Family Physicians

It is through these collaborative partnerships that Landry has seen Project HOPE "starting to take on a life of its own." As more and more organizations learn how to conduct outreach from Project HOPE, these groups can then begin to launch depression campaigns and offer screenings on their own. According to Landry, "it's starting with us, but then it's going to fill out and get off the ground… Soon it will be its own project."

Discussion

When considering the provision of mental health services for African Americans, Kristine Medea, Project HOPE's director, likes to give the example of a founder of the American Psychiatric Association who, in the mid-18th Century developed "diagnoses" for African Americans including one called "nigratude." As difficult as it is to even use such language today, it is important to be aware of the depth of institutionalized racism. The "treatment" for this "condition" was to administer beatings.

The question of providing appropriate services to the African American community is inextricably linked to the historic problems of prejudice and racism in this country.

It is no wonder, given the historic abuses that African Americans have faced in this country, that this community would be suspicious of white-dominated mental health systems. Indeed, the question of providing appropriate services to the African American community is inextricably linked to the historic problems of prejudice and racism in this country.

Landry points out that, as an African American, there were regions of southern Georgia that she was loathe to travel to in conducting public education for Project HOPE. "There's so much racism in some regions that that's the first issue that must be dealt with, and improving the quality of mental health care is only secondary."

Landry also gives the example of the training in southern Georgia where she expected 20 nurses to attend and only six arrived, because, she believes, the others were afraid of losing

Cassandra Landry, project coordinator, is a child and adolescent therapist specialized in working with African Americans.

their jobs. "Maybe the hospital where they worked didn't want us giving information on outside referral possibilities," she hypothesizes.

Medea also readily acknowledges that many consumer supporter organizations are run primarily by Caucasians who may be hesitant to provide outreach to the African American community "primarily due to their own concerns about not being able to do it right." But Medea encourages such groups, saying that "they should not be afraid to start programs like this if they are invested in developing culturally competent programs."

The trick, she says, is to "realize that as a white person you can partner in such a project, but you cannot direct." Forming partnerships with African American organizations, and recruiting African American leaders is paramount. "As a white woman, I have to recruit leadership from within the African American community and then listen to that leadership," explains Medea. "It is the community, not me, that knows what is needed for healing."

Conclusion

Because of Project HOPE's many successes, it will continue to be an ongoing program at NMHAG. In the future, Medea and Landry intend to build ever more partnerships with African American organizations, and in particular, they plan to form more partnerships with faith-based organizations. Landry notes that the African American community is "grounded in spirituality." In addition, the two women also wish to extend their outreach further into rural Georgia.

Suggestions for Conducting Outreach to African Americans

- **Don't be afraid to start.**
  Even a predominantly Caucasian organization can do good work—provided it recruits African American leadership.
- **Reach out to the younger generation.**
  College and high school students may be more open to new ideas.
- **Form collaborative partnerships.**
  African American associations, schools, fraternities and sororities can help to get the word out.
- **Work with faith-based organizations.**
  Spirituality is a cornerstone in the African American community.

Additional Resources

Publications

Byrd, W. Michael and Clayton, Linda A. *An American Health Dilemma, Volume One: A Medical History of African Americans and the Problem of Race: Beginnings to 1900.* New York: Routledge. 2000.

Cultural Competence Standards in Managed Care Mental Health Services: Four Underserved/ Underrepresented Racial/Ethnic Groups. Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services. (Available on the internet at www.samhsa.gov/centers/cmhs/cmhs.html)

Mitchell, Angela, et al. *What the Blues Is All About : Black Women Overcoming Stress and Depression*. New York: Berkeley Publishing Group. 1998.

Pouissaint, Alvin and Alexander, Amy. *Lay My Burden Down: Unraveling Suicide and the Mental Health Crisis among African-Americans.* Boston: Beacon Press. 2000.

Villarosa, Linda (editor). *Body & Soul : The Black Women's Guide to Physical Health and Emotional Well-Being*. New York: HarperPerennial. 1994.

Organization

Office of Minority Health
Department of Health and Human Resources
Tel. (800) 444-6472
Email: info@omhrc.gov
Website: www.omhrc.gov

Cultural Competency Toolkit

CHAPTER 4

Oahu's "Mixed Plate" Speakers Bureau

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Paula Heim, Project Director
Kaanoi Kaapana, Public Education Assistant

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Executive Summary

The Mental Health Association in Hawaii (MHAH) used its NCSTAC funding to strengthen its existing speakers bureau by recruiting and training mental health consumers of different cultural backgrounds. Over the course of this project, MHAH recruited eight Native Hawaiian and Asian American consumers, provided them with training in mental health education and advocacy and in developing public speaking skills, and organized engagements for these new leaders to speak and advocate in the community.

Project Goals

- To locate potential leaders in various ethnic groups.
- To provide public speaking and mental health training to consumer leaders.
- To facilitate a series of community speaking engagements.

Introduction

Hawaii, with its long history of hosting immigrant workers, is one of the country's most ethnically diverse states. In the 19th and 20th Centuries, families from the far corners of the globe — Japan, China, the Philippines, Portugal, even Scandinavia — migrated to this chain of islands in the South Pacific to build new lives for themselves as plantation workers. Today, the State Health Department reports the breakdown of ethnicity in Hawaii as 21.9 percent Caucasian, 20.6 percent Hawaiian or part Hawaiian, 19.4 percent mixed Asian, 18.2 percent Japanese, and 12.7 percent Filipino. Chinese, Korean, Samoan, and African Americans make up an additional four percent of the population.

Hawaii, with its long history of hosting immigrant workers, is one of the country's most ethnically diverse states.

Hawaiians take pride in their diverse heritage, and a popular offering at the local eateries remains the "mixed plate"—a sampling of various dishes representative of different local ethnic groups. In this spirit of embracing diversity, MHAH proposed to expand its existing speakers bureau into a "Mixed Plate Bureau," by recruiting and training Native Hawaiian and Asian American consumers in order to reach out to a broader spectrum of Oahu's population.

The speakers bureau was decisive in preventing the closing of the Diamond Head Day Treatment Center, shown here.

Organizational Overview

Before launching the Mixed Plate project, MHAH already had a long and successful history of providing public education and promoting consumer involvement in public policy by empowering consumer volunteers. Founded in 1942, the small but robust organization has been active in Hawaii for 58 years.

In 1998, key projects for the association included working with the Equal Insurance Coverage Coalition, presenting healthcare reform and advocacy trainings, and helping the State Department of Health and the Department of Human Services to establish an ombudsprogram. All of this was accomplished with a staff of five, a volunteer legal counsel, and 18 volunteers serving on the Board of Directors. At the time of this project's inception in 1999, MHAH was also fortunate to be able to draw upon the talents of some 50 consumer volunteers.

Paula Heim, project director, saw the need to reach out to Oahu's Asian-American and Hawaiian Native communities.

The Oahu Speakers bureau, the foundation for this project, was already a thriving, active body. In 1998, the bureau, comprised entirely of consumer volunteers, presented talks to over 4,000 people to reduce the persistent and destructive myths surrounding mental illness. In applying for this grant, however, Paula Heim, the project director, saw the need to reach out with this bureau to Oahu's Asian American and Hawaiian Native communities.

Implementation

In May and June, MHAH invited interested consumers to join the speakers bureau by publicizing a series of training workshops for potential bureau members. Notice of the workshops was included in the association's quarterly newsletter, and faxes were sent to local community mental health centers and clubhouses. A sample recruitment flyer is included in the appendices. Initially, ten consumers were recruited, and eight of these individuals completed the entire training agenda to become active members of the speakers bureau.

Kaanoi Kaapana, MHAH's public education assistant developed the four educational workshops designed to teach interested consumers how to become savvy mental health advocates. Workshops, which lasted from two to six hours, provided an overview of the mental health system in Hawaii and gave consumers opportunities to develop their public speaking and presentation skills.

Immediately after completing their trainings, the new Mixed Plate Speakers Bureau took on a rigorous agenda of public education and advocacy. From October 2000 through January 2001, they offered twelve presentations at local high schools, universities, television programs and churches serving Asian Americans and Native Hawaiians.

Besides providing an overview of mental illnesses and discussing the available health services in Oahu, speakers also tackled many cultural misconceptions about mental illnesses — explaining that these diseases are not the results of sin or weakness. Just how the

Speakers Bureau Presentation Schedule

Date	Location	Audience
10/09/00	Local restaurant	Religious leaders
10/20/00	Trinity Broadcast (TV 26)	Christian
10/26/00	Trinity Broadcast (TV 26)	Christian
11/02/00	Farrington High School	Adolescents
11/03/00	Mid-Pacific Institute	Adolescents
11/09/00	Moanalua High School	Adolescents
11/15/00	Nanakuli High School	Adolescents
11/16/00	Hawaii Baptist Academy	Adolescents
11/22/00	Kamehameha School	Adolescents
11/27/00	First Christian Church	Church outreach
01/17/01	Nanakuli High School	Adolescents
02/02/01	St. Andrew's Cathedral	Symposium
02/07/01	University of Hawaii	Graduate students

bureau tailored its approaches to different ethnic communities will be explored more fully in the discussion section.

Speaker bureau members also jumped feet-first into public advocacy with the impending closing of the Diamond Head Life-Skills and Mental Health Treatment Services Center, a local community treatment program providing a vast array of services to mental health consumers from dental treatment to emergency assistance to life-skills training. According to Heim, bureau members "lobbied vigorously" in the media and at legislative meetings against the closing of Diamond Head, and due to their efforts the Center is still open and running today.

Finally, Heim also called upon speakers bureau members to assist in MHAH's voter empowerment project, an effort to register mental health consumers to vote and to provide public education on candidates and policy issues.

Discussion

Brian Oishi, a Hawaiian of Japanese descent and a member of the Mixed Plate Speakers Bureau, has a story he loves to tell: When he first started experiencing psychiatric symptoms as a young man, he went to his Auntie and asked her for help. His Auntie heard him out and then told him not to worry, because in a week he would receive the help he needed.

To find a common ground that respects traditional values while still addressing consumers' medical needs is the challenge of cultural competency.

Oishi was relieved and eagerly waited for the promised cure only to be presented, after a week, with a cucumber. Etched on the cucumber were characters in Japanese. His Auntie explained to him that he was supposed to rub the cucumber over his head and he would get better.

"You can imagine my disappointment," says Oishi, when he retells this story. "I had been waiting a week and I thought I would get better, and all I got was this cucumber. But I knew that I had serious problems and I knew that I needed some kind of real medicine."

Oishi ended up "rebelling" by seeking Western medical attention for his mental health problems. He credits this medical attention with allowing him to be the capable consumer advocate that he is today.

Kaapana, also a mental health consumer and of Native Hawaiian descent uses remarkably similar language: "I rebelled to get the help I needed." In traditional Hawaiian culture, she explains, problems are addressed through spiritual healing and through a tradition of "open discussion" which "always takes place only within the family." Prayers and rituals are used, "but no one consults a professional psychiatrist. It is a matter of pride and respect to solve problems only within the family."

"The Mixed Plate Speakers Bureau workshops empowered me with the confidence, ability and desire to take action through testimony and advocacy."

—Charlene Ryerson, speakers bureau member

Finding common ground

To find a common ground that respects traditional values while still addressing the very real medical needs of people with mental illness is the challenge of cultural competency. For Heim, who is herself part Chinese American and part Hawaiian, and for Kaapana, discovering how best to reach out to Hawaii's various ethnic communities has been an ongoing process.

They cite numerous examples of cultural attitudes that could possibly present a barrier to seeking mental health services. In general, states Heim, "there is still a lot of distrust among Asian Americans of western medicine. Some societies in Hawaii see mental illness as a punishment by God. It is therefore considered a shame to the family to be mentally ill—especially among the Japanese, for example, it is shameful to even speak of mental illness."

Or in the Chinese culture, drawing any attention to oneself—even when asking for help—can be considered "boasting." "The younger generation," says Heim, "is supposed to learn by listening and watching. Asking questions is not required or welcomed."

But Heim, Kaapana and the members of the speakers bureau have found ways to bring their message to diverse groups. Heim says that because of the stigma surrounding mental illness, one of the main focuses of public education must be simply, gently "to try to get people to acknowledge to themselves that something is wrong." Once individuals can take this step, and once they see the example of speakers bureau members living productive lives of recovery, they can be encouraged to seek the help they need.

MHAH has learned to take advantage of the traditional leadership provided by members of the older generation, the "kupuna."

In working with the Native Hawaiian population, Kaapana has learned to take advantage of the traditional leadership provided by members of the older generation, the "kupuna." "We always go to the kupuna first and explain what we're doing before doing outreach." Once a public presentation has received the nod from the kupuna, it is far more likely to be attended and accepted by other community members.

Culture, not language

Initially, MHHA proposed to provide public education materials in different Asian languages as part this project. They collected informational brochures produced in Chinese from SmithKline Beecham but soon discovered that paying to translate materials would be prohibitively expensive.

Members of the Mixed Plate Speakers Bureau represent Hawaii's various native and Asian-American communities.

At the same time, they found that providing translated materials to Oahu's Asian communities was not really necessary. As opposed to mainland Asian American communities, "most people are second, third, fourth or even later generation Americans," Heim explains. Usually, English is spoken as a second language in the home." Consequently it is more a cultural than a language barrier that public educators in Hawaii must bridge.

Conclusion

Thanks to the funding this grant has provided, the Mixed Plate Speakers Bureau will continue to thrive. To date, three new consumers have been recruited in addition to the eight already in the program. With an additional grant opportunity from the National Institutes of Mental Health, MHAH will also expand the speakers bureau into a faith based community outreach program in cooperation with Pacific Health Ministry and community religious leaders. In this way, MHAH can continue to serve its ethnically diverse population while being respectful of its rich cultural heritage.

Additional Resources

Publications

(Asian Americans)

Takaki, Ronald. *Strangers from a Different Shore: A History of Asian Americans.* Boston: Little, Brown. 1998.

Tuan, Mia. *Forever Foreigners or Honorary Whites?: The Asian Ethnic Experience Today.* New Brunswick, New Jersey: Rutgers University Press. 1998.

Uba, Laura. *Asian Americans: Personality Patterns, Identity, and Mental Health.* New York: Guilford Press. 1994.

Zia, Helen. *Asian American Dreams: The Emergence of an American People.* New York: Farrar, Straus, and Giroux. 2000.

(Native Hawaiians)

Gallimore, Ronald. *Culture, Behavior, and Education: A Study of Hawaiian-Americans.* Beverly Hills, California: Sage Publications. 1974.

Kape'Ahiokalani Maenette et al. *Culture and Educational Policy in Hawaii: The Silencing of Native Voices.* Mahwah, New Jersey: L. Erlbaum Associates. 1998.

Native Outreach: A Report to American Indian, Alaska Native, and Native Hawaiian Communities. Bethesda, Maryland: National Institutes of Health and National Cancer Institute. 1999.

Organizations

Bernice Pauahi Bishop Museum
The State Museum of Natural and Cultural History
1525 Bernice Street, Honolulu Hawaii 96817-2704
Tel. (808) 847-3511 Website: www.bishop.hawaii.org

The Chinese Chamber of Commerce in Hawaii
42 N. King Street, Honolulu, Hawaii 96813
Tel. (808) 533-3181 Fax. (808) 533-6967
Email: info@ccchi.org Website: www.ccchi.org

Office of Minority Health
Department of Health and Human Resources
Tel. (800) 444-6472 Email: info@omhrc.gov
Website: www.omhrc.gov

SmithKline Beecham provided educational materials in Chinese.

Internet Resources

The Evolution of Identity in Hawaii: A Group Independent Study Project, http://www.brown.edu/Students/Brown_Hawaii_Club/HI_GISP/Index.html

Hawaiian Cultural Preservation Association, http://hawaiiancultural.org

Cultural Competency Toolkit

CHAPTER 5

The Consumer Involvement Project

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Tom Lane, Project Director

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Executive Summary

Discrimination against people with mental illness is rampant in New Mexico, but few consumers in the state are involved in self-help, advocacy and empowerment activities. NAMI-New Mexico (NAMI-NM) proposed to encourage consumer participation throughout the state by offering a series of workshops at seven different sites. In these workshops, participants would determine what consumer-run efforts they wished to undertake in their own regions. NAMI-NM would then provide continuing technical assistance as participants launched these initiatives.

Project Goals

- To offer consumer empowerment workshops at seven sites across New Mexico.
- To encourage workshop participants to start local empowerment projects.
- To provide follow-up technical assistance for these projects.

Introduction

Mental health services in New Mexico have historically promoted "learned helplessness," and although some programs are beginning to shift their basic approach to empowerment models, there is a tremendous need to replicate these programs across the state. New Mexico lacks basic mental health services, and consumers often wait two to three years to qualify for disability benefits and, therefore, for Medicaid. Only a handful of consumers have involved themselves in a decision making-capacity across the state.

New Mexico lacks basic mental health services, and consumers often wait two to three years to qualify for disability benefits and, therefore, for Medicaid.

The impact of managed care on behavioral health services in New Mexico is basically unknown, due to lack of data from behavioral health organizations, but it is generally understood to have been short on service and long on profit. Several providers have closed their doors, case management services are in short supply, and there appears to be a pattern of denied hospitalizations. Advocates for mental health services are focused more on maintaining existing services, and less on expanding or assessing the quality of services.

Public forums

Results of public forums held among six regional clusters of communities indicate that discrimination against people with a mental illness is rampant in New Mexico. Sparse and non-existent services, refusal by insurance companies to pay for necessary medical needs,

refusal by employers to hire persons with a mental illness, and reluctance by landlords to rent to people with mental illness are manifestations of this prejudice.

Out of the six clusters, only two had short-term, acute psychiatric facilities for people in crisis. Las Vegas Medical Center is the only long term, psychiatric facility for the entire state; and its purpose is misunderstood by many. In addition to the confusion about who benefits from the services in Las Vegas, clients and family members have complained about difficulty in gaining access to the facility, the numbers of persons turned away, and the expense involved — including the transportation costs and time needed to travel there and back.

Results of public forums held among six regional clusters of communities indicate that discrimination against people with a mental illness is rampant in New Mexico.

In the forums, the expressed need for education about mental illness, treatment, recovery and how to access available services was unanimous. By increasing efforts in these two areas, people believed that other concerns such as housing, employment, transportation and education would be addressed.

The need for ongoing support by the Department of Health and NAMI-NM to develop consumer and family groups was prioritized, as was a central clearinghouse for statewide information and contacts. The clearinghouse was also needed to help provide a safety net for people in crisis, as well as to offer information to providers, clergy, first responders and other community service providers.

More individuals in New Mexico are in jail, (20,200), than are in treatment (20,000). Just one in eight children and one in four adults with mental illness are receiving treatment.

Demographic profile

There are 1.6 million people in New Mexico. Most of the state is rural, and some counties are categorized as frontier due to their sparse population. The New Mexico Department of Health estimates that there are 88,000 adults and 44,000 children who have severe, chronic mental illness in New Mexico.

Project Sites

- Alamogordo
- Albuquerque
- Farmington
- Gallup
- Las Cruces
- Roswell
- Santa Fe

Sadly, more individuals in New Mexico are in jail, (20,200), than are in treatment (20,000). Just one in eight children and one in four adults with mental illness are receiving treatment. Although the number of persons who are uninsured who have mental illness is not known, one in four of the population statewide lacks health insurance. Thirty of 33 counties in New Mexico are medically underserved.

Poverty rates are equally high - one in three children lives in poverty in New Mexico, and one in four adults. The percentage of persons with mental illness who live in poverty is unknown. The rate, however, is no doubt high due to the forced state of poverty that persons must live in who receive disability benefits.

Transportation and lack of medical services are barriers for most people in the state. There are no effective public transportation systems in New Mexico, with the exceptions of limited safe ride services and of minimal bus service in Albuquerque.

With the largest Hispanic/Latino population in the United States (38 percent), 28 Native American pueblos (nine percent), a small African American population (three percent), and a broadly dispersed population of Anglos (50 percent), New Mexico offers a culturally diverse pool of committed individuals who can work together for change.

NAMI-NM works to improve the lives of the over 200,000 citizens in the state who either live with mental illness or who share in the burdens imposed by these diseases.

Program Plan

Through its Consumer Involvement Project, NAMI-NM proposed to stimulate consumer involvement and advocacy across the state by offering a series of consumer empowerment workshops. The workshops would take place at seven sites across the state, and would encourage participants to launch local advocacy projects and consumer services. Once these projects were launched, the Consumer Involvement Project would continue to provide ongoing technical assistance.

Organizational Overview

NAMI-NM is a chapter of the national organization, National Alliance for the Mentally Ill. According to its mission, "advocacy, education and information," NAMI-NM works to improve the lives of the over 200,000 citizens in the state who either live with mental illness or who, as family members and caregivers, share in the burdens imposed by these diseases. NAMI-NM works closely with state agencies and state legislators to develop policies that will enhance the well-being of people with mental illness.

NAMI-NM has a twelve-person board with members from across the state. Seven members are women and five are men, and three members are mental health consumers. Ages range from the early twenties to the mid-seventies, and one member of the board is Hispanic while another member is African American.

NAMI-NM collaborates regularly with a network of 14 NAMI affiliates in New Mexico. Affiliates conduct regular, ongoing support groups and periodic educational meetings. The Family-to-Family program is a twelve-week education course offered to families free of charge. Through the anti-stigma project, NAMI provides public education to community-based groups, businesses, and the criminal justice community. In addition, NAMI trains treatment guardians, judges and physicians in 13 judicial districts on types of illnesses, appropriate treatment, ethics and confidentiality. NAMI also administers jail diversion programs in Albuquerque and in Dona Ana County.

Implementation

The Consumer Involvement Project started with a series of one, two or three workshops offered to consumers at seven different sites across the state of New Mexico. Workshops were advertised through the local media, and Tom Lane, the project director, also contacted local service agencies so that they could invite their clients to participate.

Altogether, some 150 consumers of various ethnicities across the state attended trainings, and materials were provided both in English and in Spanish.

Altogether, some 150 consumers of various ethnicities across the state attended trainings, and materials were provided both in English and in Spanish.

Says Tom Lane, "we would go into the community, present an overview of what consumer involvement could look like — from drop-in centers to newsletters to becoming involved in advocacy — and then we would encourage people to launch projects on their own."

The next phase of the project entailed providing technical assistance and guidance to consumers as they took Lane up on the challenge to get involved. In many cases, trainees decided to become involved with existing organizations. Various trainees joined local NAMI affiliates and other consumer supporter organizations. Some participants joined state Regional Advisory Committees, and one consumer joined the state Protection and Advocacy Agency's Advisory Council.

Other sites actually launched projects. In Albuquerque and in Las Cruces, members of the Consumer Involvement Project started consumer-run drop-in centers. Another site, as of this writing, is attempting to establish a warm-line. In Farmington, a group produced a video in a Native American language.

Lane also encouraged consumers to network with existing organizations for assistance in project development and management.

In Albuquerque and in Las Cruces, members of the Consumer Involvement Project started consumer-run drop-in centers.

Project Partners

- The Counseling Center
- Counseling Associates
- Life-Link, providing housing support
- New Mexico State Behavioral Health Services
- New Mexico State Division of Vocational Rehabilitation
- Pathways, a psychosocial rehabilitation program
- Santa Fe Community Guidance
- St. Martin's, providing services to the homeless
- University of New Mexico Mental Health Center

Discussion and Conclusion

Launching the Consumer Involvement Project entailed a great deal of "proactive outreach," according to Lane. New Mexico is a largely rural state, and the project director logged in "many, many miles" travelling from one project site to another.

In particular, Lane describes the effort to reach the Native American community as "a challenge...Native providers are on reservations and they can be hard to reach." Nonetheless, Native American consumers did attend the trainings, and the project was also able to include a Native speaking hotline in its resource list.

Although New Mexico's Consumer Involvement Project reached out to the state's Native American and Hispanic/Latino communities, the main focus group of the project, ultimately, were individuals with mental illness. Cultural competency need not extend merely to peoples of various ethnicities. The term applies equally well to consumers of mental health services.

Speaking as a consumer, Lane says that the project was "a nice opportunity for me to shift from receiving services to offering services. It was a big part of my own recovery to shift roles in this way."

Although the Consumer Involvement Project, *per se*, will finish at the end of this grant cycle, it has nonetheless enabled many other consumers to begin to make this shift from receiving services to providing assistance to others in need. Most importantly, the projects initiated at each of the seven sites, thanks to the guidance provided by the Consumer Involvement Project, will continue to serve New Mexico's consumer population.

Cultural competency need not extend merely to peoples of various ethnicities. The term applies equally well to consumers of mental health services.

Additional Resources

Publications

(Hispanic/Latino Americans)

Augenbraum, Harold et al. *Growing Up Latino: Memoirs and Stories*. Boston: Houghton Mifflin. 1993.

Garcia, Jorge and Zea, Maria (editors). *Psychological Interventions and Research With Latino Populations*. Boston: Allyn and Bacon. 1997.

Olmos, Edward (editor). *Americanos: Latino Life in the United States.* Boston: Little, Brown. 1999.

Padilla, Felix. *Latino Ethnic Consciousness: The Case of Mexican Americans and Puerto Ricans in Chicago.* Notre Dame, Indiana: University of Notre Dame Press. 1985.

(Native Americans)

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O'Nell, Theresa. *Disciplined Hearts: History, Identity, and Depression in an American Indian Community*. Berkeley, California: University of California Press. 1996.

Organizations

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Cultural Competency Toolkit

CHAPTER 6

The Mental Health/ Aging Advocacy Project

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Tom Volkert, Project Director

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Executive Summary

Philadelphia has one of the highest percentages of older adults in major cities in the United States, yet only serves approximately two percent of the older adults who need mental health services. The Mental Health Association of Southeastern Pennsylvania (MHASP) proposed to address this great disparity by building upon its Mental Health/Aging Advocacy Project, first initiated 1998. MHASP planned first to train elderly consumer/caregiver advocates and then to approach providers and insurers to demand that appropriate services be made available for older adults.

Project Goals

- To develop materials and train at least five older adult leaders.
- To contact senior groups and offer presentations on mental health aging and advocacy.
- To organize and conduct follow-up with small group sessions.
- To follow up with monthly contacts to these small groups.
- To advocate for accessible and appropriate mental health services.

Introduction

More than five million Americans age 65 and older—nearly one in six—suffer from the serious, persistent symptoms of depression, while another million have major clinical depression, an immobilizing disorder that can lead to suicide. In fact, from 1980 to 1992, suicide rates rose by nine percent among all Americans 65 and older and by 35 percent among those aged 80 to 84. The suicide rate of the elderly currently stands at an alarming 21 percent, the highest rate for any age group in the United States. Every day, 17 older Americans take their own lives. Only a small percentage of those deaths are believed to indicate a well-reasoned escape from an incurable, debilitating illness.

At the same time, the number of elderly people in America is growing. In 1990, one in 25 Americans was 65 and over; by 1994, one in eight fell in this category. This is a pattern of growth that will continue well into this century.

Between 18 and 25 percent of elderly persons in general—and a staggering 66 percent of nursing home inhabitants—experience some form of mental illness.

This means that the number of older Americans who have mental illnesses will also grow. Between 18 and 25 percent of elderly persons in general—and a staggering 66 percent of nursing home inhabitants—experience some form of mental illness. These range from depression, anxiety, bereavement adjustment problems and substance abuse to schizophrenia, personality disorders, paranoia, compulsive behaviors and dementia.

However, older adults with mental illness tend to be unrecognized, undiagnosed and untreated. Elders account for only seven percent of all inpatient psychiatric services, six percent of community mental health services and nine percent of private psychiatric care. In fact, less than three percent of all Medicare reimbursement goes to psychiatric treatment.

The sad irony is that most mental illness in older adults is treatable. For instance, depression studies have shown that a combination of medication and therapy can result in significant improvement for 80 percent of older adults who receive treatment.

Serving elderly persons with mental illness has not been a high priority for most mental health agencies.

Serving elderly persons with mental illness has not been a high priority for most mental health agencies. Services are usually fragmented among the health, mental health, and human services agencies, resulting in problems in providing coordinated and appropriate services. In addition, very few professionals in mental health agencies are specifically trained to serve this population.

In addition, many obstacles — including physical disabilities, social isolation, lack of transportation, the stigma attached to psychiatric care, a fractured mental health system that requires a 50 percent co-pay for outpatient mental health treatment and the complex nature of mental illness in older adults — negatively impact attempts to serve elderly persons with mental illness. Older adults of minority cultures face the additional barriers of poverty, language, or racial, cultural or ethnic bias.

A half-million plus individuals over 65 live in Southeastern Pennsylvania, 33 percent of whom represent minority populations. Of that group, almost 30,000 have incomes low enough to make them eligible for Medicaid.

A half-million plus individuals over 65 live in Southeastern Pennsylvania, 33 percent of whom represent minority populations. Of that group, almost 30,000 have incomes low enough to make them eligible for Medicaid. The 1990 census of Philadelphia showed 19 percent of the population to be over 65. Yet a recent study by the Philadelphia Office of Mental Health showed that out of 55,000 people served in 1998, only 3,000 were older adults.

Program Plan

To help overcome these barriers, the Mental Health Association of Southeastern Pennsylvania (MHASP) saw the need for an informed and organized constituency — including older adult consumers and their caregivers and family members — to advocate for the services required. In order to advocate for appropriate and accessible services for all older adults in the area, MHASP proposed a two-pronged effort to reach out and empower older persons and their friends to educate mental health service providers through its Mental Health/Aging Advocacy Project.

First, the program would contact older adults, caregivers and advocates in order to address issues of ageism, mental health stigma, and lack of services. MHASP would teach these older adults how to get help and how to join with other people to develop a voice advocating for improved services. The project would form an active network of older consumers and caregivers to implement the new skills.

MHASP proposed to teach older adults how to get help and how to join with other people to develop a voice advocating for improved services.

Second, the project would also collaborate with the Delaware Valley Mental Health/Aging Advocacy Committee to establish systematic contact with providers, insurers, government officials and others who serve the elderly; would raise awareness of the need to provide culturally competent services to older adults; would provide relevant information on mental health and aging; and would urge all providers to develop mental health and aging committees. Specifically, MHASP proposed to have consumers/providers make presentations to the County Offices of Mental Health in two counties and meet with at least two major insurance companies to succinctly present a program of mental health needs of the elderly.

Older adults Madelyn Glover and Eleanor Campbell present as part of a panel on Mental Health and Aging in June 2000.

MHASP's Mental Health/Aging Advocacy Project was already active in the North Philadelphia region at the time of this grant proposal, and they proposed to expand their activities to a five-county region with the help of NCSTAC funding.

Organizational Overview

MHASP is an advocacy, service and education association founded in 1951 to help improve the lives of people with mental illnesses. Its president and chief executive officer, Joseph A. Rogers, is nationally recognized as a leader in the consumer movement.

MHASP employs more than 250 people, many of whom are consumers of mental health services. It has been actively involved in providing community-based support programs and services for people with mental illnesses since 1984 and today operates more than 30 such programs in Philadelphia and its surrounding counties.

MHASP is an affiliate of the National Mental Health Association, and supports its activities on behalf of people with mental illnesses. MHASP is also a member agency of United Way of Southeastern Pennsylvania.

Implementation

The Mental Health/Aging Advocacy Project's efforts were prodigious in this grant cycle. Altogether, MHASP trained seven older adults to be mental health advocates, and four of these individuals were themselves consumers.

Further, MHASP met with eight senior center coordinators in the Philadelphia area and in Delaware County. They developed training materials, gathered information on continuum of care, set up trainings for drop-in center staff, and also developed a legislative action page on their website at www.mhaging.org. They offered two day-long trainings, and they visited three senior centers and offered large group presentations. MHASP also arranged monthly gatherings of seniors and senior leaders.

MHASP developed training materials, gathered information on continuum of care, set up trainings for drop-in center staff, and also developed a legislative action page on their website at www.mhaging.org.

MHASP further implemented two sets of five-day advocacy trainings at senior centers, with some commendable outcomes: On the fifth day of these trainings, participants were asked to write an advocacy letter. Locally, one of the hot issues at the time of the trainings was the need to establish a geriatric specialist for district clinics. Participants wrote on this subject to the local commissioner of health, who later moved to establish just such a position.

MHASP's senior leaders moved quickly into the role of public advocacy. Three older adults trained by MHASP testified at the Office of Mental Health yearly public hearing in Philadelphia, while another project participant spoke out at a similar meeting in Delaware.

Six Mental Health Problems of Older Adults

1. Depression—occurs in 5-30 % of older adults
2. Suicide—17 older adults take their lives each day
3. Anxiety—occurs in 10-20% of older adults
4. Dementia—10% of older adults have dementia
5. Alcoholism—occurs in 5-10% of older adults
6. Misuse of medication—thought to be common

Discussion

Primarily, Tom Volkert, the project director, reported two types of barriers in his attempts to recruit and educate senior leaders. The first were some of the typical effects of aging, "such as difficulty in hearing, writing, and reading, which made it difficult to engage older people in advocacy work." Secondly, Volkert also found that his presentations had to compete with other senior center activities, such as bingo, and it was not always easy to persuade people to give up their favorite pastimes in order to attend a presentation on mental illness.

The main trick to overcoming the first of these barriers, said Volkert, was "being persistent—reading materials to people, moving away from written materials, (or engaging in) role playing." According to Volkert, "these strategies seem to work." He also found it worthwhile to try "to make 'mental health jargon' more simple, understandable and clear."

Similarly, attrition was a challenge Volkert faced as some senior leaders had to step back from their advocacy roles due to health problems. Consequently, the Mental Health/Aging Advocacy Project had to be adept at working with changeover in leadership.

Attrition was a challenge, project director, Tom Volkert faced as some senior leaders had to step back from their advocacy roles due to health problems.

In order to pique seniors' interest in learning about mental health, Volkert chose to focus on topics that were of particular interest to all seniors—not just those with mental health problems. For example, said Volkert, "the topic of prescription meds has been a hot topic, and people have become very engaged in that issue."

In sum, Volkert learned to "adapt the mental health message to older adults and work on their time-line."

Conclusion

Many mental health needs of the elderly continue to go unmet, and MHASP's Mental Health/Aging Advocacy Project will persevere in addressing these problems. In the future, Volkert plans to visit HMO's together with senior leaders to discuss some of the inequities in mental health provisions for elderly patients. He anticipates that this initiative will be "confrontational and difficult," but he is prepared to take the step nonetheless.

A delegation of consumers and advocates meet with State Senator Tilghman to discuss mental health and aging issues.

Additional Resources

Publications

Fogel, Barry S., Furino, Antonio and Gottlieb, Gary L. *Mental Health Policy for Older Americans: Protecting Minds at Risk.* Washington, D.C.: American Psychiatric Press. 1990.

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Zarit, Steven H. and Zarit, Judy M. *Mental Disorders in Older Adults: Fundamentals of Assessment and Treatment.* New York: Guilford Press. 1998.

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E-mail: ushc@unitedseniorshealth.org
Website: www.unitedseniorshealth.org

Internet Resources

Medicare: The Official U.S. Government Site for Medicare Information. www.medicare.gov/

Mental Health Association of Southeastern Pennsylvania: Mental Health and Aging. www.mhaging.org

Cultural Competency Toolkit

CHAPTER 7

Outreach to Seniors

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Executive Summary

Aiken County, South Carolina is rated as one of the top 100 places to retire in the United States, but local mental health services to the elderly are not sufficient for this high population of senior citizens. While eleven percent of the people residing in the area are seniors, only four percent of the consumers served by the local mental health service agency are of this age group. The Mental Health Association in Aiken County (MHAAC) proposed to confront this problem by forming a Seniors Task Force made up of local mental health organizations, organizations providing services to older Americans, and mental health consumers and caregivers. This task force would discuss how best to improve mental health services to Aiken County's senior citizens, and would then act upon these recommendations.

Project Goals

- To form a Seniors Task Force of elder-serving agencies, consumers, family members, caregivers and other interested parties.
- To follow the recommendations set by the task force.

Introduction

Aiken County, South Carolina is rated as one of the top 100 places in the United States to retire, and accordingly the region is home to a substantial elderly population. Yet research conducted by the Aiken-Barnwell Mental Health Center (ABMHC), the county's public, outpatient mental health provider, suggests that county mental health services to the elderly are lacking.

Aiken County, South Carolina, rated one of the top 100 places in the United States to retire, is home to a substantial elderly population.

ABMHC offers a traditional range of services including psychiatric evaluations, medication management, case management, crisis intervention, and outpatient therapy and psychosocial rehabilitation, to people of all ages and functional levels. For the most part, this organization does a very competent job of meeting the community's needs and it has received high marks in consumer satisfaction surveys.

As a function of its quality improvement process, ABMHC evaluates its service delivery in light of accessibility, secondary and tertiary consumer satisfaction, and effectiveness and efficiency of services. This evaluation process, which entails a minimum of one major satisfaction survey and one needs assessment conducted annually, involves a review of internal clinical and administrative data; input from consumers, families, agencies, and ABMHC staff; and comparison of ABMHC demographics with county and state demographics.

In the two years preceding this grant proposal, reviews of ABMHC's services and operations revealed services to the elderly to be an area of concern. While eleven percent of the people residing in ABMHC's catchment area were 65 years old or older, only four percent of the consumers served by the organization were of this age group. ABMHC did not have any programs or services designed specifically for the elderly, nor did it employ a geriatric mental health specialist.

At the time of this grant proposal, Aiken's public mental health provider did not have any programs or services designed specifically for the elderly.

Members of the Aiken Senior Task Force

- Aiken Area Council on Aging
- Aiken-Barnwell Mental Health Center
- Aiken County Coroner's Office
- Aiken Psychiatric Associates
- Aurora Pavilion
- Cornerstone Baptist Church
- Department of Health and Environmental Controls
- Department of Social Services
- Edengardens of Aiken
- Lower Savannah Council of Government
- Mental Health Association of Aiken County
- Parker's Community Center
- Pepperhill Nursing Center
- Shadow Oaks
- Southern Home Care Services
- Vocational Rehab
- We Care

Program Plan

MHAAC proposed to confront the problem of insufficient mental health services for senior citizens in its area by forming a Seniors Task Force made up of local mental health organizations, organizations providing services to older Americans, and mental health consumers and caregivers. This task force would discuss how best to improve mental health services to Aiken County's senior citizens, and would then act upon these recommendations.

Organizational Overview

MHAAC began in 1967 as a volunteer organization dedicated to improving services to people with mental illness, removing the stigma of mental illness, and promoting good mental health. One of twenty affiliates of the National Mental Health Association in South Carolina, MHAAC has been recognized with a number of local awards and honors, including receiving the Outstanding Affiliate Award by the state mental health association five times in ten years.

MHAAC's primary focus is the improvement of quality of life for persons with serious mental illness through advocacy and direct intervention. When deinstitutionalization became South Carolina's policy of dealing with many of the state's severely and persistently mentally ill consumers, this mission took on increased urgency. Assimilation of consumers into the mainstream of the community has become one of MHAAC's primary goals.

Accordingly, MHAAC has developed a number of programs and events to support persons with mental illness residing in Aiken County. These included, "A Place of Our Own" Drop In Center, where consumers can socialize, partake in leisure activities, learn psychosocial and employment skills, and get additional support as needed; Operation Santa, which ensures that adults with mental illness living in the community and adolescents in state hospitals receive gifts and a holiday meal at Christmas; the Consumer Trust Fund to provide consumers with assistance in budgeting, financial management and banking; and onsite leisure and socialization activities provided at local community care homes. In addition, MHAAC provides transportation for consumers in Aiken County, since the public transportation system is almost non-existent.

Implementation

MHAAC's first step in implementing this project was to invite elder-serving agencies in the area to join a senior task force to review mental health needs of Aiken County 's senior population. MHAAC was enormously successful in this endeavor, managing to bring together some 45 representatives of 17 different organizations who then met regularly, twice per month. Senior caregivers from different agencies, including consumers, family members and professionals throughout the Aiken County community gathered to evaluate the mental health and related needs of seniors, to identify barriers to seniors getting their mental health needs met, and to develop a plan to address those needs and barriers.

Senior caregivers from different agencies — including consumers, family members and professionals — gathered to evaluate the mental health needs of area seniors.

The task force decided initially to focus on providing public education on the mental health needs of seniors. In cooperation with the City of Aiken, they planned and organized a half-day "Senior Spectacular," emphasizing mental and physical health during the aging process. Seniors and other interested persons who attended could gather educational materials, visit interactive exhibits, attend speeches, fill out a needs assessment survey (to be used later by the task force), participate in screenings, and enjoy food and prizes.

Discussion and Conclusion

Aiken County's Senior Task Force provided a forum where leaders in the mental health community were able to exchange valuable insights and ideas. Mostly, the group concurred that misconceptions about senior citizens' mental health needs abound. Says Constance Shepard, project director, "there is a great deal of public education that still needs to be done concerning older adults and mental health. Many people — including treatment providers — think that depression is just a part of growing old. They don't realize that older adults can be successfully treated just like anyone else."

"Many people think that depression is just a part of growing old. They don't realize that older adults can be successfully treated just like anyone else."

— Constance Shepard, project director

Shepard readily acknowledges that getting the task force off the ground was much more difficult than she had anticipated. "It took more time than I expected for the group to gel… In the beginning, everyone was invited to participate, but it took a little while to learn which groups were really serious about participating and contributing." Some advice she offers to others attempting to replicate this project: "It is best to make it clear what it means to collaborate from the beginning." In this way, organizations can honestly evaluate whether they truly have the time and resources needed to participate.

But now that the Aiken County Senior Task Force is a stable, functioning group, its work will continue beyond this grant period. Based upon the results of the needs assessment distributed at the Senior Spectacular, the task force will be setting new goals for improving mental health services to the elderly in Aiken County. In particular, the Aiken-Barnwell Mental Health Center, Aiken Psychiatric Associates, and Aurora Pavilion of Aiken Regional Medical Services intend to take a leadership role in improving mental health service delivery.

The task force will also be turning to the broader question of providing culturally competent services to older Americans of diverse ethnic backgrounds. At the time of this writing, task force members were planning an upcoming "Aging and Mental Health: Facts and Fiction" conference that would include a discussion on cultural competency. Additionally, they were planning to offer a county-wide cultural competency training in the near future.

A King and Queen are crowned at the Senior Spectacular.

Additional Resources

Publications

Fogel, Barry S., Furino, Antonio and Gottlieb, Gary L. *Mental Health Policy for Older Americans: Protecting Minds at Risk.* Washington, D.C.: American Psychiatric Press. 1990.

Gatz, Margaret (editor). *Emerging Issues in Mental Health and Aging.* Washington, D.C.: American Psychological Association. 1995.

Knight, Bob. *Outreach With the Elderly: Community Education, Assessment and Therapy.* New York: New York University Press. 1989.

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Tice, Carolyn J. and Perkins, Kathleen R. *Mental Health Issues and Aging: Building on the Strengths of Older Persons*. Pacific Grove, California: Brooks/Cole. 1996.

Zarit, Steven H. and Zarit, Judy M. *Mental Disorders in Older Adults: Fundamentals of Assessment and Treatment.* New York: Guilford Press. 1998.

Organizations

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Website: www.aagpgpa.org

United Seniors Health Cooperative
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Tel. (202) 479-6973
Fax. (202) 479-6660
E-mail: ushc@unitedseniorshealth.org
Website: www.unitedseniorshealth.org

Internet Resources

Medicare: The Official U.S. Government Site for Medicare Information. www.medicare.gov

Mental Health Association of Southeastern Pennsylvania: Mental Health and Aging. www.mhaging.org

Cultural Competency Toolkit

CHAPTER 8

Project Intercultural Connection: Meeting Asian Americans' Mental Health Needs

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Executive Summary

Despite the pervasive stereotype that Asian Americans are relatively well-adjusted individuals who encounter few psychological difficulties, mental illnesses among Asian Americans are actually common and this group has a rate of psychopathology, including depression and psychotic disorders, equal to or higher than European Americans. Yet in the Houston area, there are few mental health providers educated in working with this community and there are only a handful of Asian American clinicians. Through Project Intercultural Connection, the Asian American Family Counseling Center (AAFCC) proposed implementing and developing a cultural competency training curriculum for mental health professionals coming into contact with the Asian American population in the greater Houston area.

Project Goals

- To assess the cultural competency needs of area service providers.
- To develop a cultural competency training curriculum for area service providers.
- To provide cultural competency training to area service providers.

Introduction

There seems to be a pervasive view that Asian Americans are relatively well-adjusted individuals who encounter few psychological difficulties. Stereotypic notions still prevail that family systems and strong community ties insulate Asian Americans from psychological concerns.

Stereotypic notions still prevail that family systems and strong community ties insulate Asian Americans from psychological concerns.

The reality, however, is that mental illness among Asian Americans is common and Asian Americans have a rate of psychopathology, including depression and psychotic disorders, equal to or higher than European Americans. Unfortunately, though, very few Asian Americans become mental health practitioners since psychology and counseling are indigenous to Western culture and are unfamiliar disciplines warranting little respect and attention in Asian cultures at this time.

In Houston, specifically, only a handful of Asian American individuals are licensed to practice mental health and most of these individuals are of Chinese and Asian Indian descent. Additionally, AAFCC has discovered, through research undertaken to develop its Asian American resource directory, that most mental health agencies in Houston do not feel that they are familiar enough with Asian cultures to provide culturally competent services.

This makes it very difficult for Asian Americans, particularly non-Chinese Asian Americans, to access culturally and linguistically competent mental health services in Houston.

Even more disturbing is the lack of culturally competent service providers in agencies offering services for clients who cannot afford to pay. The results are poor quality care for indigent and low-income Asian Americans, such as Southeast Asian refugees, who are often forced to accept culturally incompetent services.

For Asian Americans who obtain services from Western mental health practitioners, such as counselors, social workers, or psychologists, Western therapeutic treatment goals and strategies may be both inappropriate and unsuccessful if not reevaluated and tailored to the individual's specific cultural background. Western therapeutic approaches, for example, tend to be oriented towards the importance of the individual. This approach is in direct contrast with traditional Asian cultural views which place the good of the family before that of the individual.

Traditional resources have not been successful in meeting the mental health needs posed by the Asian American community in Houston.

The largest non-Asian provider of services responding to the Asian American needs in the public sector in Houston is the Mental Health and Mental Retardation Authority of Harris County (MHMRA). Their records indicate that a total of 385 Asian Americans were served in fiscal year 1995. This represents 1.2 percent of MHMRA's total clientele and less that three-tenths of one percent of the Asian community in Houston. Clearly, traditional resources have not been successful in meeting the mental health needs posed by the Asian American community in Houston.

Moreover, the Asian American population in the Houston area has continued to grow in recent years. The 1990 census indicated that Asian Americans made up four percent of Houston's population with a growth rate of 96 percent. Recent estimates from the Asian Chamber of Commerce (1995) count 352,000 Asian Americans residing in the Houston area, including 125,000 Vietnamese, 120,000 Chinese, 45,000 Asian Indians, 20,000 Pakistanis, 20,000 Koreans, 14,500 Filipinos and 7,500 Japanese.

Program Plan

To assist local mental health providers in offering more culturally competent services to Houston's Asian Americans, AAFCC proposed Project Intercultural Connection, an ambitious plan to assess local providers' cultural competency needs, to develop a curriculum based upon these needs, and to conduct cultural competency trainings.

Organizational Overview

In 1994, a group of Asian American professionals, including many in the mental health field, came together to voice their concerns about the mental health of the Asian American community in Houston, Texas. These individuals discussed strategies to address the unmet mental healthcare needs of Asian Americans in Houston. These discussions led to the creation of AAFCC, which was formally chartered in May of that year.

AAFCC's overall mission is to enhance the mental health of the Asian American community in greater Houston by: educating the Asian American public and professionals regarding Asian American psychological, social and multi-cultural issues; increasing the competency of mental health professionals in addressing Asian American psychological, social and multi-cultural issues; advocating for mental health resources for the Asian American community; and providing early intervention and mental health treatment through integrated Eastern and Western approaches.

AAFCC staff and board members have conducted training sessions on Asian American mental health issues at such organizations as Houston Area Community Services, the Alliance for Multicultural Services, Houston Area Women's Center, the Alzheimer's Association, the University of Texas Medical Branch Psychiatry Department, the Chinese Community Center, M.D. Anderson Hospital's Department of Social Work, and Fort Bend County Women's Center, among others. AAFCC also produces a quarterly educational newsletter which is disseminated to over 500 individuals and agencies in the Houston area who are interested in cross-cultural mental health issues.

AAFCC staff and volunteers are able to assist clients in ten languages including Mandarin, Cantonese, Vietnamese, Taiwanese, Japanese, Korean, Hindi and Urdu.

A cultural competency survey can assess a practitioner's understanding of . . .

- differences in symptom expression
- differences in communication styles
- mental health terms that do not translate well
- religious beliefs about mental illness
- differences in what is considered "normal" behavior
- differences in help-seeking behavior
- effective, culturally specific counseling skills
- various subcultures within ethnic groups

At the time of this proposal, AAFCC was staffed by an experienced administrator, two licensed clinicians, a cultural diversity educator, and a multi-lingual case manager. In addition to these positions, AAFCC also offered student internships for graduate students in the mental health field, and recruited a number of volunteers from a variety of ethnic backgrounds to assist staff and interns in various capacities. Through a combined effort, AAFCC staff and volunteers were able to assist clients in a total of ten languages including Mandarin, Cantonese, Vietnamese, Taiwanese, Japanese, Korean, Hindi and Urdu.

Implementation

At the outset of this project, Project Intercultural Connection developed a concise, four-page questionnaire to assess service providers' cultural competency based upon the Cultural Competency Standards in Managed Care (2000) and the Multicultural Counseling Awareness Scale (MCAS) developed by Ponteretto, et al (1996). (See Appendix A.)

The survey was sent out to various agencies and organizations in the Houston area that provided counseling and assessment services to clients from different cultural backgrounds, including, among others, the Houston Independent School District's Psychology Department and the Houston Area Women's Center.

Houston practitioners seem to be more knowledgeable about African American and Hispanic minorities than about Asian Americans.

Based upon this survey, Project International Connection gathered some interesting information about clinicians in the Houston area's understanding of diversity issues. Deborah Sorensen, project co-director, comments that "people seemed more knowledgeable" about cultural competency than AAFCC expected. At the same time, she attributes this knowledge to some extent to a built-in bias in the survey. "The people who responded to the survey were most likely those who are interested in cultural issues," she explains.

Yet even those individuals most aware of cultural differences seemed to be more knowledgeable about Houston's African American and Hispanic minorities than about the area's Asian American minorities. And in particular, survey respondents exhibited "little knowledge about 'between group' differences. They were not aware that there are many different cultural groups within the Asian American community," says Sorensen.

AAFCC's Brown Bag Lunch Series

- Intergenerational Conflicts in Asian Families
- Stress and Stress Management in Asian Families
- Cultural Factors Contributing to Psychopathology in Asian Americans
- The Interaction between Cultural Adaptation and Identity Formation
- The Impact of Culture on the Manifestation of Individual Psychopathology

Survey results helped AAFCC to determine what materials should be covered by their cultural competency trainings. In addition, Sorensen and project co-director, Kim Szeto, also considered some of the typical issues that they encountered among the center's client population. The problem that presented itself most was the question of intergenerational conflict, hence the subject of the first brown bag lunch.

From March, 2000 through January, 2001 Project Intercultural Connection sponsored a series of brown bag luncheons providing information on Asian American mental health issues to professionals. Local Asian American clinicians designed and presented these talks.

To recruit participants, Sorensen and Szeto sent invitations to various mental health and community organizations including the Houston Independent School District's Psychology Department, the Chinese Community Center, the MHA of Greater Houston, and the University of Houston's counseling center. They also combed through local directories and attempted exhaustively to contact counselors in the Houston area.

Houston practitioners attend the first brown bag luncheon.

Attendance at the luncheons varied, with the smallest group including 14 people and the largest group including 25. At the end of each brown bag, participants were given evaluation forms to fill out, and the brown bags consistently received high marks.

Discussion

America's Asian American population is actually comprised of a vast array of different nationalities and cultures. In the Houston area alone, AAFCC reports the presence of over twenty different Asian ethnicities—each with its own history, language and customs. Therefore, any project that attempts to reach out to Asian Americans must carefully research exactly who the target audience is. And consumer supporter organizations wishing to serve this heterogeneous body of Asian Americans must be prepared to offer services in an array of languages—or at least to have some cultural understanding of the various groups involved.

There are many different Asian ethnicities—each with its own history, language and customs. Project managers must know who their target audience is.

Another factor to consider when developing programs for Asian Americans is the amount of time a particular group has spent in the United States. Sorensen reports that "most of our Asian population here in Houston are immigrants." This, she says, is in contrast to Asian Americans on the West Coast, most of whom have been living in the United States for several generations. With immigrant populations, where the younger generation is growing up American while the older generation has immigrated from another country and is now adapting to a new American culture, intergenerational conflict may be particularly prevalent.

With immigrant populations, intergenerational conflict may be particularly prevalent.

Conclusion

AFCC will continue to offer Project Intercultural Connection in the years to come, and Sorensen even plans to expand upon the program. For example, she says that "we have had requests to offer longer sessions—people feel that an hour just isn't enough." In the future, consequently, the project might offer longer, evening trainings.

Sorensen also wishes to expand her current pool of trainers and to draw upon all available Asian American practitioners in the Houston area. She acknowledges that "there are not many clinicians to choose from in Houston, and I am constantly on the look-out for new people." Recently, she recruited a researcher who is completing an internship in Houston. His area of specialty is trauma and Post Traumatic Stress Disorder.

Sorensen encourages consumer supporter organizations wishing to launch programs such as Project Intercultural Connection to "be flexible." It is important to learn to answer to the educational needs of the provider community while drawing upon the talents and specialties of the existing pool of trainers.

Additional Resources

Publications

Takaki, Ronald. *Strangers from a Different Shore: A History of Asian Americans*. Boston: Little, Brown. 1998.

Tuan, Mia. *Forever Foreigners or Honorary Whites?: The Asian Ethnic Experience Today*. New Brunswick, New Jersey: Rutgers University Press. 1998.

Uba, Laura. *Asian Americans: Personality Patterns, Identity, and Mental Health*. New York: Guilford Press. 1994.

Zia, Helen. *Asian American Dreams: The Emergence of an American People*. New York: Farrar, Straus, and Giroux. 2000.

Organization

Office of Minority Health
Department of Health and Human Resources
Tel. (800) 444-6472
E-mail: info@omhrc.gov
Website: www.omhrc.gov

Cultural Competency Toolkit

CHAPTER 9

The Campaign to Increase Cultural Competence

The Mental Health Association in Utah
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Mack Gift, Ph.D., Project Director

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Executive Summary

Utah's population is growing and becoming increasingly diverse; out of a total 1,916,000 inhabitants, some 203,000 individuals are minority persons. The Mental Health Association in Utah (MHAU) proposed to organize a training for one hundred mental health practitioners to meet and to learn about competently serving the state's various minority communities.

Project Goals

- To train 100 mental health professionals in cultural competency.
- To promote the training through an extensive media campaign.
- To develop recruitment and evaluation materials.
- To provide information on the training on MHAU's website.

Introduction

Utah's population is growing and becoming more diverse. As of May 1996, according to the Utah Department of Employment Security, there were a total of 203,266 minority persons out of a population of 1,916,000. Of these, 14,254 were African Americans, 27,058 were Native Americans, 45,371 were Asian Americans/Pacific Islanders, and 116,583 were Hispanic/Latino. And at least 29,000 people from various minority groups in Utah have serious mental illness.

As Utah's population becomes more diverse, the need for appropriate mental health services grows as well. Currently, there are not nearly enough culturally trained therapists, and without direct intervention this gap will only widen. At the time of this grant proposal, no public or private entity in Utah was providing in-depth, specific, multi-cultural training for mental health professionals.

No public or private entity in Utah was providing in-depth, specific, multi-cultural training for mental health professionals.

Program Plan

It is critical for public and private agencies to be staffed with culturally competent and appropriately qualified personnel, and it is consequently necessary for direct care staff to receive multi-cultural training. To see that Utah's growing minority populations were better served, MHAU proposed to organized a conference where 100 mental health professionals could meet to learn about working with minority populations. Conference presenters would be representatives of all of Utah's racial and ethnic groups.

Organizational Overview

MHAU was well-suited to carry out the proposed training. In Utah, there are five offices of Racial and Ethnic Affairs at the state level, and MHAU has worked with all of the executive directors of these offices to provide educational programs on mental illness. Additionally, MHAU has representation on the State Board of Mental Health, the Children's Mental Health Advisory Board, and the Chamber of Commerce.

MHAU staff and board members are also experienced in multi-cultural initiatives. Dr. Mack Gift, the project director and CEO of MHAU, wrote the curriculum for a community college for Native Americans and designed, implemented and directed "Project Respect," a self-help training program for inner city youth. Additionally, one of MHAU's board members serves as the Director of the Division of Indian Affairs for the State of Utah.

Dr. Mack Gift, the project director and CEO of MHAU, wrote the curriculum for a community college for Native Americans.

MHAU operates with a twelve member board composed of people strategically placed within the Salt Lake City community. Business professionals, mental health professionals, consumers, and widely known public personalities make up this board.

Implementation

As a first step to organizing the Conference on Cultural Competency, Gift established a planning committee with representatives from the different mental health provider organizations in Utah. The main purpose of this committee, according to Gift, was "to get commitment from these big providers that they would be supportive of the conference."

The committee met throughout June and July and assisted both in recruiting speakers for the conference and in publicizing the conference to mental health professionals. In September, flyers and brochures announcing the conference were sent out to all of the major mental health providers in the state and to twelve different treatment centers. Gift personally spoke with the directors of these centers to make sure that they encouraged their staff to attend.

MHAU aimed to find representatives from all of Utah's ethnic minorities to speak at the Cultural Competency Training Conference.

The conference was also published on MHAU's website with great success. Gift reports that the site received some 10,000 hits once details of the conference were posted.

MHAU aimed to find representatives from all of Utah's ethnic minorities to speak at the Cultural Competency Training Conference, and this goal was achieved. Keynote speakers included Native Americans, a Hispanic American, an African American, a Pacific Islander and an Asian American — all individuals with previous experience in offering cultural competency trainings. Additionally, Gift was able to recruit experts in Deaf culture and in interpreting.

Interest in the conference was much higher than expected, with 200 professionals from across the state registering to attend. Consequently, Gift offered the program on two consecutive weekends so that all interested individuals could take part.

Discussion and Conclusion

Clearly, MHAU's Cultural Competency Training was a remarkable success, with double the amount of mental health professionals attending as anticipated. Even though NCSTAC funding will not continue beyond this grant cycle, Gift is already making plans to offer a similar program next Fall. A local HMO, InterMountain Health Care, provided a generous grant for the 2000 conference and has already expressed an interest in providing further assistance for the 2001 conference.

> "Make contact with persons of different racial and ethnic groups; become friends with the key players."
>
> — Dr. Mack Gift, project director

Gift's advice for those interested in organizing similar programs is "to make contact with persons of different racial and ethnic groups; become friends with the key players." It was primarily through his personal contacts that Gift was able to recruit so many talented speakers to present at the conference.

Furthermore, MHAU made the conference particularly desirable to attend by providing continuing education credits to attendants. This option was arranged with the Continuing Education Committee of the National Association of Social Workers' Utah Chapter.

Additional Resources

(African Americans)

Byrd, W. Michael and Clayton, Linda A. *An American Health Dilemma, Volume One: A Medical History of African Americans and the Problem of Race: Beginnings to 1900.* New York: Routledge. 2000.

Cultural Competence Standards in Managed Care Mental Health Services: Four Underserved/Underrepresented Racial/Ethnic Groups. Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services. (Available on the internet at www.samhsa.gov/centers/cmhs/cmhs.html)

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Cultural Competency Toolkit

CHAPTER *10*

Implementing a Multi-Lingual Warm-Line

Consumer Voices Are Born
3303-B N.E. 44th Street
Vancouver, Washington 98663
Tel. (360) 695-5012
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Donna Roberts, Project Director

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Executive Summary

Consumer Voices Are Born (CVAB), a consumer-run drop-in center, proposed to establish a warm-line where individuals in the Clark County, Washington area facing mental health challenges could call in and discuss their problems with a peer. These consumer volunteers would be trained by crisis personnel and would be able either simply to listen or to make referrals to crisis or other community sources as needed. Additionally, CVAB proposed to recruit individuals representative of Clark County's multi-ethnic communities and to publicize the warm-line throughout these various communities.

Project Goals

- To set up phone and pager systems for a multi-cultural warm-line.
- To recruit and train consumer volunteers to staff warm-line.
- To network with service providers conducting minority outreach.
- To translate materials into appropriate languages.
- To advertise and promote warm-line.

Introduction

At the time of this grant proposal, Clark County, Washington had a county-wide crisis response plan to address the needs of people in acute psychological crisis. Under this system, people in crisis could be assessed by professionals and referred for hospitalization. There were no intermediate services available, however, for people simply to talk and de-escalate. Local consumers could not meet with a crisis worker simply to talk, or to focus on problems that, while not acute, could potentially escalate through lack of attention.

If any such new services were to be established, it was also important that they take into account Clark County's multi-ethnic makeup. In recent years, significant numbers of Russian families had settled in the area, as well as South East Asian immigrants and people of Hispanic/Latino descent. Many of these populations were quite insular, and their members faced a cultural isolation which could only make more difficult the burden posed by mental illness.

Many of Clark County's ethnic populations were quite insular, and their members faced a cultural isolation which could only make more difficult the burden posed by mental illness.

Program Plan

CVAB proposed to establish a warm-line where members of the Clark County community could call in and discuss their problems with a peer. These peer volunteers would be trained by crisis personnel and would be able either simply to listen or to make referrals to crisis or other community sources as needed.

Служба **WARM LINE** под эгидой CVAB
Не с кем поговорить?
Все не так?
ЗВОНИТЕ НА ПЕЙДЖЕР:
(360) 750-2012 или (360) 750-2014
вторник — суббота с 12.00 до 22.00
Мы реагируем незамедлительно!

Warm Line notice in Russian.

The warm-line would be staffed by mental health consumers representative of Clark County's multi-ethnic population. By networking with other service providers already conducting minority outreach, CVAB would publicize the warm-line throughout these various communities. And information materials on the warm-line would be made available in different languages.

Organizational Overview

Consumer Voices Are Born (CVAB) is an organization made up of consumers for consumers serving the Clark County, Washington area. A 501(c)(3) entity, it receives support from the Clark County Mental Health Community. At the time of this grant request, CVAB was already managing an entirely consumer-operated drop-in center.

Consumer Voices Are Born is an organization made up of consumers for consumers serving the Clark County, Washington area.

CVAB is recognized by its various partners within the mental health community as an independent, yet integral part of the community. CVAB board members provide regular feedback to the community regarding quality of care and consumer needs. The Clark County Regional Support Network, which is the governmental agency that manages the county's Medicaid mental health dollars, has long supported CVAB and has encouraged its growth. CVAB also works closely with the county mental health authority and with the private managed care association, United Behavioral Health.

Implementation

In March, 2000, CVAB entered into an agreement with a group of county-designated mental health professionals, the Columbia River Mental Health Services crisis team, to provide warm-line training to consumer volunteers. Columbia River then offered two, day-long trainings in 2000 to altogether twenty individuals.

The trainings were rigorous and thorough. Participants learned about symptomology, or the ways that individuals may behave when they are experiencing certain symptoms. Workshop leaders reviewed the differences between a warm-line call and a crisis call, and discussed under what circumstances it is appropriate for warm-line volunteers to contact crisis

services. Participants also learned how to take "DAP" notes, a form of charting that provides a description of what the caller is saying; an assessment of the caller's behavior and emotional state; and an action plan that the caller and warm-line volunteer agree upon together.

Important time during the trainings was also devoted to how the volunteers should prepare and protect themselves emotionally when taking calls. Issues of boundaries and self-care were discussed.

Monthly training topics could cover how to help someone who was hearing voices or simply how to assist someone in finding the right doctor.

Once warm-line volunteers had completed a day-long training, CVAB followed up with ongoing, monthly training sessions to help the volunteers further develop their skills. Monthly training topics could cover how to help someone who was hearing voices, how to connect an individual with appropriate faith-based services in the community, or simply how to help someone to find the right doctor.

Additionally, CVAB offered separate cultural competency trainings. According to Donna Roberts, the project director, these detailed trainings focused "not just on ethnic diversity, but also on understanding diversity within a particular community. For example, there may be two people who are both from Russia, but one comes over because he wants to go to school in the United States, and the other comes as a refugee… They will have two very different approaches."

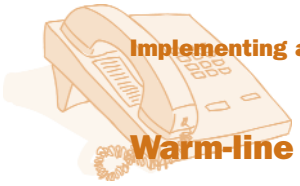
Minority outreach

CVAB was able to provide assistance to individuals in a variety of languages. Warm-line volunteers included Native Americans, Russian speakers, Spanish speakers and one Laoatian speaker. In addition, a sign interpreter was available for non-hearing individuals who wished to visit the facilities for assistance. Roberts reports, "we never had a problem of someone calling and not having a volunteer who knew their language."

Roberts conducted extensive public outreach to the Clark County's various ethnic communities, meeting with community leaders and attending community functions to provide information on the warm-line. She describes these public outreach efforts as "absolutely necessary and ongoing." In addition, CVAB prepared translations of their informational brochures in Cambodian, Russian, Vietnamese, Laotian and Spanish.

Translation services can be the most expensive part of a multi-lingual operation. Translating one brochure can cost several thousand dollars.

To find translators, Roberts spoke with several public offices that she knew, by law, were required to provide translations of their written materials, and she asked them to recommend translators. She was also able to gather some translated materials for free this way: "Some of the documentation — like our complaint and grievance policy — is the same one used by the county regional support network, so I received copies from them."



Warm-line staffing/ usage

CVAB rented two pagers per month with voice mail for $15.00 each. Each pager could handle 500 calls per month.

The number of calls the warm-line received could vary, with peak volume reaching some two hundred calls per month. Calls could also be lengthy, and Roberts reports that "on the average people will call and talk from 30 to 90 minutes." She adds, "we have had calls that have been six hours in length."

To meet this demand, CVAB relied upon a group of twenty volunteers. For the day shift, typically CVAB tried to have two volunteers available at all times to field calls, with a supervisor also present. At night, they also tried to have two individuals available, but sometimes it was necessary to have one person handle both pagers—with a back-up person available to take extra call as needed.

CVAB received all calls through a system of two pagers with voice mail. Incoming calls went directly to the pager and were then answered typically within ten seconds. The longest a call-back might ever take was six minutes.

To make the warm-line known throughout Clark County, Donna Roberts, project director, relied on her connections with various minority community leaders.

Discussion

In conducting minority outreach, "most of the work I have done has not been in publicizing the warm line," says Roberts. "It has been in getting someone to introduce me into the community's inner circle, and then letting them get to know me and trust me." To make the warm-line known throughout Clark County, Roberts relied on her connections with various minority community leaders.

For example, Roberts met a South East Asian woman through the YMCA who was a recognized leader in that community. Says Robert, "I spoke with her when we first started the warm-line. Then I kept her posted about our progress along the way, and I gave our translated materials to her." Ultimately, the community leader invited Roberts to attend a conference on South East Asians in America held in Clark County.

With the Russian community, Roberts went through a similar process. Through her work on the county's mental health cultural competency committee, Roberts met a Russian-American woman who worked with a local managed care provider. This woman then provided Roberts with further introductions into the local Russian community.

Making these inroads, according to Roberts, requires time and patience. "Once you have made the contact with the local leaders, then they will ask you more about your program and then they'll go back and let their community know. So it's a long a process."

Providing a safe venue

Roberts does feel that the warm-line offers a venue for individuals who might be hesitant to seek help in other forms. For example, "especially in the South East Asian community, it is still not widely accepted to go outside of the family unit for help — and if you do, you go to a community elder or a spiritual leader rather than to the mental system. We offer some anonymity that you won't find in going into a mental health organization."

Moreover, the fact that the warm-line is run by consumers may also make it easier for people in need to pick up the phone and ask for help. "We also offer a little more because we're not professionals, we're peers. So there's not the same stigma that's entailed in going to a professional."

"Once you have made the contact with the local leaders, then they will ask you more about your program and then they'll go back and let their community know. So it's a long a process."

—Donna Roberts, project director

Finally, Roberts adds, "and one of the other things that we try to do because what's accepted in our (predominantly Caucasian) culture is not necessarily accepted in other cultures, is we try and team a male and a female so that people can speak to the gender they're more comfortable with."

Conclusion

CVAB's warm-line has been such a success that in April 2000 the Clark County Board of Commissioners and the Mental Health Advisory Board adopted CVAB as a formal entity in the Clark County Crisis System. *The Oregonian* and *The Columbian*, local newspapers, have both run articles reporting on the warm-line, and Roberts has also been interviewed by the local cable television news channel.

The Oregonian and The Columbian, local newspapers, have both run articles reporting on the warm-line.

With this interest and support, the warm-line will continue to grow. As of this writing, Roberts has 22 new consumer volunteers awaiting warm-line training, and she has hopes of eventually making services available 24 hours a day, seven days a week.

Roberts would like also to serve as an example to mental health organizations interested in launching similar initiatives. "I'd like to see us partner with other places across the state that are trying to get their own programs going." She has already received queries from different organizations, including one as far away as Wichita, Kansas.

Most importantly, Roberts wants warm-line services to continue to penetrate into Clark County's various minority communities. She sees continued growth and outreach in this direction as "absolutely necessary... We just got the census back. The Hispanic community has more than doubled and there have been significant rises in the rest of the minority communities as well." With continued effort and planning, CVAB should be well-placed to meet these growing needs.

Additional Resources

WARM LINE của CVAB

Hỡi những người hưởng dịch vụ, quý vị có cần nói chuyện với ai không?
Có phải quý vị đang có những khó khăn đang xảy ra chăng?
NẾU CÓ HÃY NHẮN (PAGE) CHO CHÚNG TÔI Ở SỐ:
(360) 750-2012 hoặc (360) 750-2014
Thứ Ba – Thứ Bảy; 12 GIỜ TRƯA – 10:00 GIỜ TỐI
Chúng tôi sẽ gọi lại cho quý vị ngay!

Warm Line notice in Vietnamese.

(Asian Americans)

Takaki, Ronald. *Strangers from a Different Shore: A History of Asian Americans*. Boston: Little, Brown.1998.

Tuan, Mia. *Forever Foreigners or Honorary Whites?: The Asian Ethnic Experience Today*. New Brunswick, New Jersey: Rutgers University Press. 1998.

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(Hispanic/Latino Americans)

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