

Learning From Those We Serve: Piloting a Culture Competence Intervention Co-Developed by University Faculty and Persons in Recovery

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Objective: This article describes the development and piloting of a bilevel intervention codeveloped by persons in recovery from mental illness and addiction and university faculty with expertise in cultural competence to improve the cultural competence of a community mental health center in the northeastern United States. **Method:** Two faculty and 5 persons in recovery met for 6 months to develop the bilevel training intervention. They discussed experiences of culturally responsive care and developed experiential activities and case examples for the 2-day training. Forty-five community mental health service providers attended the 2-day training. Trainees' self-reported awareness, knowledge, and skills in cultural competence were measured pre and post training and analyzed with repeated measure *t* tests. Next, faculty and persons in recovery provided follow-up training and helped to establish an infrastructure supported to support the agency cultural competence plan. One hundred twenty-five providers completed the Organizational Multicultural Competence Survey and between-subjects *t* tests measured increases in organizational cultural competence. **Results:** Significant increases were found in providers' multicultural knowledge, awareness, and skills. Qualitative responses demonstrated the contribution of the experiences of persons in recovery to the training. Ratings of the organizational-level cultural competence intervention showed significant improvements in the agency's cultural competence policies (e.g., implementation of strategies to hire and retain a diverse workforce). **Conclusions and Implications for Practice:** These data suggest that bilevel interventions codeveloped by persons in recovery and researchers may be effective in increasing provider and organizational-level cultural competence. Future research should evaluate the effect of these interventions on consumers and health outcomes.

Keywords: cultural competence, organizational intervention, peers, provider training

Inequities in mental health access, service quality, and outcomes are pervasive and long-standing among individuals from diverse racial, ethnic, and cultural communities. Studies show that African Americans and Hispanics underutilize outpatient and supplemental services, suggesting a greater unmet need for care (Alegria et al., 2002; Cabassa, Zayas, & Hansen, 2006; Cooper-Patrick et al., 1999; Alvidrez & Havassy, 2005; Lopez, 2002; Ojeda & McGuire, 2006; Robins & Regier, 1991; Schoenbaum, Miranda, Sherbourne, Duan, & Wells, 2004; U.S. Department of Health & Human

Services, 2001; Wells, Klap, Koike, & Sherbourne, 2001; West et al., 2006). Similarly, Hispanics are overrepresented in prevalence rates of depression and substance abuse when compared with their white non-Hispanic and other minority counterparts (Caetano, Field, Ramisetty-Mikler, & McGrath, 2005; Substance Abuse and Mental Health Services Administration, 2007).

The 2013 National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS) and a broad range of mental health reports and studies have noted the importance of increasing health care provider cultural competence as one strategy for eliminating disparities (New Freedom Commission on Mental Health, 2003; Office of Minority Health, 2001; U.S. Department of Health & Human Services, 2005). Cultural competence has been defined as knowledge, information, and data from and about individuals and groups that is integrated and transformed into clinical standards, skills, service approaches, techniques, and marketing standards that match the individual's culture and increase both the quality and appropriateness of health care and health outcomes (Davis, 1998). Recent systematic reviews suggest that cultural trainings are associated with improvements in cultural knowledge, attitudes, and skills as well as consumer satisfaction (Beach et al., 2005; Smedley, Stith, & Nelson, 2003). The interventions described in this article were developed

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based on the Davis (1998) definition of cultural competence and the measures used in this study (i.e., the MAKSS and the Organizational Multicultural Competence Survey) are intended to measure these aspects of cultural competence (e.g., multicultural knowledge, awareness and skills; organizational planning processes, human resource administration).

In addition to training in cultural competence, there is a growing recognition that to create systemic change, organizations must intervene at multiple levels simultaneously (Evans, Delphin, Simmons, Omar, & Tebcs, 2005; U.S. Department of Health and Human Services, Office of Minority Health, 2001). Thus, along with cultural competence training, additional strategies are needed to help promote change such as offering language assistance services and supports and conducting cultural audits. Although the National CLAS standards, the American Psychological Association Multicultural Guidelines, and other similar national documents are viewed as the gold standard in the mental health field for promoting organizational cultural competence, to our knowledge, no empirical studies have evaluated the impact of system change interventions based on these standards.

Another growing recognition in psychiatry is the value of peers (i.e., persons in recovery - PIR) as service providers, coresearchers, trainers, and policy advisors (U.S. Department of Health & Human Services, 2005). Their lived experience with mental illness, with navigating communities while living with mental illness, and with mental health services has proved to be an extremely valuable contribution that is not offered when only professionals are designing, implementing, and evaluating services (Davidson, Bellamy, Guy, & Miller, 2012; Moran, Russinova, Gidugu, Yim, & Sprague, 2012; Repper & Carter, 2011; Solomon, 2004). Given the importance of the lived experience of PIR, especially persons from culturally, racially, and ethnically diverse populations, the powerful element of this intervention is that it is built on the lived experience of persons of color and persons with mental health challenges.

This project builds on the ongoing research of the Connecticut Department of Mental Health and Addiction Services Health Disparities Initiative, a public-private partnership between Yale University, and the Connecticut Department of Mental Health and Addiction Services to identify and develop statewide system change interventions to eliminate behavioral health disparities. Quantitative and qualitative studies from this Initiative have shown disparities in access, quality, and outcomes and have revealed that individuals from diverse cultural groups reported feeling stereotyped by providers (Delphin-Rittmon et al., 2012, 2013, 2015). In response to these findings, faculty and PIR in the Yale Program for Recovery and Community Health built on a cultural competence training we had previously developed for providers (Delphin & Rowe, 2008) to codevelop a bilevel intervention that targeted both providers and organizational policies to improve the cultural competence of a community mental health center. All faculty and PIR who codeveloped this training are authors on this article. We hypothesized that, as a result of the bilevel interventions, provider and organizational cultural competence would increase.

Method

This study was approved by the Human Investigation Committee at Yale School of Medicine. All research participants gave written, informed consent to participate.

Participants

This intervention was developed at a racial-ethnically diverse urban community mental health center of a midsized northeastern city that serves people who have no health insurance. The center includes a clinic for monolingual Spanish speaking individuals.

Provider cultural competence training. Participants were recruited through verbal or e-mail invitations from their team leader or the agency CEO from three clinical teams at the mental health center ($N = 45$ providers) and from the local Community Services Network comprising 17 agencies ($N = 8$ agencies participating) that each employed approximately 20 to 60 providers. Thirty-four providers participated in piloting this intervention ($n = 34$ at Time 1 and Time 2). From this total, 81% were female. 65% described their race as White, and 29% identified as Black or African American, 3% as Asian, and 3% were missing. Across races, 8% indicated they were Hispanic or Latino. More than half of the participants (i.e., 64%) had a master's level social work degree and a minority (i.e., 11%) were at the doctoral level (i.e., M.D., Ph.D. or Ed.D.). Providers had their licenses for an average of 14.6 years ($SD = 11.6$) and had worked at the participating community mental health center for an average of 7.8 years ($SD = 7.1$).

Organizational cultural competence assessment. Mental health center providers and staff (approximately 450 people total) were invited by the agency CEO via email to complete the assessment. Across the two time-periods (i.e., preintervention and postintervention), 125 people responded to this survey ($n = 48$ in Time 1, $n = 77$ in Time 2). Eighty-two percent of respondents were female, with an average age of 50.0 ($SD = 10.7$). Seventy-eight percent of respondents self-identified their race as White, 18% as Black or African American, 3% as Other, 2% as Asian, and 2% as American Indian/Native American (respondents could choose more than one category). Across racial groups, 10% indicated they were Hispanic or Latino. In terms of job roles, 38% indicated they held administrative positions, 46% indicated they were full-time or part-time providers, 10% held clerical positions, 12% had research positions, and 8% indicated they offered supportive services (respondents could select more than one type of position). Respondents had worked at the agency for an average of 13.8 years ($SD = 9.9$; range 1 to 35).

Procedure

To develop the bilevel intervention, two faculty with expertise in cultural competence assessment, training, and research as well as five persons in recovery (i.e., PIR) met weekly for 2 to 4 hours for 6 months. The PIRs were three females and one male. Two of the PIRs identified as Black or African American, one as Hispanic or Latino American, and one as non-Hispanic White American. All of the PIRs had had extensive personal experience (i.e., greater than 10 years) living with mental illness and/or addiction and were employed part-time as peer recovery support specialists at the Yale Program for Recovery and Community Health. Several of the PIRs had worked as peer support specialists for multiple years (i.e., up to 8 years previously). The PIRs who were invited to participate in this research project had participated as coresearchers (i.e., analyzing themes from focus groups) in a previous research project about people's experiences of culturally competence care in the CT Department of Mental Health and Addiction Services

(DMHAS) system (Delphin-Rittmon, 2013). During the analysis meetings, the PIRs expressed interest in implementing change in response to the experiences they read about in the focus group transcripts. Subsequently, they were invited to participate in the development and evaluation of this intervention.

During the first group meetings to develop the current intervention, the faculty and persons in recovery shared their experiences in receiving culturally responsive (or not) health care. They also discussed their experiences of marginalization, inclusion/exclusion, and lack of privilege based on cultural identity or mental health status in order to prepare themselves for discussing these issues in the training. Then, the group developed the training. The theoretical foundation was provided by the Multicultural Counseling Competencies, and all activities addressed one or more of the 31 competencies included in this framework (Arredondo, 1999; Arredondo et al., 1996). Specifically, the training addressed areas such as cultural identity, privilege, stereotype identification and reduction, strategies for eliciting cultural beliefs about distress, and use of translators and other strategies to address linguistic needs of service users.

To select activities for the trainings, first, the group reviewed existing cultural competence trainings, interactive activities and exercises previously used by our group (Delphin & Rowe, 2008), and activities in the Wellness Recovery Action Plan training (Copeland, 1997). One example of an exercise previously used by our group and selected for this training is the "First memory of difference," where participants are asked to discuss their first memory of when they knew they were different from other people in some way. This activity helps participants to develop empathy for others' feelings of difference. Second, the group developed their own activities for the training. For example, the group selected scenarios from the TV show "What Would You Do?" and developed discussion questions to use in the training. They also developed clinical vignettes based on their experience or the experiences of others in their communities to present for discussion during the training.

After selecting or developing the activities for the training, the group examined the individual activities in depth and added items and examples based on their personal experience. For instance, the group revised a training used previously called "Walk through privilege" (Delphin & Rowe, 2008) in which participants line up shoulder to shoulder in the center of a room and take one step forward if the facilitator reads a statement that applies to them. The statements describe experiences of privilege such as "I can be sure that if I need legal or medical help my race will not work against me." After the statements are read, participants are asked to look at how other participants are dispersed throughout the room and a discussion of one's own placement in the room and the placement of others follows. For the current training, PIR added additional statements to the Walk through Privilege that addressed mental health status, poverty and gender.

After finalizing the activities, scenarios, and events for discussion, all individuals in the group practiced leading different activities and offering their personal expertise to the discussion. Then, they piloted the training at a local peer-run agency and modified the training based on feedback. Once finalized, 2-day trainings, with continuing education credits, were offered to the community mental health center's providers and providers in the extended community services network in April, May, and June 2011. Most

of the PIRs had worked previously as peer support specialists at the community mental health center and affiliate community agencies and were known to many of the providers at the agencies.

To evaluate the impact of the training on providers, their cultural competence level was measured using the Multicultural Awareness, Knowledge, and Skills Survey (MAKSS; D'Andrea, Daniels, & Heck, 1991). This 60-item, five-point, Likert-type measure is designed to assess an individual's perceived multicultural awareness, knowledge, and skills through three subscales. Providers completed the MAKSS before and after participating in the training. The reliability and validity of this measure were good when the measure was validated. The reliability of the scales and the total scores were high (.72–.94) for all scales except Awareness (.59–.63). The distinctiveness of the scales were suggested by the relatively low correlations among scales at Time 1 (range $r = .55-.73$) and Time 2 (range $r = .40-.63$).

Organizational-Level Intervention

The activities in the organizational cultural competence intervention developed in response to the provider training. First, follow-up meetings were held with the providers post training: the participants in the training asked for follow-up meetings to solidify the cultural competence information and to continue to grapple with cultural competence issues in clinical care, so the faculty and PIR meet biweekly with the clinical teams for several months to discuss current clinical scenarios. The PIR were able to use their personal expertise in receiving care and in working with others receiving care to help in the ongoing trainings.

Second, meetings were held with agency leadership. The group of faculty and PIRs advised them on multiple issues and an action plan was developed by agency leadership, faculty, and PIR. First, an ongoing cultural competence committee was convened that met regularly to organize cultural competence activities at the agency, coordinate an organizational-level cultural competence assessment at the agency, and develop and implement a cultural competence plan. The early meetings of the cultural competence committee were attended by the faculty and PIR who advised the committee on developing their infrastructure (e.g., deciding who should be invited to join the committee, establishing a regular meeting schedule). Second, the organizational level cultural competence assessment was conducted. This assessment was intended to be used as a basis for developing a cultural competence plan. Third, the cultural competence plan for the agency was developed in consultation with the faculty and PIRs and using templates and tips on developing an effective cultural competence plan that matched the agency's capacity for implementation.

To measure the impact of the organizational-level intervention, all administrative, direct care, and support staff at the participating mental health center were invited to complete the Organizational Multicultural Competence Survey (Delphin-Rittmon, Flanagan, & Dinzeo, 2008) before and after the organizational-level intervention. This 33 item, 6-point Likert-type scale measures six dimensions of organizational cultural competence including the following: (a) Governance, Policies, and Procedures; (b) Quality Evaluation and Monitoring; (c) Human Resource Development; (d) Service Delivery; (e) Language and Communication; and (f) Community Relationships. The survey was distributed by the CEO of the community mental health center via an online survey web-

site. Reliability analysis of the scales and total scores shows that the consistency of the scale answers were good for both time periods (.75–.93).

Results

Efficacy—Provider Level

According to providers' answers on the Multicultural Awareness, Knowledge, and Skills Survey (MAKSS; D'Andrea et al., 1991), repeated measures *t* tests measured that providers' awareness of cultural competence issues increased as a result of the training, $t(34) = -6.79, p < .001$ (e.g., "How would you rate yourself in terms of understanding how your cultural background has influenced the way you think and act"?). In addition, providers' knowledge increased as a result of the intervention, $t(34) = -7.96, p < .001$ (e.g., extent of agreement with a statement such as "Clients from different ethnic/cultural backgrounds should be given the same treatment that White mainstream clients receive"). Finally, providers indicated they thought their skills increased as a result of the intervention, $t(34) = -4.49, p < .001$ (e.g., ratings of "very good" in response to a statement such as "How well would you rate your ability to accurately identify culturally biased assumptions as they relate to your professional training?").

The qualitative responses of providers about what they liked about the training, what they didn't like about the training, and what they thought could be improved offer a window as to the effect of contribution of the PIRs to training. Providers listed the "enthusiasm of the presenters," the PIRs sharing their stories and experiences, and the willingness of the PIR to share their experiences as primary reasons why they liked the training. One provider in particular said that they appreciated that presenters represented a variety of perspectives, and that they worked together well to present the information. When asked what they thought should be improved, providers indicated they wanted more—more days of training, more handouts for further resources, more follow-up, more information on various cultures, for more employees (including administrators) to receive the training, and to include more

information on groups such as those physical disabilities and hearing impairment and those who identify as Muslim.

Efficacy—Organizational-Level

Independent samples *t* tests analyzing providers' responses before and after the organizational-level intervention show that there were significant changes for the organization in several areas (see Table 1). In particular, providers at this agency reported differences across the intervention in the development and implementation of a cultural competence plan, the establishment of a cultural competence committee, ongoing analysis of the demographic composition of the staff and consumers, the conduct of a self-assessment, requests for client feedback, strategies to hire people from various backgrounds, and availability of various services and technologies that target people with different abilities. All *p* values less than .05 are included in Table 1; however, because multiple comparisons were made a more conservative alpha, such as .01, may be warranted.

Discussion

The present study sought to pilot an innovative, bilevel cultural competence intervention at an urban community mental health center—a collaborative endeavor between a private and academic school of medicine and a state agency in the northeastern of the United States with consumers of services. This intervention was unique in that it addressed both provider and organizational level cultural competence. In addition, the provider training was codeveloped and delivered as a conjoint effort between faculty with multicultural expertise and individuals in recovery from mental illness and addictions.

The development of this intervention demonstrated the feasibility and acceptability of codeveloping an experiential cultural competence intervention by faculty and persons in recovery (PIR). The successful development of this intervention also established the multiple contributions of PIR to developing cultural competence trainings through their abilities to evaluate and revise existing interventions, to develop new interventions based on their experi-

Table 1
Questions With Significant Change Over Time ($p < .05$) on the Organizational Cultural Competence Measure

Question	Statistic
4. There is a written cultural competence plan that summarizes goals, action steps, and oversight mechanisms for providing culturally and linguistically competent services.	$t(120) = -2.3, p = .03$
5. The cultural competence committee or advisory group includes representatives from staff, people in recovery, family members, and the community.	$t(125) = -2.6, p = .01$
8. The implementation of the cultural competence plan is monitored and evaluated on an ongoing basis.	$t(121) = -2.3, p = .03$
9. The organization compares demographic composition of staff to the demographic composition of the service area and the clients served.	$t(122) = -2.3, p = .02$
10. An organizational cultural competence self-assessment is conducted at least every two years.	$t(121) = -2.5, p = .02$
12. Clients are asked for written feedback (e.g., in satisfaction surveys) regarding the manner in which culture (e.g., race, ethnicity, language, spirituality) is incorporated into services.	$t(122) = -2.4, p = .02$
14. The organization implements ongoing recruitment strategies to hire staff, including leadership, from different cultural and linguistic backgrounds.	$t(120) = -2.6, p = .009$
15. Active strategies are being implemented to retain and promote staff, including leadership, from different cultural and linguistic backgrounds.	$t(121) = -2.6, p = .009$
28. Services and technologies are available that target the different visual, auditory, speech, literary, and developmental abilities of clients.	$t(114) = -2.1, p = .04$

ences, and to use their personal experience to guide case examples and discussion throughout the training. The qualitative responses from providers reported the strong effect providers felt from hearing PIR stories and using these stories to problem-solve effective strategies for other clinical situations.

The efficacy studies established that service providers who participated in the intervention showed meaningful improvements in cultural awareness, knowledge, and skills. These results are consistent with findings reported in several systematic reviews of the literature, which document a strong link between cultural competence trainings and education and intermediate outcomes such as increased awareness, knowledge, and skills among health professionals (Beach et al., 2005). The organizational assessment from pre to post intervention showed tangible changes that covered a wide range of issues including infrastructure changes (e.g., establishment of a permanent cultural competence committee and development of a cultural competence plan), workforce development efforts (e.g., recruitment and promotion of diverse staff), and innovations in the types of services provided to the mental health center's clientele (e.g., availability of services to accommodate consumers with different levels of ability).

Although the results of this pilot study are promising, several limitations are worth noting. First, we pilot tested both the provider and organization-level interventions with a limited number of participants collected through convenience sampling and using an uncontrolled case series design. Follow-up studies assessing the effectiveness of this intervention would benefit from the inclusion of a random pretest posttest control group design. Further, the present study relied on only one self-report measure to assess changes in provider level cultural competence and one self-report measure to assess this construct at the organizational level. Although the psychometric properties of each scale appeared to be sound, the inclusion of other forms of measuring the construct, especially measurement that does not rely on self-report, at each level may provide a richer picture of the interventions efficacy. Another limitation is that our assessment did not measure observable cultural change and whether the intervention affected the services offered or the care experienced by clients. These important areas should be addressed in future research.

In spite of the aforementioned limitations, the current study has important strengths. To our knowledge, this study is one of the first efforts to codevelop and test a bilevel cultural competence intervention by faculty and PIR. These results are exciting news for both cultural competence trainings and trainings led by persons in recovery. Future research should build on these promising findings by comparing this training with other effective trainings for cultural competence and documenting the effect of this trainings on the health outcomes for clients and observable cultural change at the agency.

References

- Alegría, M., Canino, G., Ríos, R., Vera, M., Calderón, J., Rusch, D., & Ortega, A. N. (2002). Inequalities in use of specialty mental health services among Latinos, African Americans, and non-Latino whites. *Psychiatric Services*, 53, 1547–1555. <http://dx.doi.org/10.1176/appi.ps.53.12.1547>
- Alvirez, J., & Havassy, B. E. (2005). Racial distribution of dual-diagnosis clients in public sector mental health and drug treatment settings. *Journal of Health Care for the Poor and Underserved*, 16, 53–62. <http://dx.doi.org/10.1353/hpu.2005.0002>
- Arredondo, P. (1999). Multicultural counseling competencies as tools to address oppression and racism. *Journal of Counseling & Development*, 77, 102–108. <http://dx.doi.org/10.1002/j.1556-6676.1999.tb02427.x>
- Arredondo, P., Toporek, R., Brown, S. P., Sanchez, J., Locke, D. C., Sanchez, J., & Stadler, H. (1996). Operationalization of the multicultural counseling competencies. *Journal of Multicultural Counseling and Development*, 24, 42–78. <http://dx.doi.org/10.1002/j.2161-1912.1996.tb00288.x>
- Beach, M. C., Price, E. G., Gary, T. L., Robinson, K. A., Gozu, A., Palacio, A., . . . Cooper, L. A. (2005). Cultural competence: A systematic review of health care provider educational interventions. *Medical Care*, 43, 356–373. <http://dx.doi.org/10.1097/01.mlr.0000156861.58905.96>
- Cabassa, L. J., Zayas, L. H., & Hansen, M. C. (2006). Latino adults' access to mental health care: A review of epidemiological studies. *Administration and Policy in Mental Health and Mental Health Services Research*, 33, 316–330. <http://dx.doi.org/10.1007/s10488-006-0040-8>
- Cactano, R., Field, C. A., Ramisetty-Mikler, S., & McGrath, C. (2005). The 5-year course of intimate partner violence among White, Black, and Hispanic couples in the United States. *Journal of Interpersonal Violence*, 20, 1039–1057. <http://dx.doi.org/10.1177/0886260505277783>
- Cooper-Patrick, L., Gallo, J. J., Powe, N. R., Steinwachs, D. M., Eaton, W. W., & Ford, D. E. (1999). Mental health service utilization by African Americans and Whites: The Baltimore epidemiologic catchment area follow-up. *Medical Care*, 37, 1034–1045. <http://dx.doi.org/10.1097/00005650-199910000-00007>
- Copeland, M. E. (1997). *Wellness recovery action planning*. San Francisco, CA: Peach Pit Press.
- D'Andrea, M., Daniels, J., & Heck, R. (1991). Evaluating the impact of multicultural counseling training. *Journal of Counseling & Development*, 70, 143–150. <http://dx.doi.org/10.1002/j.1556-6676.1991.tb01576.x>
- Davidson, L., Bellamy, C., Guy, K., & Miller, R. (2012). Peer support among persons with severe mental illnesses: A review of evidence and experience. *World Psychiatry: Official Journal of the World Psychiatric Association (WPA)*, 11, 123–128. <http://dx.doi.org/10.1016/j.wpsyc.2012.05.009>
- Davis, K. (1998). Race, health status, and managed health care. In F. L. Brisbane (Ed.), *Cultural competence for health care professionals working with African American communities: Theory and practice* (pp. 145–163). Rockville, MD: Center for Substance Abuse Prevention, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services.
- Delphin-Rittmon, M., Andres-Hyman, R., Flanagan, E. H., Ortiz, J., Amer, M. M., & Davidson, L. (2012). Racial-ethnic differences in referral source, diagnosis, and length of stay in inpatient substance abuse treatment. *Psychiatric Services*, 63, 612–615. <http://dx.doi.org/10.1176/appi.ps.201100322>
- Delphin-Rittmon, M., Bellamy, C. D., Ridgway, P., Guy, K., Ortiz, J., Flanagan, E., & Davidson, L. (2013). 'I never really discuss that with my clinician': US consumer perspectives on the place of culture in behavioural healthcare. *Diversity & Equality in Health & Care*, 10, 143–154.
- Delphin-Rittmon, M. E., Flanagan, E. H., Andres-Hyman, R., Ortiz, J., Amer, M. M., & Davidson, L. (2015). Racial-ethnic differences in access, diagnosis, and outcomes in public-sector inpatient mental health treatment. *Psychological services*, 12, 158–166. <http://dx.doi.org/10.1037/a0038858>
- Delphin-Rittmon, M. E., Flanagan, E., Dinzeo, T. (2008). *The Organizational Multicultural Competence Survey*. Hartford, CT: Connecticut Department of Mental Health and Addiction Services.
- Delphin, M. E., & Rowe, M. (2008). Continuing education in cultural competence for community mental health practitioners. *Professional*

- Psychology: Research and Practice*, 39, 182–191. <http://dx.doi.org/10.1037/0735-7028.39.2.182>
- Evans, A. C., Delphin, M. E., Simmons, R., Omar, G., & Tebes, J. K. (2005). Developing a framework for culturally competent systems of care. In R. T. Carter (Ed.), *Handbook of racial– cultural psychology and counseling, training and practice* (pp. 492–513). New York, NY: Wiley.
- López, S. R. (2002). A research agenda to improve the accessibility and quality of mental health care for Latinos. *Psychiatric Services*, 53, 1569–1573. <http://dx.doi.org/10.1176/appi.ps.53.12.1569>
- Moran, G. S., Russinova, Z., Gidugu, V., Yim, J. Y., & Sprague, C. (2012). Benefits and mechanisms of recovery among peer providers with psychiatric illnesses. *Qualitative Health Research*, 22, 304–319. <http://dx.doi.org/10.1177/1049732311420578>
- New Freedom Commission on Mental Health. (2003). *Achieving the promise: Transforming mental health care in America*. Rockville, MD: DHHS Pub. No. SMA-03–3832.
- Office of Minority Health. (2001). *A practical guide for implementing the recommended national standards for culturally and linguistically appropriate services in healthcare*. Rockville, MD: U.S. Department of Health and Human Services.
- Ojeda, V. D., & McGuire, T. G. (2006). Gender and racial/ethnic differences in use of outpatient mental health and substance use services by depressed adults. *Psychiatric Quarterly*, 77, 211–222. <http://dx.doi.org/10.1007/s11126-006-9008-9>
- Repper, J., & Carter, T. (2011). A review of the literature on peer support in mental health services. *Journal of Mental Health*, 20, 392–411. <http://dx.doi.org/10.3109/09638237.2011.583947>
- Robins, L. N., & Regier, D. A. (Eds.). (1991). *Psychiatric disorders in America: The Epidemiologic Catchment Area study*. New York, NY: Free Press.
- Schoenbaum, M., Miranda, J., Sherbourne, C., Duan, N., & Wells, K. (2004). Cost-effectiveness of interventions for depressed Latinos. *Journal of Mental Health Policy and Economics*, 7, 69–76.
- Smedley, B., Stith, A., & Nelson, A. (2003). *Unequal treatment: Confronting racial and ethnic disparities in health care*. Washington, DC: Institute of Medicine, National Academies Press.
- Solomon, P. (2004). Peer support/peer provided services underlying processes, benefits, and critical ingredients. *Psychiatric Rehabilitation Journal*, 27, 392–401. <http://dx.doi.org/10.2975/27.2004.392.401>
- Substance Abuse and Mental Health Services Administration. (2007). *Results from the 2006 national survey on drug use and health: National findings*. Rockville, MD: Author.
- U.S. Department of Health and Human Services. (2001). *Mental health: Culture, race, and ethnicity—A Suppl. to mental health: A report of the surgeon general*. Rockville, MD: U.S. Department of Health and Human Services, Public Health Service, Office of the Surgeon General.
- U.S. Department of Health and Human Services. (2005). *Transforming mental health care in America: Federal action agenda: First steps*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health.
- U.S. Department of Health and Human Services, Office of Minority Health. (2001). *Assuring cultural competence in health care: Recommendations for national standards and an outcome focused research agenda*. Rockville, MD: Author.
- Wells, K., Klap, R., Koike, A., & Sherbourne, C. (2001). Ethnic disparities in unmet need for alcoholism, drug abuse, and mental health care. *The American Journal of Psychiatry*, 158, 2027–2032. <http://dx.doi.org/10.1176/appi.ajp.158.12.2027>
- West, J. C., Herbeck, D. M., Bell, C. C., Colquitt, W. L., Duffy, F. E., Fitek, D. J., . . . Narrow, W. E. (2006). Race/ethnicity among psychiatric patients: Variations in diagnostic and clinical characteristics reported by practicing clinicians. *Focus (American Psychiatric Publishing Online)*, 4, 48–56.

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