

Notes from a Roundtable on Conceptualizing and Measuring Cultural Competence



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INTRODUCTION

Over the last three decades there has been a slow movement in the field of mental health toward improved services for members of minority populations. The questions that have always been in the background for this movement are "What critical components of mental health service need to be changed to make them culturally appropriate for each of the major racial/ethnic populations?" and "Which new services need to be added?"

The creation of the knowledge base needed to answer this critical, complex question was initiated in the early 1970s, when the National Institute of Mental Health (NIMH) established the Minority Mental Health Research Center. The Minority Center developed a project grant program for individual research studies and also funded a "research center" for each of four major racial/ethnic groups: African Americans, Asian Americans, Hispanic Americans, and Native Americans. Each of the four centers established their own research agenda to study the critical needs and issues for their respective groups. Each of the research centers have facilitated planning and education conferences for their stakeholders as the knowledge base has been synthesized.

A second major national milestone in the movement toward culturally competent mental health services came in 1988, when the NIMH Child and Adolescent Service System Program (CASSP) established a Minority Initiative Resource Committee. A subcommittee made its first priority the development of a monograph on culturally competent services. This effort, begun in May 1988, resulted in a monograph entitled *Toward A Culturally Competent System of Care* (Cross et al., 1989). The monograph was a seminal effort because it provided a definition of cultural competence and established a six-point cultural competence continuum for mental health services provided to minority children and adolescents and their families. A second monograph, entitled *Towards A Culturally Competent System of Care: Programs Which Utilize Culturally Competent Principles*, was published in December 1991 to "assist states and communities in planning, designing, and implementing culturally competent systems of care" (Issacs and Benjamin, 1991).

The pioneering work within the CASSP minority initiative influenced the development of culturally competent programs for adults with serious mental illness. In April 1993, the first national conference on *The Journey of Native American People with Serious Mental Illness* was held in Albuquerque, New Mexico, with "tribal, state, and federal representatives and all of the parties really involved in the service system sitting down in the same room together" (Sanchez & McGuirk, 1994). A major goal of the conference was working together to ensure a coordinated, efficient, culturally relevant system of care. A second national conference, titled *The Continuing Journey of Native American People with Serious Mental Illness: Building Hope* was held in Rapid City, South Dakota, in October 1995, to continue the work initiated in 1993 (Bull Bear & Flaherty, 1997). In 1994, the Community Support Branch of the newly constituted Center for Mental Health Services

(CMHS) contracted with the WICHE Mental Health Program to do a cultural competence manual for state mental health authorities (Muñoz & Sanchez, 1996). In 1995, the *Strategic Planning Conference on Hispanic Behavioral Health Workforce Development* focused on the need for increased cultural competence in state and community mental health systems (Sanchez & Obata, 1986). It was this conference which recommended the development of cultural competence standards for mental health services to Hispanic populations. As a result, with the sponsorship of the WICHE Mental Health Program, a national panel of Hispanic mental health professionals, family members, and consumers was established to develop cultural competence standards for programs serving Hispanic populations.

In 1996, as part of their Managed Care and Work Force Training Initiative, CMHS contracted with the WICHE Mental Health Program to continue working with the Hispanic panel and to establish two new panels to work on standards for Native American/Alaskan Native populations and Asian/Pacific Islander populations. Similarly, a panel to develop standards for African American populations was established separately under the auspices of the University of Pennsylvania. During the standard development process under the leadership of the WICHE Mental Health Program, the four national panels began sharing materials and ideas. After drafting ethnic-specific standards, representatives of the four panels met together in Washington, DC in June 1997, under the sponsorship of CMHS and the WICHE Mental Program, to reach consensus about which core cultural competence standards would be applicable to all four groups. Consensus was achieved and the core standards were presented to CMHS in early 1998 by the WICHE Mental Health Program.

Several states have taken the initiative in implementing cultural competence standards and/or regulations. California has been the most active and progressive by issuing regulations under their Medicaid Mental Health Program, which required that each County Mental Health Authority submit a cultural competence plan by July 1998. The regulations included standards to guide the county plans (California Department of Mental Health, 1997). The plans were submitted and reviewed by committees established by the state. The counties are now in various stages of implementation of their plans.

There has been a three-decade history of concern about the need to develop appropriate mental health systems of care for racial/ethnic populations concluding with the relatively recent development of cultural competence guidelines and standards to facilitate related systems change. CMHS, the Evaluation Center at HSRI, and the WICHE Mental Health Program all recognize a great need to improve the mental health system capacity to evaluate the process of implementation of systems change related to cultural competence. There is also a great need to be able to define and measure the consumer outcomes that result from the systems change and to measure the cost-effectiveness of these changes. Of course, the impact of these changes cannot be evaluated without baseline data collected with valid instruments for assessing the current cultural competence at system, program, and individual clinician levels.

To begin to clarify the issues inherent in these evaluation needs and to develop a strategy for resolving these issues, a roundtable discussion of experts in evaluation methodology and experts in cultural competence was convened last December in Denver, Colorado.

References

Bull Bear, M. & Flaherty, M.J. *The Continuing Journey of Native American People with Serious Mental Illness: Building Hope*. Boulder, CO: WICHE, 1997.

California Department of Mental Health. *DMH Information Notice No.97-14: Addendum for Implementation Plan for Phase II Consolidation of Medi-Cal Specialty Mental Health Services --Cultural Competence Plan Requirements*. Sacramento, CA, 1997.

Cross, T.L., Bazron B.J., Dennis, K.W., & Issacs, M.R. *Towards a Culturally Competent System of Care*. Washington, D.C.: CASSP Technical Assistance Center, Georgetown University Child Development Center, 1989.

Isaacs, MR & Benjamin, MP. *Towards a Culturally Competent System of Care: Volume II*. Washington, D.C.: CASSP Technical Assistance Center, Georgetown University Child Development Center, 1989. Volume II

Muñoz, RH & Sanchez, AM. *Developing Culturally Competent Systems of Care for State Mental Health Services*. Boulder, CO: WICHE, 1996.

Sanchez, AM & McGuirk, FD. *The Journey of Native American People with Serious Mental Illness: Building Hope*. Boulder, CO: WICHE, 1994.

Sanchez, AM & Obata ML. *Building An Effective Workforce To Meet The Behavioral Health Needs Of Hispanic/Latino Communities*. Boulder, CO: WICHE, 1986.

ROUNDTABLE OVERVIEW

National experts with experience and background in evaluation methodology and cultural competence met at a roundtable in Denver, Colorado, on December 16-17, 1998 (see Agenda, Appendix A). The group was asked to discuss the challenges and to propose some practical approaches for conceptualizing and measuring cultural competence in the delivery of mental health services.

The two-day roundtable was supported by the Evaluation Center@HSRI (Human Services Research Institute) of Cambridge, Massachusetts, and the Multicultural Mental Health Research Center (MMHRC) of Boston. The Western Interstate Commission for Higher Education (WICHE) Mental Health Program provided support in planning and conducting the roundtable. The Evaluation Center is funded by the Center for Mental Health Services (CMHS) within the Substance Abuse and Mental Health Services Administration (SAMHSA) to provide technical assistance in the area of adult mental health system evaluation to state and community mental health programs.

The roundtable was invitational and involved 20 participants (Appendix B). All major mental health disciplines were represented in the participant group as were the four major racial/ethnic groups: African American, Asian and Pacific Islander American, Hispanic/Latino, and Native American. Ten individuals with strong backgrounds in evaluation methodology and/or cultural competence were invited to participate; nine of them submitted individual papers and brief abstracts addressing practical measures of cultural competency to be used in mental health system evaluation. These papers provided the theme for the roundtable.

The first day, in addition to individual presentations and discussions on the topics presented, Stephen Leff, Ph.D., Director of the Evaluation Center@HSRI, gave participants an overview of the Evaluation Center and discussed the purpose of the roundtable and the desired outcome. Leff stated that he would like the roundtable to result in some guidance to the field on how to move forward in evaluating and measuring cultural competence in the delivery of mental health services. He expressed his hope that the group would identify an existing measurement instrument even if it was less than ideal. Leff acknowledged the existence of evaluation instruments already in the field and proposed that the group discuss both refinements of current instruments and/or creation of new ones. Kermit Crawford, Ph.D., Director of the Multicultural Mental Health Research Center, shared information on activities of the MMHRC and its goals for cultural competence and evaluation issues.

The second day focused on major issues raised in the presentations and expectations of the group about the purpose of the roundtable and what could actually be accomplished. The roundtable ended with an in-depth discussion of issues of defining

and measuring cultural competency and the role of roundtable participants in planning next steps for developing needed evaluation tools.

MAJOR ISSUES IN MEASURING CULTURAL COMPETENCE

The following questions were raised by Stephen Leff at the beginning of the meeting as key issues to address in the discussions.

1. *Is it possible to have behaviorally based measures that are demonstrative rather than assertive of cultural competence?* Many of the organizational measures in the field presently are assertive; they do not measure a system's ability to be culturally competent. He used multiplication tests as an analogy. We need tests that measure the ability to multiply rather than the opinion that one can multiply.
2. *Is it possible to have measures that, in some way, control for the social desirability component (i.e., the desire of individuals and organizations to look good and to answer items accordingly) of measuring cultural competence?*
3. *Can we identify measures that are predictive of service systems outcomes?* While the relationship between measures and outcomes cannot really be tested until we have measures, can we arrive at measures that have a good chance of being related to outcomes both in the sense of creating more behavioral change in the desired direction and in making peoples' experience in the system both empowering and affirming?
4. *Can we develop measures of cultural competence that are now being talked about in the managed care and quality improvement worlds as actionable measures that relate to a specific quality improvement and education activity?*
5. *Can we develop evaluation instruments that are practical for use in large systems, instruments that are not too long or burdensome in both time and resources required to administer them?*

The nine papers addressing cultural competence in performance measurement systems and evaluation research were circulated to participants prior to the meeting in preparation for roundtable discussions. The papers explored a number of issues, including the dilemmas of defining and measuring cultural competence, domains of assessment, and types of assessment. Frederick T. L. Leong, Ph.D. of the Department of Psychology at Ohio State University, and Joseph G. Ponterotto, Ph.D. of the Counseling Psychology Program at Fordham University, Lincoln Center, in New York City were unable to attend. However, material from their papers was presented by Stephen Leff. A synopsis of Dr. Francis Lu's presentation, for which there is no paper, is also included. Brief summaries of papers and presentations by seven of the presenters who attended the roundtable are presented below.

PAPER AND PRESENTATION SUMMARIES

These paper and presentation summaries are given in the order they were dealt with during the roundtable meeting. Appendix C has the texts of all papers organized alphabetically by author.

Practical Measures of Cultural Competence In Managed Care

Jeff King, Ph.D., Director, Native American Counseling, Inc., Denver, Colorado, and co-chair of the National Native American Managed Care Panel, one of the four cultural competence panels that developed the Core Cultural Competence Standards in Managed Mental Health Care for Four Underserved/Underrepresented Racial/Ethnic Groups.

The development of an instrument to assess cultural competency among mental health agencies is a formidable task. There are numerous dimensions to cultural competency as well as to mental health provisions in a managed care setting. King identifies key issues and questions to consider in developing a measure of cultural competence in managed care examining the following areas:

- The approach to be taken in the evaluation.
- The specific purpose of the measure.
- Levels of analysis.
- Levels of cultural competence.
- Systemic questions.
- Rating agency effectiveness.
- Provider competencies.

Practical Measures for Population-Based Planning: A Prerequisite in Developing Culturally Competent Services

Josie Torralba Romero, LCSW, consultant on cultural competence and a member of the National Latino Behavioral Health Workgroup, one of four cultural competence panels that developed the Core Cultural Competence Standards in Managed Mental Health Care for Four Underserved/Underrepresented Racial/Ethnic Groups.

Two elements of cultural competence - population-based planning and organizational self-assessment - should be considered as prerequisites if one is to measure the cultural competence of individuals and organizations. Romero provides an overview of these two elements, which she sees as essential in establishing a baseline knowledge to begin measuring developmental growth in individuals and organizations. These two

planning elements also provide the “context” from which all planning and training must be derived.

The two elements mentioned in this paper, population-based planning and organizational self-assessment, are not new to the literature of cultural competence. However, Romero describes them as they relate to the findings of the populations in a particular community, region, or county.

Measuring Cultural Competency: Issues and Dilemmas

Stanley Sue, Ph.D., Professor of psychology and psychiatry, Director of the Asian American Studies Program at the University of California at Davis, and co-chair of the National Asian and Pacific Islander American Panel, one of four cultural competence panels that developed the Core Cultural Competence Standards in Managed Mental Health Care for Four Underserved/Underrepresented Racial/Ethnic Groups.

One of the most important tasks in the provision of mental health services is the development of cultural competency and cultural competency measures. Sue proposes three critical characteristics of cultural competence. These are having good general skills, having skills in dynamic sizing, and having culture specific knowledge. Sue maintains that four tasks need to be addressed in establishing measures of cultural competency:

- Defining cultural competency (while a number of definitions do exist, the real problem is to arrive at a reasonable consensus on the nature of the term).
- Developing measures.
- Ensuring adequate psychometric properties and validity.
- Considering the usefulness of measures.

The issues within the four tasks have not been satisfactorily addressed in existing measures of cultural competency. Progress on the establishment of measures must be guided by the four tasks.

Issues Pertinent to the Selection of Cultural Competence Measures in Performance Measurement Systems

Mildred Vera, Ph.D., Center for Evaluation and Sociomedical Research, School of Public Health, University of Puerto Rico.

Managed care environments have the responsibility of developing systems of care that address the cultural variations of consumers from diverse ethnic populations. In her paper, Vera examines the product of a joint effort of four national racial/ethnic panels in the formulation of a set of viable performance indicators aimed at improving the

ability of managed care organizations to meet cultural competence standards.¹ The role of culture in performance assessment is explored and relevant factors examined for selecting appropriate measures of cultural competence that address *systems*, and *clinical* and *provider* elements.

Cultural Competence Prerequisites for Managed Behavioral Health Care Programs

Joseph M. Torres, Ph.D., consultant, Massachusetts Department of Mental Health, and member of the National Latino Behavioral Health Workgroup, one of four cultural competence panels that developed the Core Cultural Competence Standards in Managed Mental Health Care for Four Underserved/Underrepresented Racial/Ethnic Groups.

The primary purpose for strategic implementation of the national *Cultural Competence Standards for Managed Mental Health Care Programs* is to promote the systematic development of culturally competent public and private systems of care.² Achievement of this goal will require public and managed care organizations to develop strategic cultural competence implementation plans and also program evaluation plans to measure the progress and effectiveness of the cultural competence system of care.

Some basic concepts considered by four national cultural competence workgroups when developing the *Cultural Competence Standards for Managed Mental Health Care Programs* are discussed in Torres's paper. Torres believes that the Program Evaluation Plan and the Cultural Competence Plan should be concurrently developed and implemented. This would ensure that essential principles and values that generated the *Cultural Competence Standards for Managed Mental Health Care Programs* would be accurately represented by the evaluation protocols used. In his paper, Torres contends that the gradual development of an effective cultural competence evaluation plan will require the continuous linking and active collaboration between specialists with cultural competence expertise and specialists with program evaluation expertise. The paper considers some of the issues inherent in developing appropriate cultural competence indicators or outcome measures, and the appropriate methodology to assess progress in the implementation of the cultural competence plan and its effectiveness over a specified period of time.

¹ WICHE/CMHS. *Core Cultural Competence Standards in Managed Mental Health Care for Four Underserved/ Underrepresented Racial/Ethnic Groups*. (Boulder, CO: WICHE, 1998).

Additional priority issues and barriers to effective mental health care service delivery to Hispanic consumers are discussed from the perspective of the National Latino Behavioral Health Workgroup, including:

- Cultural Competence (requires a highly specialized developmental, long-term, multistage process to implement).
- Representative participation in workforce.
- Quality and design of programs.
- Qualified interpreters.
- Quality care.
- Community improvement and system change.

Linking Values Orientation, Acculturation, and Life Experiences to the Implementation of Services: Recommendations for Four Constructs to be Measured in an Instrument on Cultural Competence of Mental Health Services Delivery

Daniel A. Santisteban, Ph.D., Center for Family Studies, University of Miami, and Frederick L. Newman, Ph.D., Florida International University & Center for Family Studies, University of Miami.

Measurement of cultural competence is a complex but critically important endeavor. Without cultural competence, a system cannot be expected to effectively bring consumers into service or effectively treat consumers of different ethnic and racial backgrounds. In developing an instrument that can be used in evaluating a service systems' cultural competence, there are a number of domains that the measure must cover. The purpose of this paper is to articulate how and why these important domains must be addressed.

- First, the instrument must assess the overall competence of the service system in understanding the treatment model and in delivering interventions consistent with the model. That is, cultural competence must be built upon a foundation of basic professional competence and that professional competence cannot be assumed to be present.
- Second, the instrument must assess the degree to which a system understands the range of basic values' orientations that consumers from diverse cultures may endorse. This must also include an understanding of how the values and assumptions on which the intervention model is based may be compatible or incompatible with those of the consumers.
- Third, the instrument must be capable of assessing the service system's knowledge of the life experiences (immigration and acculturation stress, racial prejudice and discrimination, the sociopolitical standing of the

consumer's ethnic group within the host society) that shape the consumers' everyday lives.

- Fourth, the instrument must be capable of measuring the systems ability to engage and treat the consumer with ease - that is, the extent to which there is tolerance and comfort with the diverse customs, habits, beliefs, and behaviors that ethnic clients bring with them.

Defining and Measuring Cultural Competence in the Evaluation of Mental Health Services

Lee Sechrest, Ph.D. and Michele Walsh, The Evaluation Group for Analysis of Data, Department of Psychology, University of Arizona.

Race, ethnicity, and culture should not be used interchangeably as they have different meanings. In most instances, in the delivery of mental health services, culture is of focal interest, but occasionally ethnicity, which refers to group identification, is at issue. It may be difficult in many instances to specify what is intended by cultural competence and to distinguish it from general sensitivity to differences among people. This situation arises partly because people are culturally complex and at any given time it may be difficult to determine what the relevant culture is, even if one knows its characteristics. Cultural competence will require broad training in principles of sensitive social interaction as well as in characteristics of local populations being served and the cultural factors likely to be operating among them.

Specific features of local populations and their adaptations need consideration. Language barriers may be of overestimated importance if only because they are usually so obvious. Expectations about patterns of communications and health care beliefs and practices must be known and taken into account, as must sources of stress and coping skills. Family organizational and relational roles are also likely to determine the nature of interactions in service delivery settings.

In general, effective and efficient delivery of mental health services will be fostered if we learn to identify and measure the actual cultural variables in which we are interested rather than simply treating a social address as a proxy for standing on those variables. It is particularly important to identify those variables related to the ways in which services are to be organized and delivered. A wide range of measures is now available, but they need to be both improved and extended.

California's Cultural Competence Plan

Francis Lu, M.D., Professor, Department of Psychiatry, San Francisco General Hospital, University of California.

California's Cultural Competence Plan is an example of a cultural competence requirement that is already in place for county mental health programs across the state. California may be the first state that has regulations in this area. The large number of culturally diverse people in the Medicaid population was the driving force behind the state's effort to get counties to incorporate cultural competence in their managed care plans.

The move to add cultural competence requirements began in June 1995 when California issued its Managed Care Mental Health Plan for Medicaid recipients that had some but not much of a focus on cultural competence. At the request of a number of people, the state moved to add cultural competence to the plan. A Cultural Competence Task Force was created in November 1996 to develop cultural competence plan requirements as an addendum to the Managed Care Plan. The Task Force included California State Department of Mental Health staff, county mental health directors, county cultural competence specialists, academicians, consumers, family representatives, and community-based organizations. In October 1997, the California Cultural Competence Plan requirements were completed using a number of documents to create the requirements, including:

- New York State Office of Mental Health Cultural and Linguistic Competence Standards (December 1995 draft).
- SAMHSA/CMHS Evaluation Agenda (June 1996).
- WICHE/CMHS Latino Cultural Competence Standards (1996) and the Core Cultural Competence Standards (April 1996 prepublication draft).

Each county was required to submit a cultural competence plan to the California Department of Mental Health by July 1998. These plans were reviewed and feedback given to the county.

Definitions and Measurement of Cross-Cultural Counseling Competencies

Frederick T. L. Leong, Ph.D., Department of Psychology, Ohio State University.

Leong's paper begins with some definitions of multicultural counseling versus cross-cultural counseling and cultural competence versus cross-cultural competence. Leong clarifies some concepts in cross-cultural counseling and points out the misapplication of concepts of multicultural counseling and cultural competence. A strong recommendation is made for the use of more specific and accurate terminology of cross-cultural counseling and cross-cultural competence.

Using the conceptual model provided by the Division 17 position paper for cross-cultural counseling competencies,³ the paper reviews different measures for assessing the awareness, knowledge, and skills dimensions represented by this model. Finally, some caveats about the model and the measures are discussed in detail.

Assessing Cultural Competence in Mental Health Service Delivery

Joseph G. Ponterotto, Ph.D., Counseling Psychology Program, Fordham University, Lincoln Center, New York City.

Mental health delivery systems will be working with an increasingly diverse client base in the coming decades. The majority of providers are not adequately prepared to work across cultural and linguistic differences. Two pressing needs at this time are an adequate definition of cultural competence and the reliable and valid assessment of this competence in both individual and organizational contexts.

This brief position paper addresses these issues and outlines extant competency measures. A recommendation for long-term, combined qualitative and quantitative assessments is presented. Three appendices present sample competency assessments:

- The Multicultural Counseling Knowledge and Awareness Scale (MCKAS).
- The Multicultural Counseling Competencies Portfolio Assessment.
- The Multicultural Counseling Competency Checklist for Academic Counseling Training Programs.

³ Position Paper on Cross-Cultural Counseling Competencies commissioned by the Division of Counseling Psychology (Division 17) of the American Psychological Association and published in 1982 in *The Counseling Psychologist*, the Division 17 journal.

DISCUSSION SUMMARY

Evaluation of cultural competence is a critical issue because the federal government is unable to systematically enforce the cultural competence requirements of its programs unless adequate evaluation instrumentation exists. Several roundtable participants who have worked on cultural competence issues for years expressed a strong desire for the collective expertise present in the room to come up with a plan, a product, or some resolution by the end of the meeting. In general, there was a sense of urgency by the group to get something done right away. It was pointed out that much of the information contained in the papers submitted by participants about practical measures of cultural competence is a review of what is known to be out in the field. This knowledge base could be used as a starting place for the group.

One cultural competence assessment instrument that surfaced several times in the discussions as an interesting model was James Mason's *An Organizational Cultural Competence Self-Assessment*. The Mason instrument was described as one of the most comprehensive models and one that would need the fewest changes to meet the needs of the group. This tool assesses existing skills and knowledge in seven domains that cover both the organizational and individual clinician levels. Josie Romero of JTR & Associates and the New Jersey Division of Mental Health Services have developed modified versions of the Mason instrument and are currently using them in California and New Jersey. The Missouri Department of Mental Health also has a revision available.

Comments and recommendations throughout the discussions were varied and broad. The group struggled with the formidable task of reaching a consensus on how to measure cultural competence in mental health service delivery, or even how to define cultural competence. Several major issues surfaced, some involving more in-depth discussion than others. They are presented in the next section along with some of the discussion. It was clear that those participants selected primarily for their expertise in evaluation came with a different perspective than those selected for their cultural competence expertise.

The group was also challenged to consider issues that might arise with regard to managed care companies if new measures are proposed. For example, in light of the understanding that there is a typical attitude by managed care companies that adding something new is going to cost them more money, what will their attitude be about new measures being proposed?

Major Issues Raised in Discussions

Several issues raised during the roundtable included:

- What is cultural competence?
- How do you measure cultural competence?
- What is cultural identity of an individual, (e.g., consumer)?
- How do you measure staff capacity to determine cultural identity?
- What evaluation instruments are currently available to measure cultural competence?
- What cultural competence standards are currently available? How can they be used in the development of measures?

1. What is cultural competence?

Cultural competence was described as a broad issue, multidimensional, and very difficult to measure. Participants were reminded of the importance of distinguishing between linguistic and cultural competence. These can be considered mutually exclusive competencies; that is, one may be trained in a language without necessarily being made culturally competent or a person may be culturally competent but lack the ability to communicate this competence.

Developing definitions of cultural competence at three different levels (i.e., systems, organizations, and individual clinicians) surfaced as a high priority item. One suggestion was to learn what cultural competence is by first trying to measure different aspects of it at the three levels. Measurement issues are discussed in more detail below.

There was some discussion about whether cultural competence, at a provider level, can be demonstrated to be anything beyond general interpersonal sensitivity and general practitioner competence. That is, are sensitive, competent practitioners likely to be able to negotiate the challenges of cultural difference without specific training in those differences? There was not consensus on this issue as some felt strongly that there would always be a need for specific training on the cultural differences across regions and over time. However, participants, for the most part, agreed with the statement that every person seeking help from an agency deserves the very best and most appropriate treatment available, and that professionals need to think of culturally competent treatment as something they are required to provide all their clients.

Additionally, there was discussion about how one defines culture as it relates to the individual seeking treatment and his/her identity. That is discussed in more detail

under cultural identity.

2. How do you measure cultural competence?

There was a general consensus that one of the most important tasks in the provision of mental health services is establishing measures of cultural competence. However, the task of identifying scientifically sound measures of cultural competence for use by behavioral healthcare systems, organizations, individual providers, and consumers proved to be more difficult.

One suggestion was that we begin by measuring cultural competence at the levels (systems, organizations, and individual clinicians) defined in the *Core Cultural Competence Standards in Managed Mental Health Care for Four Underserved/Underrepresented Racial/Ethnic Groups*. It was also suggested that development of evaluation measures be a collaborative effort between evaluators, cultural competence experts, consumers, families and front line providers. Additionally:

- Measures should be pragmatic and relevant to the community in which they are used.
- Measures should be research oriented.
- Measures should be useable at multiple levels including systems, organizations, and individual clinicians.
- Development of measures should start at the consumer level.
- Measures should capture cultural competence issues but also address specific community issues.
- Organizations need to be measured in partnership with the community stakeholders including consumers and families and other relevant agencies.
- Measures should capture the various complexities of an individual's culture (for example, multiple racial ethnic identities, age, gender, sexual orientation, immigration, acculturation).
- Measures should include a population-based needs assessment including assessment of service utilization.
- Measures should address the cost-effectiveness of and individual consumer outcomes associated with cultural competence.

One remaining issue is whether there should be measures for each of the three levels identified above or whether measures can be developed for use at multiple levels.

3 & 4. What is the cultural identity of an individual (e.g., consumer)? How do you measure staff capacity to determine cultural identity?

Two critical considerations in developing measures of cultural competence are: 1) how

a person identifies him/herself and 2) which element of identity a person determines as most important in the treatment setting. Individuals have multiple cultural identities beyond their race or ethnicity that impact who they are. Elements of a person's identity can vary in importance across time and situations. An evaluation instrument that includes identity variables such as age, gender, multiple race and ethnicity identifications, immigration status, acculturation, family ties, and sexual orientation would provide valuable information about a person's cultural identity and facilitate culturally competent practice. Participants were cautioned about the need to have an intensive level of sensitivity training to go along with any forms or measures that would be used for evaluation. Therapists must have the skills to get clients to identify their own culture. This is part of an ability to engage a client and these skills should be measured.

5. What instruments are currently available to measure cultural competence?

While some of the discussion focused on where to begin, several participants felt the place to start is by identifying and reviewing cultural competence evaluation instruments currently in the field. Although some instruments have demonstrated reliability and validity, none apparently adequately address all three levels of cultural competence, systems, organizations, and individual clinicians. *Cultural Competence Performance Measures for Managed Behavioral Healthcare Programs*, recently developed by the New York State Office of Mental Health, is considered important to the work of the group. Some participants expressed a desire for CMHS efforts toward developing such instruments be more unified. A streamlined approach to refining cultural competence evaluation will yield a product that can be implemented in a more systematic and meaningful way.

6. What cultural competence standards are currently available? How can they be used in the development of measures?

Participants are aware of several current cultural competence standards in existence and agreed on the need to review cultural competence standards that have already been developed. There was general agreement that the *WICHE/CMHS Core Cultural Competence Standards in Managed Mental Health Care for Four Underserved/Underrepresented Racial/Ethnic Groups* capture the essence of most of the others and provides a good framework for looking at cultural competence. The *NYOMH/CMHS Cultural Competence Performance Measures for Managed Behavioral Healthcare Programs*, which build upon the *WICHE/CMHS* work, could also be a good framework. Several roundtable members are members of four national racial/ethnic panels that developed ethnic specific and core cultural competence standards under the auspices of WICHE. Torres pointed out that the *Core Cultural Competence Standards in Managed Mental Health Care for Four Underserved/Underrepresented Racial/Ethnic Groups*, the product of a national

collaborative effort by these four panels, is now in various phases of implementation and assessment. The *Core Cultural Competence Standards in Managed Mental Health Care for Four Underserved/Underrepresented Racial/Ethnic Groups* has gone through an official approval process at the Substance Abuse and Mental Health Services Administration (SAMHSA) level of government. The standards are accessible through the SAMHSA Website (www.mentalhealth.org) and WICHE Website (www.wiche.edu).

RECOMMENDATIONS FOR NEXT STEPS

Several recommendations for future directions were made including:

- A commitment from CMHS of knowledge development resources to identify best practices for the implementation and evaluation of cultural competence standards.
- A follow-up meeting of those with expertise in cultural competence and evaluation to develop consensus around:
 - Defining the construct of cultural competence at the system, organization, and individual clinician levels.
 - Adopting the WICHE/CMHS *Core Cultural Competence Standards in Managed Mental Health Care for Four Underserved/Underrepresented Racial/Ethnic Groups*.
 - Forming workgroups for each of the three levels of cultural competence: systems, organizations, and individual clinicians. (Each workgroup will build upon existing measures to identify key items to include in an evaluation tool for that area. The newly developed evaluation instrument shall be piloted and tested to establish reliability, validity, and utility).
- Convene a joint conference of key groups working on cultural competence evaluation issues (i.e., CMHS, HSRI, WICHE, NYOMH).
- Tie development of an instrument or instruments to assess cultural competence to the further development and implementation of the *Core Cultural Competence Standards in Managed Mental Health Care for Four Underserved/Underrepresented Racial/Ethnic Groups* and the *Cultural Competence Performance Measures for Managed Behavioral Healthcare Programs*.
- Explore collaboration opportunities with other CMHS-funded projects, including the adult and child evaluation technical assistance centers that relate to the work being considered.
- Compute the cost of cultural competence to managed care to see if it can demonstrated that cultural competence has a positive effect in a cost neutral way.
- Explore involvement of licensing boards and others to gain leverage for cultural competence.

SYNTHESIS OF NEXT STEPS (BY DR. FRANCIS LU)

Using the analogy of launching a satellite with a three-stage rocket, Francis Lu provided his synthesis of ideas presented at the roundtable for arriving at a plan of implementation.

Analogy/Vision: To launch a satellite that will be of enduring value to behavioral healthcare systems, agencies, individual providers, and consumers to measure concretely existing core cultural competence standards and indicators.

Envision a three-stage rocket to launch the satellite.

First Stage (completed):

- WICHE/CMHS *Core Cultural Competence Standards in Managed Mental Health Care for Four Underserved/Underrepresented Racial/Ethnic Groups* - WICHE leadership linked with CMHS.
- Four cultural competence panels of underserved/underrepresented racial/ ethnic groups, focusing on:
 - Four cultural competence panel co-chairs (leadership).
 - Four existing cultural competence panels.
 - Broad-based consumers, families, providers, community organizations, academia to assure credibility and legitimacy.

Second Stage

- Specify and refine measures that can utilize state data sources.
- Assess feasibility of obtaining information, conceptual validity of measures for markers of indicators (e.g., literature, expert opinion).
- Enfold New York Office of Mental Health (NYOMH) Project as participant in the second stage focus groups of consumers and expert panels to refine measures. There is a need for the NYOMH Project to be reviewed by the four Cultural Competence Panels because NY did not use only the WICHE Standards; they also used others.
- Use paradigm to specify/refine remaining measures and make revisions to the four Cultural Competence Panel documents.

Third Stage

- Develop specific instruments based on the measures/indicators for the Core Cultural Competence Standards. The focus should be on the measures as refined in the second stage above using NYOMH Project materials.
- Instrument development involves pilot testing for reliability and validity. Need to prioritize among systems, agency, individual providers. Also review existing databases for data that can be dropped into measures to the extent that these data can be used. Incorporate other instruments, (e.g., MHSIP Report Card with cultural competence items.)

Satellite

- Pilot tested, reliable, validated instruments of measures, indicators of Core Cultural Competence Standards. These instruments would be used for further research as well as ongoing CQI evaluation. Synergistic collaboration between:
 - Four cultural competence panels.
 - Evaluation experts (HSRI, NYOMH, others).
 - State and county mental health directors (involve in measure, instrument development, and pilot testing).
 - NIMH minority mental health research centers, e.g. Asian, Hispanic, Black, Native American, Psychobiology (i.e., Keh-Ming Lin); psychopharmacology as aspect of cultural competence.

Implementation Steps

1. Form synergistic collaboration.

HSRI	Other Evaluation Experts	WICHE
State Directors	NYOMH	Four Cultural Competence Panels
County Directors	Other	NIMH Minority Research Centers
IAPSRs		
Consumer Groups		

2. Submit proposal to CMHS to get funding for comprehensive evaluation package.

- Vision/Three Stage Rocket Analogy
- Concrete Steps

- 18-Month Plan
- 3-Year Plan

CONCLUSION

Leff, in his closing remarks, stated that HSRI, under its contract with CMHS to provide evaluation technical assistance, will continue to provide technical assistance towards the development of a cultural competency evaluation strategy. HSRI will review input provided by participants and their recommendations and assess whether a follow-up working meeting needs to take place. If the decision is made to reconvene the group, HSRI will send everyone material in advance for them to review and submit proposed measures.

Additionally, HSRI will share information it has on cultural competency related instruments, guidelines, standards, and indicators.

Kana Enomoto of CMHS stated that once valid evaluation instruments for each of the three levels identified (systems, organizations, and individual clinicians) have been developed, it will be possible to conduct the necessary field research demonstrating the link between cultural competence in mental health services and improved treatment outcomes (broadly defined).

APPENDIX A: AGENDA

the Evaluation Center@HSRI Roundtable
Conceptualizing and Measuring Cultural Competence
Denver, Colorado
December 16-17, 1998

Agenda

December 16

- 8:00 a.m. **Continental Breakfast**
- 8:30 *Welcome and Introductions*
 Courtenay Harding, WICHE
- 8:50 *Overview of the Evaluation Center, Roundtable Purpose and Goals*
 H. Stephen Leff, HSRI
Overview of MMHRC
 Kermit Crawford, Multicultural Mental Health Research Center
 (MMHRC)
- 9:10 *CMHS Projects*
 Harriet G. McCombs, CMHS
- 9:30 *Practical Measures for Population - Base Planning: A Prerequisite in Developing
Culturally Competent Services*
 Josie Romero, Consultant, San Jose, CA
- 10:00 *Defining and Measuring Cultural Competence in the Evaluation of Mental Health
Services,*
 Lee Sechrest, Evaluation Group for Analysis of Data, Department of
 Psychology, University of Arizona
- 10:30 **Break & Networking**
- 11:00 *Assessing Cultural Competence in Mental Health Service Delivery,*
 (Paper by Joseph G. Ponterotto, Counseling Psychology Program,
 Fordham University, New York City) Presenter: H. Stephen Leff,
 HSRI
- 11:30 *California Plan for Cultural Competence*
 Francis Lu, Department of Psychiatry, San Francisco General Hospital,
 University of California
- 12:00 **Group Lunch**

- 1:30 *Measuring Cultural Competency: Issues and Dilemmas*
Stanley Sue, National Research Center for Asian American Mental Health, Dept of Psychology, University of California at Davis
- 2:00 *Practical Measures of Cultural Competence in Managed Care*
Jeff King, Native American Counseling Inc., Denver
- 2:30 *Definitions and Measurement of Cross-Cultural Counseling Competencies*
(Paper by Frederick T.L. Leong, Depart. of Psychology, Ohio State University) Presenter: H. Stephen Leff, HSRI
- 3:00 **Break**
- 3:15 *Cultural Competence Prerequisites for Managed Behavioral Health Care Programs*
Joseph Torres, Massachusetts Department of Mental Health
- 3:45 *Issues Pertinent for the Selection of Cultural Competence Measures in Performance Measurement Systems*
Mildred Vera, Center for Evaluation and Sociomedical Research, University of Puerto Rico
- 4:15 *Recommendations for Constructs to be Measured by an Instrument on the Cultural Competency of a Mental Health Service from Family Intervention Science*
Daniel A. Santisteban, Frederick L. Newman, Center for Family Studies, University of Miami
- 4:45 *Wrap-up*
H. Stephen Leff, HSRI; Jim Stockdill, WICHE
- 5:00 **Adjourn**

December 17

- 8:30 am **Continental Breakfast**
- 9:00 *Major Issues Raised in Presentations*
Jim Stockdill, WICHE; H. Stephen Leff, HSRI; Bob Egnew, Monterey County Mental Health (California); Kermit Crawford, MMHR Center
- 10:00 *Roundtable Discussion* (with working break)
- 11:00 *Next Steps*
H. Stephen Leff, HSRI
- 11:30 *Closing Remarks*
H. Stephen Leff, HSRI; Courtenay Harding, WICHE

12:00

Adjourn

APPENDIX B: PARTICIPANT LIST

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Conceptualizing and Measuring Cultural Competence
Denver, Colorado
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APPENDIX C: PAPERS

Practical Measures of Cultural Competence in Managed Care

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December 1998

The development of an instrument to assess cultural competency among mental health agencies is a formidable task. There are numerous dimensions to cultural competency as well as mental health provision in a managed care setting. My approach will be to identify what I think are the key areas to consider, to offer what others have contributed in this area, and to ask pertinent questions about this type of evaluation. These, in turn, will help formulate more specifically the design of the measure or measures.

Initial Approach

Obviously, the first question is “What approach are we going to take in our evaluation?”. Are we evaluating all the components within an agency from executive board to clerical staff? Or, are we to highlight the aspects of the agency more directly related to mental health provision? Are we evaluating consumer/community satisfaction or competency within the agency or both? Hopefully, these are related. Furthermore, are we evaluating cross-sectionally, longitudinally, or what?

Are we evaluating a program as “in development toward competence” or are we summarizing a program’s effectiveness over a specified period of time? What perspective are we taking? Orlandi (1992) suggests there are three basic perspectives: (a) Process Level evaluation looks at the ongoing operating procedures (more of a quality assurance review) and requires a formative perspective; (b) Program Level, which addresses how a program achieves its specific goals and uses both formative and summative perspectives; (c) Evaluation Research Level which uses rigorous experimental designs and statistical analyses to examine the internal and external validity of programmatic effectiveness.

Purpose of Measure

Hopefully, the measure will be used to increase the quality and sensitivity of services and that these services will improve over time. This measure can also provide

the opportunity to discover both positive and negative effects associated with service provision strategies. Finally, this measure may be able to allow staff, clinicians, and administrators to provide specific, pragmatic, comprehensive, and effective descriptions of their cultural competencies. These in turn can be used by other agencies making these same attempts (Casas, 1992).

Specificity of Measure

If this measure is going to be used across cultures, it must be generic enough to access common dimensions across ethnicities. Perhaps the measure can have a generic component for cross-comparisons of the programs for various ethnic groups and a certain portion allotted to culture-specific items that can provide much needed emic information for local evaluation and programmatic purposes.

Cultural Competency Levels

Cross, Bazron, Dennis, and Isaacs (1989) suggest a cultural competency continuum on which agency effectiveness may be evaluated, ranging from cultural destructiveness on one end to cultural proficiency on the other. A detailed quote of these “stages” is provided as it gives specific definitions for levels of competency.

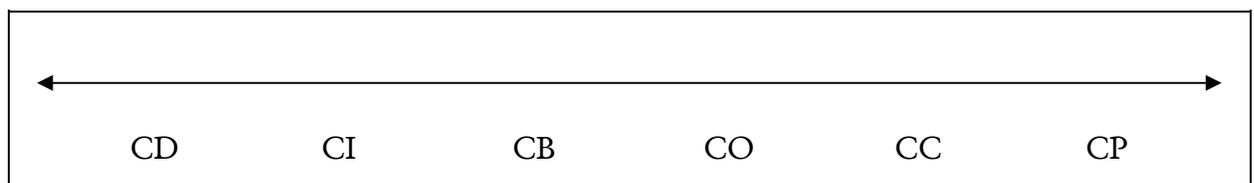


Figure 1. Cultural Competency Continuum (Cross, et al., 1989)

CD: Cultural destructiveness.

CI: Cultural incapacity

CB: Cultural blindness

CO: Culturally open

CC: Culturally competent

CP: Culturally proficient

These continuum processes are further defined in Cross, et al, (1982) can provide a framework for developers in determining item content

Domains of Cultural Competence for an Agency

Needs Assessment

An agency must know the community it reports to serve in terms of needs. The following questions are taken (with modifications) from Kim, McLeod, and Shantzis (1992) and relate to this type of assessment:

Has the agency conducted a formal needs assessment within the community within the last two years? Were community members consulted/employed in the development of this assessment? Where was the instrument administered? What was the community's response to this survey?

Are data collected and kept for racial/ethnic populations? Are these data shared with consumers, community members, and other community agencies? Are these data used in annual reports, self-evaluation, and planning? Are they submitted to the review of community members, cultural consultants, or consumers?

Training

Has the agency required training for its staff in cultural competency within the last 2 years? Who were the trainers? Were they from the local community? Were these trainings subjected to evaluation by community members, consumers, or cultural consultants? Are there data to reflect the impact of training? Have board members been trained in cultural competency in the last 2 years? Who were the trainers? Were they from the local community? Were these trainings subjected to evaluation by community members, consumers, or cultural consultants? Are there data to reflect the impact of the training?

Staffing Hiring Procedures

What percentage of the targeted ethnic minority group is employed in this agency? In what capacity and at what level? What percent of the staff is bilingual? What percent of the staff is trained in cultural awareness? What percent of the targeted ethnic minority group is represented in an ethnic racial advisory council? What percent of the board members is from the targeted ethnic minority group? What percent of the targeted ethnic minority group is represented at the administrative (or decision-making) level of the agency?

Prior Performance Patterns

Are there linkage with other ethnic minority community groups? Are contract awards given to ethnic/racial service providers for issues specifically related to them? Does the agency set aside funds on behalf of the ethnic minority consumers or communities? Does the mission statement of the organization provide for culturally competent services?

Does the agency adjust holidays to accommodate cultural differences? Does the agency contract with local healers from the community? Does the agency allow consumers/community members to evaluate their performance? Is the agency located in or around the vicinity of the targeted group? Do service hours reflect client accessibility? Does the agency provide educational and other materials in the language or style that can be understood by ethnic minority consumers/community members? Does the agency actively seek to improve relations with the targeted ethnic minority community?

Agency Effectiveness Defined

Kim, McLeod, and Shantzis (1992) provide a formula which gives an overall performance rating for agency effectiveness called the Minority Service Success Rate:

$$EX = NT \times TY/N \qquad MSS = AX/EX \times 100$$

EX = Expected number of ethnic minority group clients who could have been served during a selected time period.

NT = Total size of targeted community relative to the larger community.

TY = Total number of clients served by a reference agency during this selected time period.

N = Total population size of a larger community in which targeted community resides.

MSS = Index score of minority service rate.

AX = Actual number of target group clients served by targeted agency during selected time period.

This formula or one like it can help determine item selection and rating schedule for a competence measure.

Provider Competence

There are many scales available that rate provider competency. In fact, The Education and Training Committee of the American Psychological Association's Division of Counseling Psychology (Division 17), conceptualized three dimensions of cross cultural counseling competencies: (a) beliefs-attitudes, (b) knowledges, and (c) skills. Included in these were 11 specific minimal skills (Sue, Bernier, Durran, Feinberg, Pedersen, Smith, & Vasquez-Nuttal, 1982). Later, the Professional Standards Committee of the Association for Multicultural Counseling and Development introduced three additional characteristics: (a) counselor's own awareness of their assumptions, beliefs, and biases, (b) an understanding of the world view of the culturally different client, and (c) the development of appropriate

intervention strategies and techniques (Sue, Arredondo, & McDavis, 1992). These areas for cultural competence are echoed by many other clinicians and researchers (Cayleff, 1986; Helms, 1990; Lynch & Hanson, 1992; & Smith, 1985).

Some measures hold promise in terms of their statistical validity, however, I think a formal review of these instruments by the panel would be necessary, if indeed, it is decided to assess cultural competence at this level.

References

Casas, J. M. (1992). A Culturally Sensitive Model for Evaluating Alcohol and Other Drug Abuse Prevention Programs: A Hispanic Perspective. In, Orlandi, M. A. (Ed.) *Cultural Competence for Evaluators: A Guide for Alcohol and Other Drug Abuse Prevention Practitioners Working With Ethnic/Racial Communities*. Office for Substance Abuse Prevention, OSAP Cultural Competence Series 1, U.S. Dept of Health and Human Services, Public Health Service, Alcohol, Drug Abuse, and Mental Health Administration, pp. 75-116.

Cayleff, S. E. (1986). Ethical issues in counseling gender, race, and culturally distinct groups. *Journal of Counseling and Development*, 64, 345-347.

Cross, T. L., Bazron, B. J., Dennis, K. W., & Isaacs, M. R. (1989). *Toward a Culturally Competent System of Care*. Washington D.C.: Georgetown University Child Development Center.

Helms, J. (1990;). Toward a model of White racial identity development. In J. E. Helms (Ed.) *Black and white racial identity: Theory, Research and Practice*. New York: Greenwood Press.

Kim, S., McLeod, J. H., & Shantzis, C. (1992). Cultural Competence for Evaluators Working With Asian-American Communities: Some Practical Considerations. In, Orlandi, M. A. (Ed.) *Cultural Competence for Evaluators: A Guide for Alcohol and Other Drug Abuse Prevention Practitioners Working With Ethnic/Racial Communities*. Office for Substance Abuse Prevention, OSAP Cultural Competence

Series 1, U.S. Dept of Health and Human Services, Public Health Service, Alcohol, Drug Abuse, and Mental Health Administration, pp. 203-260.

Lynch, E. W., & Hanson, M. J. (1992). *Developing Cross-cultural Competence: A Guide for Working With Young Children and Their Families*. Baltimore: Paul H. Brookes Publishing Co.

Orlandi, M. A. (1992). Defining Cultural Competence: An Organizing Framework. In, Orlandi, M. A. (Ed.) *Cultural Competence for Evaluators: A Guide for Alcohol and Other Drug Abuse Prevention Practitioners Working With Ethnic/Racial Communities*. Office for Substance Abuse Prevention, OSAP Cultural Competence Series 1, U.S. Dept of Health and Human Services, Public Health Service, Alcohol, Drug Abuse, and Mental Health Administration, pp. 1-22.

Smith, E. M. J. (1985). Ethnic minorities: Life, stress, social support, and mental health issues. *The Counseling Psychologist*, 13, 537-579.

Sue, D. W., Arredondo, P., & McDavis, R. J. (1992). Multicultural competencies and standards: A call to the professional. *Journal of Counseling and Development*, 70, 477-486.

Sue, D. W., Bernier, J. E., Durrant, A., Feinberg, L., Pedersen, P., Smith, E. J., & Vasquez-Nuttal, E. (1982). Professional Forum Position Paper: Cross-Cultural Counseling Competencies, *The Counseling Psychologist*, 10, 2, 45-52.

Definitions and Measurement of Cross-Cultural Counseling Competencies

Frederick T. L. Leong, Ph.D.

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December 1998

Definitions

Multicultural Counseling Versus Cross-cultural Counseling

I believe that it is important to clearly define the constructs under consideration and to differentiate similar but not identical concepts. In our attempts to measure cross-cultural counseling competencies, we need to begin with some definitions and clarifications. First, there has been a tendency in the field to use the terms multicultural counseling and cross-cultural counseling interchangeably. As I have pointed out (Leong, 1994), these are different concepts and the latter term is more appropriate for two different reasons. The first reason has to do with the concept of multicultural which refers to “many cultures”. Owing to the multiculturalism movement in the United States, many psychologists and counselors had begun using the term “multicultural counseling” inappropriately to refer to what they do when they work with culturally different clients. They have confused multiculturalism as a social movement with what they do. The more appropriate term is cross-cultural counseling since it accurately describes what they do – a counselor from one particular culture is counseling a client from a different culture.

Multicultural counseling, on the other hand, means counseling with many different cultures and this is rarely what counselors and therapists are doing unless they happened to be conducting group psychotherapy with a culturally heterogeneous group of clients (i.e., counseling with many different cultures). Another exception would be a White European therapist conducting couples therapy with a Hispanic American man married to an African American woman and her co-therapist is an Asian American. Such instances are relatively rare. A White European American counselor seeing an African American client on Monday and a Mexican American client on Wednesday is not conducting “multicultural counseling”; rather she is conducting cross-cultural counseling each time she see a client from a cultural background different from hers. Similarly, a therapist who uses a cognitive-

behavioral approach with one client on Monday and a humanistic approach with a different client on Wednesday cannot really claim that he is using a multidimensional eclectic approach to therapy with his clients.

A second and more important reason why we should not use the term multicultural counseling in place of cross-cultural counseling is the nature and extent of our knowledge-base. The majority of the studies that have examined the role of culture and its potential influence on counseling and psychotherapy have been bi-cultural, i.e., it has examined and compared only two cultures. Early research in cross-cultural psychology was heavily influenced by anthropology which tended to study one culture at a time in significant depth. Using this monocultural approach, namely the study of one culture at a time, psychologists would, for example, investigate the nature and existence of schizophrenia in different countries around the world. Cross-cultural psychologists now recognize the extreme limitations of such an approach. This approach not only did not provide for direct comparisons between cultures, which is the primary focus of cross-cultural psychology, but it also provided inferences and conclusions based on implicit and biased assumptions of the investigators who tended to be from the West. This problem in turn gave rise to the second approach in cross-cultural psychology, namely bicultural studies. These studies usually involve directly collecting data from 2 countries and comparing the results (e.g., schizophrenia in Britain and the United States). The limitations of this approach is that later studies could not be easily compared to earlier studies since different instruments, sampling procedures, and designs may have been used even though the same topic was studied in many different bicultural studies. The ideal approach in cross-cultural psychology was of course, the multicultural study, where 3 or more cultures were studied using the same design, instruments, and procedures. The more cultures that were included the better. However, these studies tend to be very expensive to undertake and there are only a handful of them in the cross-cultural psychological literature.

The implications of this methodological dilemma (i.e., multicultural studies are best but too expensive for most investigators to undertake) is that much of the knowledge-base on which cross-cultural psychology in general and cross-cultural counseling in particular is discussed and debated is derived mainly from bicultural and not multicultural studies. This predominance of bicultural studies (only two cultural groups) is also true for racial and ethnic minority psychology. Cultural diversity in the United States is usually represented by five major cultural groups. These groups include White-European Americans, African Americans, Hispanic Americans, Asian Americans, and American Indians. There are actually very few psychological studies of all five groups together using the same design, instruments, and procedures. In fact, most of the studies use the bicultural approach where only 2 groups are compared. Even worse, the typical comparison group is between White-European Americans and African Americans or between White-European Americans and Hispanic Americans. There are actually very few studies comparing African Americans with Hispanic Americans and comparing Hispanic Americans with Asian Americans. In summary, we do not have a knowledge-base to guide multicultural counseling since there are very few multicultural studies.

Cultural Competence Versus Cross-cultural Competence

A second definition problem has to do with the concept of cultural competence versus cross-cultural competence. Most White-European American counselors and psychotherapists have always been a culturally competent psychologists. To be culturally competent is to be able to adapt and function effectively in one's culture. In the same way, African American counselors and psychotherapists are also culturally competent psychologists with reference with their African American cultural heritage. So, the problem is not with cultural competence but with limited cross-cultural competence, i.e., the knowledge and skills to relate and communicate effectively with someone from another culture different from your

own.

White-European American psychology has always been a Eurocentric paradigm. Its characteristic is not a flaw in and of itself any more than an Afrocentric psychology or an Asian-centered psychology is inherently flawed. No, the first major flaw in White American psychology is not that it is Eurocentric, rather it is that it does not often realize nor acknowledge that it is Eurocentric. The second major flaw is that American psychology operates on the assumption that its theories, scientific data, and formulations are universal when in reality it is quite Eurocentric. In other words, White American psychology not only believes that its culture-specific theories and data are universal, it actively intervenes in the lives and societies of those who are culturally-different with these mistaken or at best untested theories and models.

In essence, White American psychology is a culturally competent psychology on a WITHIN-culture level, namely, its theories and interventions are quite effective and appropriate for White European Americans. However, it is not a culturally competent psychology when it comes to an ACROSS-culture dimension. Hence, as pointed out by Tony Marsella and Paul Pedersen, White-American psychology, as it currently exists, violates its own ethical codes whenever it crosses cultural boundaries without the requisite training and competencies in cross-cultural psychology, and White cultural competence is concerned with how White American psychotherapists can function with White American clients or African American psychotherapists can function with African American clients, cross-cultural competence is concerned with how and whether White American psychotherapists can function effectively with White American clients or vice versa. In other words, what we need to research and measure is NOT cultural competence but cross-cultural competence.

Measurement of Cross-cultural Counseling Competencies Conceptual Model

In discussing the measurement of cross-cultural counseling competencies, it would be useful to have a conceptual model to guide those discussions. Fortunately, there is a well articulated model for examining cross-cultural counseling competencies. This model was first specified in the position paper on Cross-Cultural Counseling Competencies commissioned by the Division of Counseling Psychology (Division 17) of the American Psychological Association and published in 1982 in *The Counseling Psychologist*, the Division 17 journal. This model which is the most comprehensive statement to date on the topic of cross-cultural counseling competencies has also generated the most empirical research. It has also undergone some expansion and elaboration (see Pope-Davis & Coleman, 1997; Sue, Carter, Casas, Fouad, Ivey, Jensen, LaFromboise, Manese, Ponterotto, Vazquez-Nuttall, 1998).

The Division 17 position paper identified three dimension of cross-cultural counseling competence, Awareness, Knowledge, and Skills. Awareness refers to the counselor's awareness of his or her own cultural background and how this may bias or skew his perception of the client's experiences and problems due to the client's different cultural background. It requires sensitivity to these cultural differences in the client's attitudes, beliefs and values and the important role these differences may play in the counseling relationship. Knowledge refers to the cross-cultural knowledge that the counselor needs to acquire about client's from different cultural backgrounds so that he or she can work effectively with a range of clients. Skills refer to the special abilities that counselors have acquired in order to work effectively with culturally different clients in providing therapeutic interventions that are culturally relevant and culturally effective. Next, we will provide a quick overview of the different instruments that have been developed to measure these cross-cultural counseling competencies. As indicated below, many of these instruments were developed on the basis of the conceptual model proposed in the Division 17 position paper.

Awareness: Attitudes and Beliefs

All three of the instruments reviewed below for the knowledge and skills dimension also contain measures of the awareness dimension. It is assumed that certain attitudes and beliefs may serve as barriers to counselors developing an awareness of the importance of cross-cultural difference and their impact on both the process and outcome of counseling. A discussion of some of the psychological attitudes and beliefs that may serve as barriers are discussed by Leong and Santiago-Rivera (1998). Items that measure this dimension of awareness try to identify these attitudes and beliefs serving as barriers.

A broader approach to this awareness dimension is provided by John Berry and his colleagues (Berry & Kalin, 1995). As mentioned above, there has been an increasing attention to cultural pluralism or multiculturalism as either a national policy or an educational philosophy. For two decades now, Berry and his colleagues have been measuring the multicultural ideology of Canadian citizens. Similar studies have been conducted in the United States. These attitudes towards creating and supporting a culturally pluralistic society has been measured by Berry and his colleagues by using their scale of multicultural ideology in national surveys.

The Multicultural Ideology Scale (MIS) assesses “support for having a totally diverse society in which ethnocultural groups maintain and share their culture with others”. It consists 10 items, with five items in a negative direction five in the positive direction. Of these 5 negative items, 2 advocate assimilation ideology, 1 advocates segregation and 2 claim that diversity weakens unity. An example of an item supporting multiculturalism is as follows: "Recognizing that cultural and racial diversity is a fundamental characteristic of Canadian society". An item representing opposition to multiculturalism is as follows: "The unity of this country is weakened by Canadians of different ethnic and cultural backgrounds sticking to their old ways". Berry has found moderate support for multiculturalism in the Canadian population.

This Multicultural Ideology Scale may be a useful measure of support for cultural pluralism in various mental health agencies and training institutions. Unlike the awareness items from the other measures reviewed below, the MIS measures the attitudinal barriers at the institutional and not individual level. As a short measure, it can be used to assess the positive or negative climate in institutions for the support of the development of cross-cultural counseling competencies among its staff or trainees.

Knowledge and Skills

The Cross-cultural Counseling Inventory (CCCI)

The CCCI was developed by LaFromboise, Coleman and Hernandez (1991) to assess counseling effectiveness with culturally diverse clients. The inventory consist of 20 items and is completed by an observer. Using a 6 point Likert type format which ranges from strongly disagree to strongly agree, respondents rate extent to which the inventory items describe the counselor being observed. The CCCI is based on 11 cross-cultural counseling competencies outlined in the Division 17 position paper mentioned above. These competencies are organized around the three dimensions of awareness, knowledge, and skills.

In terms of reliability, the internal consistency of the inventory is adequate ranging from .88 to .92. Using three experts in cross-cultural counseling, inter-rater reliability was found to be around .78. The inter-rater reliability coefficient rose to .84 when one of the problematic vignettes was removed. Content validity was demonstrated when students were able to classify the items from the CCCI into the appropriate dimension (i.e., awareness, knowledge, and skills) with 80 % agreement. Criterion related validity of the CCCI was demonstrated in several studies. Counselors trained in cross-cultural counseling received higher ratings on the CCCI than counselors who did not receive such training. Factor analytic studies were able to capture three factors that resemble the three dimensions outlined in the Division 17 position paper.

Examples of items from the CCCI include the following: (a) Counselor is aware of how own values might affect the clients (awareness item), (b) Counselor demonstrates knowledge about client's culture (knowledge item), (c) Counselor is willing to suggest referral when cultural differences are extensive (skill item).

Multicultural Counseling Awareness Scale (MCAS)

The MCAS is a 45 item self-report scale developed by Ponterotto and his colleagues in 1991 to measure the three dimensions of the Division 17 position paper. The scale uses a 7 point Likert type format to measure knowledge, skills, and awareness with responses ranging from "not at all true" to "totally true". The scale in the accompanying demographic crushed man requires 1525 minutes to complete the scale is a revised version of the 70 item prototype multicultural counseling awareness scale developed by Pont Toronto in 1991. Like the CCCI, the MCAS is conceptually based on the Division 17 competency report . But unlike the CCCI, it is a self-report measure that counselors complete on themselves.

Using item analysis and sequential factor analysis procedures, an original 70 item version was reduced to the final 45 item version. Unlike the CCCI, the MCAS does include several (3) social desirability items. This is particularly important with a self-report measure of counselor competencies within uses like items for revised scale. The remaining 41 are divided into 12 items related to awareness and 29 items pertaining to knowledge and skills.

The reliability of the MCAS is quite acceptable with coefficient alphas around .93 for the full scale. The alpha for the knowledge and skills factor scale was also .93 while the alpha for the awareness factor scale was lower at .78. Other studies have found similar levels of internal consistency with the knowledge and skills factor

around .92 and the awareness factor at .72.

In terms of validity, content validity was established by experts judgment of the items in terms of clarity and conciseness and domain appropriateness. Unlike the CCCI, factor analytic studies of the MCAS found that the two factor solution worked best with one factor measuring knowledge and skills (eigen value of 14.4) while a second factor represented awareness (eigen value of 5.2). In terms of criterion related validity, studies found that Ph.D. double respondents scored significantly higher than Masters and Bachelors level respondents on both subscales (knowledge/skills and awareness). It was also found that a sample of national experts scored significantly higher than did both the practicing school counselors and graduate student samples on both knowledge/skills and awareness factors on the MCAS. Furthermore, respondents who had completed a multicultural workshop or received supervised clinical training with the minority clients scored significantly higher on the knowledge/skills factor than those who did not.

Example of items from the MCAS include the following: (a) I feel all the recent attention directed towards multicultural issues in counseling is overdone and not really warranted (awareness item), (b) I am knowledgeable of acculturation models for various ethnic minority groups (knowledge/skill item), and (c) At this point in my professional development, I feel I could benefit little from clinical supervision of my multicultural client case load (social desirability item).

Multicultural Counseling Inventory (MCI)

The MCI was developed by Sadowski and her colleagues (1994). Like the MCAS, it is also a self-report measure and consists of 43 statements measuring cross-cultural counseling competencies across the three dimensions. Using a 4-point Likert scale format, respondents indicate the extent of accuracy of the statements in relation their own work as counselors, psychologists, or trainees. Responses can range from “very inaccurate” to “very accurate”. It can be completed in approximately 15 to 25

minutes. Like the CCCI and MCAS, the MCI is based conceptually on the Division 17 position paper and the delineated three categories of competencies. Unlike the previous measures, the MCI has four subscales: (a) Multicultural counseling skills (14 items), (b) Multicultural awareness (10 items), and (c) Multicultural counseling knowledge (11 items) and (d) Multicultural counseling relationship (8 items). The unique feature of the MCI is the focus on the multicultural counseling relationship in the fourth subscale. The subscale measures the counselor's stereotypes of ethnic minorities and their comfort level with these clients.

In terms of reliability, the internal consistency coefficient alphas for the MCI is quite acceptable. In one study, the total scale alpha was .90 while the multicultural counseling skills factor alpha was .83; the multicultural awareness factor was also .83; the multicultural counseling knowledge factor was .79, and the multicultural counseling relationship was .71. Content validity of the MCI was demonstrated by expert judgment of item clarity and content. Inter-rater agreement among these experts were high ranging from 75 to 100 percent. Using counselors who had worked 50 percent or more in the multicultural areas, criterion related validity was demonstrated when these counselors scored significantly higher on the multicultural awareness and multicultural counseling relationship factors than those respondents who had worked consistently with less than 50 percent minority client load service agencies. Further evidence of criterion-related validity was found when 42 graduate students in counseling scored significantly higher at post test on three of the MCI scales after completing a one semester multicultural course than those who had not. In terms of the factor structure of the MCI, the four factor model was the most interpretable.

Examples of items from the MCI include the following: (a) When working with minority clients, I have experience at solving problems in unfamiliar settings (awareness item), (b) When working with minority clients, I form effective working

relationships with the clients (skill item), (c) When working with minority clients, I use innovative concepts and treatment methods (knowledge item), and (d) When working with minority clients, I perceive that my race causes the clients to mistrust me (relationship item).

Multicultural Awareness Knowledge and Skills Survey (MAKSS)

The MAKSS was designed by D'Andrea, Daniels and Heck (1991) to assess the effectiveness of training students in cross-cultural counseling. It is also a self-report measure consisting of 60 survey items that cover the three dimensions of awareness, knowledge, and skills. While it has some evidence of reliability (alphas ranging from .75 to .96), it has the least supporting research in terms of validity. Due to this limited research, the MAKSS cannot be recommended at this point and will not be reviewed further.

Conclusion: Some Caveats

It is promising that there are now several instruments available to us to measure the various dimensions of cross-cultural counseling competencies. However, in presenting these measures, I also feel that we need to recognize some of the limitations in these measures. First, there is a difference between interpersonal versus therapeutic cross-cultural competencies. The former refers to a set of interpersonal knowledge and skills that enables a person to related effectively with a person from a different culture. This is the same set of interpersonal cross-cultural competencies that many of the workshops and training programs are providing to the managers and supervisors in order for them to work effectively with co-workers and subordinates from many different cultures. Such interpersonal cross-cultural competencies are also useful to counselors and psychotherapists but primarily in the relationship building aspects of the therapy and early on in the counseling relationship. Therapeutic cross-cultural competencies refer to the set of knowledge and skills that a counselor must have in order to intervene effectively with the client's problem in light of his or her

cultural background. This set of competencies involve how culture actually affects diagnosis, etiology and presentation of psychopathology, client's conceptualization of mental illness, and the treatment process itself. Unfortunately, our research and theoretical advances have primarily been focused on the interpersonal cross-cultural competencies and much less so on the therapeutic cross-cultural competencies.

Relatedly, it is not surprising then that many of the instruments reviewed above are more concerned with these relationship building elements in the cross-cultural counseling encounter than the actual treatment process. To-date, there have been very few cross-cultural counseling process studies to help delineate what actually happens in cross-cultural counseling relationships beyond the initial few sessions. Instead, most of these studies have been based on analog designs rather than clinical field studies with real clients being treated by practicing counselors and therapists. Furthermore, there is even more limited linkage between these cross-cultural counseling measures and actual counseling outcomes. There are even fewer studies of counseling outcomes in cross-cultural counseling relationships than studies of the counseling process.

There is also the problem of the distinction between knowledge and skills in cross-cultural counseling competencies as delineated in the conceptual model (Division 17 position paper). This model differentiates between knowledge and skills. Conceptually, this distinction makes sense since it is quite possible that a newly trained counselor or psychologist having been exposed to good training program would possess the knowledge about cross-cultural counseling but not the skills. It is only with extended application of this knowledge with real life clients that such skills develop. Yet, at least one of the instruments find that these two dimensions are combined for their respondents (i.e., knowledge and skills are not qualitatively different). For the other measures, I suspect that the skills dimension is being measured at a global and generic level and does not represent a well sampled domain.

One just has to review some of the items representative of the skills domain to see how global and non-specific there are. This problem is probably due to the fact that we have not conducted many empirical studies into the actual counseling process in cross-cultural counseling dyads to identify the relevant elements to be measured. As such, our current measurement of cross-cultural counseling skills are quite crude and of unknown predictive validity in relation to actual counseling outcomes.

Finally, it should be pointed out that the two major problems in providing effective mental health services to racial/ethnic and cultural minorities is that of these groups' underutilization of mental health services and their premature termination from such services when they do seek help for their psychological problems. The measures reviewed in this paper only addresses the latter problem (i.e., to minimize ethnic minority clients' premature termination from treatment). This cross-cultural competencies approach, represented by the conceptual model (Division 17 position paper) and the measures reviewed in this paper, is concerned mainly with engaging culturally different clients and minimizing premature termination. There is still the need to address second half of problem, namely underutilization of mental health services by racial and ethnic minorities.

References

- Berry, J.W., & Kalin, R. (1995). Multicultural and ethnic attitudes in Canada. Canadian Journal of Behavioral Science, 27, 301-320.
- D'Andrea, M., Daniels, J. & Heck, R. (1991). Evaluating the impact of multicultural counseling training. Journal Counseling and Development, 70, 143-150.
- LaFromboise, T.D., Coleman, H. & Hernandez, A. (1991). Development and factor structure of the cross-cultural counseling inventory-revised. Professional Psychology: Research and Practice, 22, 380-388.
- Leong, F.T.L. (1994). Emergence of the cultural dimension: The role and

impact of culture on counseling supervision. Counselor Education and Supervision, 34,115-116. (Introduction to special section: Cross-cultural counseling supervision).

Leong, F.T.L. & Santiago-Rivera, A. (1998). Climbing the multiculturalism summit: Challenges and pitfalls. In P. Pedersen (Ed.), Multiculturalism as a fourth force. Washington, D.C.: Taylor & Francis.

Ponterotto, J.G., Rieger, B.P., Barrett, A., & Sparks, R. (1994). Assessing multicultural counseling competence: A review all instrumentation. Journal of Counseling and Development, 72, 316-322.

Pope-Davis, D.B. & Coleman, H.L.K. (1997). Multicultural counseling competencies: assessment, education and training, and supervision. Thousand Oaks, CA: Sage publications.

Sodowsky, G.R., Taffe, R.C., Gutkin, T.B., & Wise, S.L. (1994). Development of the multicultural counseling inventory: itself report measure of multicultural competencies. Journal Counseling Psychology, 41, 137-148.

Sue, D.W., Bernier, J.E., Durran, A., Feinberg, L., Pedersen, P., Smith, E., & Vazquez-Nutall, E. (1982). Position paper: cross-cultural counseling competencies. The Counseling Psychologist, 10, 45- 52.

Sue, D.W., Carter, R.T., Casas, J.M., Fouad, N.A., Ivey, A.E., Jensen, M., LaFromboise, T., Manese, J.E., Ponterotto, J.G., & Vazquez-Nuttall, E. (1998). Multicultural counseling competencies: Individual and organizational development. Thousand Oaks, CA: Sage publications.

Assessing Cultural Competence in Mental Health Service Delivery

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As the "demographic face" of America continues to evolve, there is little doubt that our mental health system will be challenged to meet the mental health needs of an increasingly culturally diverse clientele (Sue, Parham, Santiago, 1998). It is fair to say that at present, the majority of mental health service administrators and providers are mono-lingual Anglo Americans who have not received adequate multicultural training (Atkinson, Brown, & Casas, 1996). My personal view is that the mental health system in this country is not equipped nor prepared to meet the needs of a culturally and linguistically diverse client base (Ponterotto, 1998).

There is an abundance of professional literature that speaks to the need for mental health service providers to increase their multicultural competence. Two questions we must address at this time are: a) what is cultural competence? and b) how can it be measured? In this brief paper I will cover these two points and also highlight the need for a non-static approach to competency assessment.

Defining Multicultural Competence

The counseling/therapy relationship is quite complex; and this relationship is even more complex when the members involved represent different cultural groups. It has taken scholars in the field 15 years to develop a comprehensive definition and profile of multicultural competence. Fortunately, thanks to the pioneering work of Derald Wing Sue and his colleagues, the profession has at its disposal a good working definition of cultural competence in individual and organizational contexts. I assume that the members of this roundtable are familiar with the cross-cultural competency reports that are being increasingly recognized and endorsed by our professional associations, namely the American Psychological Association and the American Counseling Association. Therefore, in this paper, I just want to reference these reports as WICHE has them available for closer scrutiny: Arredondo et al. (1996); Sue et al (1982); Sue, Arredondo, & McDavis (1992); and Sue et al. (1998). The latest report, *Multicultural Counseling Competencies: Individual and Organizational*

Development (Sue et al., 1998), provides the most comprehensive profile of the culturally competent provider and organization currently available, and I suggest this source be used as a base for further instrument development and refinement.

Assessing Multicultural Competence: Quantitative and Qualitative Perspectives

Quantitative Assessments. Quantitative measures of multicultural counseling competence have dominated the professional literature. There are currently four paper-and-pencil instruments that are being used regularly in mental health research. Three of the instruments are provider self-report measures, and one is used as a supervisor's evaluation tool. These four instruments have been discussed and critiqued extensively in the literature, and only the references are provided below.

The evaluator's form is the Cross-Cultural Counseling Inventory-Revised (CCCI-R; LaFromboise, Coleman, & Hernandez, 1991). The clinician self-report surveys are the Multicultural Counseling Inventory (MCI; Sadowsky, Taffe, Gutkin, & Wise, 1994), the Multicultural Counseling Awareness Scale (MCAS; Ponterotto et al., 1996), and the Multicultural Awareness-Knowledge-Skills Survey (MAKSS; D'Andrea, Daniels, & Heck, 1991). Critical reviews of these instruments (Ponterotto & Alexander, 1996; Ponterotto, Rieger, Barrett, & Sparks, 1994; Pope-Davis & Dings, 1995) indicate that though promising, they need further validation work. Furthermore, any paper-and-pencil measure, particularly self-report, is limited with regard to assessing accurate levels of cultural competence in providers. Attachment 1 presents the latest version of the Multicultural Counseling Awareness Scale, recently re-titled the Multicultural Counseling Knowledge and Awareness Scale (MCKAS).

Qualitative Assessments. Very recently, qualitative assessments, particularly Portfolio Assessments, have received attention in the professional literature. I find the work of Coleman (1996) particularly promising in this regard. Portfolio Assessments provide trainees and providers with greater opportunity for self-

reflection and more specific avenues for needed "cultural growth." Attachment 2 presents the Portfolio Assessment I developed and use with master's and doctoral level counseling psychology students. The portfolio is based on the 31 Sue et al. (1992) competencies. Since the competency list was recently expanded to 34 competencies (Sue et al., 1998), I will be updating the portfolio next semester.

Organizational Assessments

The assessments described above focus primarily on individual assessments of multicultural counseling comfort and competence. Recently, organizational measures have been developed and include the Multicultural Competency Checklist (Ponterotto, Alexander, & Grieger, 1995) and the Multicultural Environment Inventory (Pope-Davis & Lui, 1995). These measures are designed for academic training programs in the mental health professions, but could be adapted for mental health delivery systems. Attachment 3 presents the Multicultural Competency Checklist.

The Need for Non-Static, Ongoing Evaluations of Multicultural Competence

Often times the nature of assessment is perceived as static -- once a competency is met, it is met for life. I believe strongly that the development of cultural competence is a life-long, evolving activity. Therefore, it would be beneficial if assessment procedures tapped this perspective and encouraged continued reflection and growth in the multicultural arena. I believe, qualitative approaches, such as Portfolio Assessments, constitute the most comprehensive assessments of developing competence. Portfolio assessments can be designed for any level of professional or organizational service. Understandably, augmenting portfolio assessments with periodic paper-and-pencil objective measures would allow for method triangulation and will increase the validity of the assessment process. Of course, quantitative assessments would allow for much larger sampling evaluations.

In summary, we are at the forefront in defining, operationalizing, and measuring multicultural competence. The outcome of this Roundtable will have significant impact on a national level, and follow-up work and discussion will be important. We are at a critical juncture in establishing reliable, valid, and convenient measures of cultural competence. I expect these topics will also constitute an important focus for the upcoming First Annual Multicultural Conference and Summit to be held January 28-29, 1999 in Newport Beach, California. I hope WICHE will be involved in this landmark conference.

References

Arredondo, P., Toporek, R., Brown, S. P., Jones, J., Locke, D. C., Sanchez, J., & Stadler, H. (1996). Operationalization of the multicultural counseling competencies. *Journal of Multicultural Counseling and Development, 24*, 42-78.

Atkinson, D. R., Brown, M. T., & Casas, J. M. (1996). Achieving ethnic parity in counseling psychology. *The Counseling Psychologist, 24*, 230-258.

Coleman, H. L. K. (1996). Portfolio assessment of multicultural counseling competence. *The Counseling Psychologist, 24*, 216-229.

D'Andrea, M., Daniels, J., & Heck, R. (1991). Evaluating the impact of multicultural counseling training. *Journal of Counseling and Development, 70*, 143-150.

LaFromboise, T. D., Coleman, H. L. K., & Hernandez, A. (1991). Development and factor structure of the Cross-Cultural Counseling Inventory - Revised. *Professional Psychology: Research and Practice, 22*, 380-388.

Ponterotto, J. G. (1998). Charting a course for research in multicultural counseling training. *The Counseling Psychologist, 26*, 43-68.

Ponterotto, J. G., & Alexander, C. M. (1996). Assessing the multicultural competence of counselors and clinicians. In L. A. Suzuki, P. Meller, & J. G.

Ponterotto (Eds.), *Handbook of Multicultural Assessment: Clinical, Psychological, and Educational Applications* (pp. 651-672). San Francisco, CA: Jossey-Bass.

Ponterotto, J. G., Alexander, C. M., & Grieger, I. (1995). A multicultural competency checklist for counseling training programs. *Journal of Multicultural Counseling and Development, 23*, 11-20.

Ponterotto, J. G., Rieger, B. P., Barrett, A., Harris, G., Sparks, R., Sanchez, C. M., & Magids, D. (1996). Development and initial validation of the Multicultural Counseling Awareness Scale. In G. R. Sodowsky & J. C. Impara (Eds.), *Multicultural Assessment in Counseling and Clinical Psychology* (pp. 247-282). Lincoln, NE: Buros Institute of Mental Measurements.

Ponterotto, J. G., Rieger, B. P., Barrett, A., & Sparks, R. (1994). Assessing multicultural counseling competence: A review of instrumentation. *Journal of Counseling and Development, 72*, 316-322.

Pope-Davis, D. P., & Dings, J. G. (1995). The assessment of multicultural counseling competencies. In J. G. Ponterotto, J. M. Casas, L. A. Suzuki, & C. M. Alexander (Eds.), *Handbook of Multicultural Counseling* (pp. 287-311). Thousand Oaks, CA: Sage.

Pope-Davis, D. P., & Lui, W. (1995). The Multicultural Environment Inventory. Unpublished manuscript, Department of Psychology, University of Maryland, College Park, MD.

Sodowsky, G. R., Taffe, R. C., Gutkin, T., & Wise, S. L. (1994). Development of the Multicultural Counseling Inventory: A self-report measure of multicultural competencies. *Journal of Counseling Psychology, 41*, 137-148.

Sue, D. W., Arredondo, P., & McDavis, R. J. (1992). Multicultural competencies and standards: A call to the profession. *Journal of Multicultural Counseling and Development, 20*, 64-88.

Sue, D. W., Bernier, J. E., Durrant, A., Feinberg, L., Pedersen, P., Smith, E. J., & Vasquez-Nuttall, E. (1982). Position paper: Cross-cultural competencies. *The*

Counseling Psychologist, 10, 45-52.

Sue, D. W., Carter, R. T., Casas, J. M., Fouad, N. A., Ivey, A. E., Jensen, M., LaFromboise, T. D., Manese, J., Ponterotto, J. G., & Vazquez-Nuttall, E. (1998). *Multicultural Counseling Competencies in Individual and Organizational Development*. Thousand Oaks, CA: Sage.

Attachment 1
Multicultural Counseling Knowledge and Awareness Scale (MCKAS)

Attachment 2
Multicultural Counseling Competencies Portfolio Assessment

Attachment 3
Multicultural Counseling Competency Checklist
(for Academic Counseling Training Programs)

(See full article, *Journal of Multicultural Counseling & Development*, 23, 1995:11-20,
for rationale of specific items.)

Practical Measures for Population Based Planning "A Prerequisite in Developing Culturally Competent Services"

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This paper attempts to address two elements which in this author's opinion are a prerequisite if one is to measure "Cultural Competency of Individuals and Organizations." I will briefly provide an overview of what I believe are essential elements in establishing a baseline knowledge from where to measure developmental growth in individuals and Organizations. These two planning elements also provide what I believe is the "context" from where all planning and training must be derived. The two elements I will describe are not new to the literature of Cultural Competence; however, I will relate them to the context of measuring Cultural Competency. These are Population Based Planning and Organizational Self Assessment as they relate to the findings of the populations in their particular community, region, county, etc.

We will assume that all current literature is correct about the specific cultural and ethnic groups who over-utilize higher level and more restrictive care, who underutilize and/or are underserved by mental health services. This information is clear and is documented by utilization data; however, what these data do not tell us is how we can correct these inequities in view of managed care and cost-effective services. It is the opinion of this author that one way of addressing this is to assess the population we need to serve and the programs and staff who serve them from a different vantage point; that is, from strengths-based and true "inclusion" perspectives. These two perspectives are also not new; however, seldom are they done in the true sense of the word - by applying the guiding principles of the Cultural Competency model. The Cultural Competency Model provides an imaginary continuum from:

1. Cultural destructiveness
2. Cultural blindness
3. Pre-competence
4. Basic Cultural competence
5. Advanced Cultural Competence

Several tools exist that attempt to assess an organization along this continuum. (See addendum.) Again, this is only an imaginary continuum that provides what I believe is the beginning in measuring some developmental growth.

A baseline of existing agency strengths and weaknesses is needed in the areas of skills and knowledge to further develop the organization toward a positive continuum. Cultural competency has been described by Cross, et al, as “The ability of individuals and organizations to work effectively across cultures.” Because cultures are dynamic and change throughout time, it is important for organizations to plan for culture competence as part of their strategic planning process. Integration of cultural competence principles is critical for the overall success in the inclusion of culturally diverse populations in a service delivery system.

I. How Do You Measure the Developmental Progress of Effective and Appropriate Culturally Competent Services?

One has to start with two basic and fundamental elements.

1. A population-based assessment which determines the most current population demographic profile residing in a particular region, county or community. These demographics should include – age, ethnicity, social economic levels, primary language, Medicaid eligibility, unemployment rates, education levels, immigration status, etc.
2. An agency cultural competence self assessment to establish a strength baseline of skills and knowledge and strengths to match those needed to service the population identified in the population-based assessment.

These two planning elements form the context for the developmental growth toward cultural competency. This paper will briefly detail the elements of population-based planning, agency self-assessment, and the domains recommended for measurements.

II. What is Population-based Planning and Why is it Important in Measuring Cultural Competency?

Population-based planning is not a new concept. This concept was very popular in the late 60's and 70's. How does it differ in the late 90s? Population-based planning has replaced, to a degree, what we know as "community needs assessments" which utilized the approach of "assessing deficits or needs of a particular region, community, ethnic groups and might be age specific ." This approach was narrow in scope for two reasons:

1. It looked only for problems and did not recognize what I call "el oro del barrio," (i.e., "the gold nuggets in the community"). It did not look for natural and effective healing practice resources used in the community. The process did not acknowledge and/or invite community leaders/elders to join the assessment/planning process as equal partners in educating systems and actually share what worked for them and what needed improvement with suggestions on how to improve services.
2. The needs assessment process was done by mental health staff with questions which were already formulated to look for problems. The system would take the responses and on their own, again "using the system knowledge," would design, plan and implement programs and services to meet the needs identified. These programs were "more of the same" traditional mental health services and only added language skills and changed locations closer to communities of color. If, when these programs did not render increased utilization of services, no assessment was done to determine why and find ways to improve. Measurement of effective services was based solely on quantitative measures.

III. How is Population-based Planning Different?

Population-based planning utilizes two dimensions. One is assessment of the

population profiles of a particular community through the eyes and ears of consumers, family members, potential consumers, (i.e., Medicaid eligible) community stakeholders, which includes leaders, elders, community-based organizations, religious group representatives, etc.

The second dimension is administering an agency cultural competence self-assessment for administration and staff. This tool allows the agency to assess itself in terms of its strengths, skills and knowledge in relationship to serving the population identified in their community profile. There are several tools on the market to do self assessments. In this abstract I will discuss one particular tool that I am most familiar with.

These two dimensions of population-based assessments establish a baseline of strengths and knowledge/skills, by assessing two populations: consumers/families/community and the program and staff which would serve them. This baseline analysis is what I believe establishes the “context” for measuring an agency’s cultural competency through time, consistent with the developmental process which is the philosophical base of the cultural competence model. Because culture is dynamic and changing through time, assessments need to be organized bi-annually, at a minimum.

IV. What are the Elements of a Population-based Assessment?

I have identified the elements I consider critical for conducting a population-based assessment which identifies strengths and program gaps. The following census related information should be looked at to get a historical view of change in population profiles:

- demographic profiles are most accurate when you get them from school districts, social service agencies, federal, state, county, government entities such as planning departments, local/state public health divisions and criminal justice.

- demographic profiles from local business chambers of commerce
- employment/unemployment data
- local news organizations, TV, newspaper, radio, etc.

These are a few of the groups where population based data can be acquired. In addition to the gathering of traditional data, a population-based assessment must also include activities such as community based focus groups which can render demographic information. A special invitation can be issued to community leaders, elders, civil groups, religious leaders, and ethnic specific community based organizations to come and share knowledge of their communities from a strength base and also share their perspective of the mental health system, responsiveness to the specific ethnic community and suggested ways to improve them.

The success of getting these individuals to come to you will depend on the established/existing relationships of the mental health system with their communities. If no relationship exists, identifying key community persons who are credible and respected needs to be the first step. Going to these individuals and meeting them in their territory is very important. These are the first steps of true population based assessments, where relationships and partnerships begin to take form. The information gathered here is both anecdotal and emotional. Community leaders are passionate about their communities, and provider systems must be prepared to hear what they have to say about mental health services and the need for culturally syntonic services.

V. What are the Elements of an Agency/Provider Competence Self Assessment?

While there are several cultural competence tools in the market, one of the most practical and the one that I'm most familiar with is Dr. James Mason's "An Organizational Cultural Competence Self Assessment." This tool assesses existing skills and knowledge in seven domains. These domains cover both the organizational

and individual levels, renders a baseline of existing strengths and clearly identifies gaps in knowledge of the organization. The gaps identified are the basis for the training/staff/organizational developmental plans. Developmental growth can be measured by using baseline scores and organizational policies/structure reviews and reassessing for developmental milestones/growth. The assessment domains include the following:

1. Knowledge of Communities. This assesses the individual staff's knowledge of who lives in the community in which they work, by ethnicity, language, cultural strengths, values and beliefs and utilization rates, etc.
2. Personal Involvement. This assesses the individual's involvement beyond one's own cultural groups, from where we shop and spend recreational time, to feelings of safety.
3. Resources and Linkages. This domain assesses the agency's ability to identify/link with formal and informal community resources, and evaluates its ability to institutionalize cultural knowledge through literature availability, collaboration, partnerships and relationships with community based organizations, and civil groups, etc.
4. Staffing. This domain assesses agency staffing patterns at all levels of the organization, which includes staff skills, languages, and reflection of community based populations; in addition to representation of Board of Directors, Mental Health Boards, contractors from the diverse community in the region, etc. .
5. Service Delivery and Practice. This domain looks at culturally specific assessment tools, culturally syntonic interventions, family involvement, multi-

dimensional assessments of quality of life issues such as housing, employment, educational, etc.

6. Organizational Policy and Procedures. This domain assesses existing policy and procedures, and determines the absence of policies which value and support culturally syntonic practices, structures, partnerships, collaborations, staff training and development, etc.
7. Reaching Out to Communities. This domain assesses the marketing tools used to inform ethnic communities about the services and benefits available to them; outreach, education about culturally syntonic presentations, mental health promotion practices, inclusion of multi-cultural families in the agency's brochures.

These domains assess the staff and agency's base knowledge/skills/strengths. These are matched to the community's potential consumer base identified in the population based assessment to determine the baseline from where the progressive growth and development can be measured.

Conclusion

This brief abstract outlines two key population based assessments (i.e., community and agency staff assessments), to determine a baseline of knowledge/skills from where development of cultural competence can be measured. These two population based assessments provide the beginnings of "inclusion" of two critical stakeholder groups which will determine the cultural competence needed by an organization/individual. This population based assessment provides the "context" from where measurement can be determined or identified. The "inclusion" of consumer/community and providers provide the first level of buy-in necessary to establish the measurements of developmental growth in skills and knowledge which

can help an organization move towards a proactive continuum of cultural competency, and eventually to quality and cost effective services for the underserved populations.

References

Cross T., et al. "Towards a Culturally Competent System of Care," Vol. I National Technical Assistance Center for Children's Mental Health, Georgetown University, Wash. D.C. 1989.

Davis, King, Ph.D. "Exploring the Intersection Between Cultural Competency and Managed Behavioral Health Care Policy" Dec. 1997, NTAC, State Mental Health Planning.

Mason, James, Ph.D. "Cultural Competency Self Assessment" Portland, Oregon.

Romero, J.T. "Operationalizing Cultural Competence in a Managed Care Environment" Nov. 1996. Focal Point - A National Bulletin on Family Support and Children's Mental Health. Portland, State University.

WICHE. *Cultural Competence Guidelines in Managed Mental Health Services for Latino Populations*. Boulder, CO: WICHE, December 1996.

WICHE. *Cultural Competence Standards in Managed Mental Health Care of Four Underserved/Underrepresented Racial/Ethnic Groups*. Boulder, CO: WICHE, April 1998.

**Linking Values Orientation, Acculturation, and Life Experiences to the
Implementation of Services: Recommendations for Four Constructs to be
Measured in an Instrument on Cultural Competency of Mental Health Services
Delivery**

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Introduction¹

The measurement of cultural competence is a complex but critically important endeavor. Without cultural competence, a service delivery system cannot be expected to effectively engage into services, or effectively treat, consumers of different ethnic and racial backgrounds. In developing an instrument that can be used in evaluating a service system's cultural competence, there are a number of domains that should be assessed. First, and at the most basic level, the instrument must assess "overall competence", for example, the extent to which the service system can deliver interventions consistent with a specified treatment model. Second, the instrument must assess the degree to which a system has knowledge of the range of basic values orientations that consumers from diverse cultures may endorse. Third, the instrument must be capable of assessing the service system's knowledge of the life experiences (immigration and acculturation stress, racial prejudice and discrimination, the socio-political standing of the consumer's ethnic group within the host society) that shape the consumer's everyday lives. Finally, the instrument must be capable of measuring the systems ability to engage and treat the consumer with "ease", showing tolerance of and comfort with diversity.

This paper describes our work on these issues and offers specific recommendations for dimensions that should be included in any measure of cultural competence. Although the Round Table Discussion focuses on Adult Mental Health Services, there is much to be learned from taking a family perspective and focusing on the struggles that an adult must go through with spouses, extended family, and with their children, resulting from acculturation and other immigration-related processes. In the special case of ethnic families, where there is an identifiable clash of the family's cultural values with that of the larger community, research findings appear to offer

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the clearest guides as to how these cultural value dimensions are related to family functioning. Our own work at the University of Miami's Center for Family Studies has been enriched by our efforts to work with families of troubled youth where the cultures and their respective values have been wonderfully diverse (Hispanic, African-American, Caribbean-Non Hispanic, and Caribbean Non-African American). Even within these bold cultural headings, the heading labels do not clearly identify the diversity within each. It is from the experience of confronting this diversity in our treatment and preventive intervention research, that we needed to find a set of guidelines for understanding how cultural values related to family interactions and the family's functioning that would transcend the specific ethnic label, yet inform the intervention approach. Further, in developing new manualized interventions, we were challenged to specify ways in which therapists could be trained to be culturally competent. In the discussion that follows, we describe the dimensions that we use to guide our family intervention services research, along with specific recommendations as to including these in an instrument on a mental health service's cultural competence.

1. Basic competence: Having a solid foundation

One of the most common mistakes in attempting to achieve cultural competence is failing to start from a foundation of technical competence and assuming that a practitioner can be culturally competent while having weak technical skills in the treatment model used. For this reason, it is important to stress that practitioners must be competent in delivering a specified model of treatment before attempting to be culturally competent in extending this model to ethnic individuals or families. The practitioner must know how and when to use certain interventions and when to deviate from the model and add components of other therapeutic approaches. An example of our work with family therapy is that the practitioner must know the destructive nature of runaway negativity in families and therapy sessions (Alexander, Holtzworth-Munroe & Jameson, 1994) and the importance of

promoting good conflict resolution (Szapocznik, Rio, Hervis, Mitrani, Kurtines & Faraci,1991). This knowledge and expertise must be attained before attempting to understand the different ways in which this may emerge in ethnic families and how techniques might need take into account special family characteristics of ethnic families such as lower tolerance for negativity and face to face challenges/disputes (Santisteban, Muir-Malcolm, Mitrani & Szapocznik, in press).

Recommended Cultural Competency Construct Regarding Basic Competence in the Treatment Model

Does the service system have the technical expertise to deliver their core treatment model competently? Do they understand the theoretical assumptions on which their models are based?

2. Value Dimensions Directly Relevant to Family Intervention Services

People of different ethnic cultures can diverge markedly in their values, beliefs, and behaviors, and these differences can have a profound effect on how symptoms develop, are expressed, how symptoms are explained, and how and to whom people communicate their distress. Further, they may have a profound effect on how individuals respond to certain types of treatment because treatments themselves work under certain assumptions that may or may not be compatible with those of the consumer.

For these reasons, a critical step is to better understand the range of core values and beliefs and how these values/beliefs interact with our work as service delivery systems. It is important to note that while the core values of the ethnic consumer are proximal to the work of the practitioner, the ethnic classification of the consumer is quite distal. We use ethnic classification simply as a proxy to help us predict what is of real importance, namely the individual's world-view in important domains that

may predict how ethnic individuals/families perceive problems, seek and accept help, and respond to specific family therapy strategies and interventions.

We have found that the best model for organizing the information on values and beliefs is the values orientations work conducted by Kluckhohn and Strodtbeck (1961). Their model identifies the diversity of basic assumptions different people may have, assumptions that are based on shared intergenerational teachings and life-experiences, and which are keys to understanding how different people view the world. Kluckhohn and Strodtbeck postulated five human problems (Human Nature, Person-Nature, Activity Orientation, Time Orientation, and Relational Orientation) common to all cultures. The solutions provided by each culture to these problems are indicative of world view or basic value orientation. In the remainder of this section we present Kluckhohn and Strodtbeck's five dimensions and show the profound influences that these differing values orientations can have on core constructs in family intervention science.

2a. The Human Nature dimension pertains to a culture's perception of innate human qualities as good or bad – with a range of a) good, b) bad, or c) neutral. Many western theories take a clear stand on this question, teaching that individual's are good and it is learned behaviors that are bad. In our clinical experience with minority families, we have found that the tendency of parents of some cultures to see their misbehaving children or family member as inherently "bad" or "influenced by evil" is qualitatively different from those who see behavior as bad but perceive the family member as inherently good. Furthermore, the value on this dimension can contribute directly to a core construct in family therapy which is described as the rigidity of Identified Patienthood (Szapocznik, et al, 1991). Identified Patienthood is defined as the extent to which all responsibility for a problem is attributed to one person while other contributions to the problem are dismissed. The degree to which one individual is perceived as "the bad seed" or "the black sheep", may directly determine the extent to which family members are willing to accept the need to

change family interactions in order to modify a presenting complaint. In these cases, the assumptions of the therapy model were limited when attempting to understand the family's perspective. It must be acknowledged that failure of the consumer to engage into services or to remain in treatment may be due to the incompatible assumptions that consumers and treatment models have about the etiology of the problem.

2b. The Person-Nature Dimension refers to the perceived relationship of people to natural phenomena — with a range of a) subjugation to nature, b) harmony with nature, and c) mastery over nature. The epitome of Eurocentric Western values is the conquest of the new continent by the Europeans and the conquest of the wild west by "Americans". American "can doism" and perseverance in the face of problems derives from a world view that supports mastery. We must therefore begin by acknowledging that most western models of therapy are founded on the value of mastery over nature (i.e., identifying and changing those characteristics that are problematic). However, many cultures see the role of individuals as accepting rather than conquering nature. Rather than striving to defeat cancer, some may strive to gracefully accept this fate. In therapy the latter group may be less likely to want to harp on problems or talk about how they can "battle" the life situation but on what blocks them from accepting it. This has important implications for working with ethnic families because the clashes of assumptions and the apparent "passivity" that families may show, can easily be labeled as lack of motivation, resistance or dependency. Because family therapy is primarily about mastery (persons changing their condition), it may be perceived by the consumer as antithetical to their preferred belief in acceptance. It should also be noted that from the client perspective, the drive toward battling subjugation may be seen as anti-spiritual because the idea of looking to a higher power may appear to be devalued by the model. Because much has been learned, particularly in working with ethnic minority groups, about the strength of looking to the person's spirituality as a powerful resource (Boyd-Franklin, 1989), the competent therapist must have the ability to meet the family where they

are, use the resources the family members have successfully relied on over their lives, and be prepared to discuss this set of assumptions in a respectful manner. Further, the competent clinician must be vigilant to situations in which the family does not follow therapeutic prescriptions because of incompatible beliefs along these dimensions.

2c. The Activity Orientation Dimension refers to the nature of behaviors through which a person is judged or judges herself or himself — with a range of a) doing (i.e., achievement oriented), b) being (i.e., who I am) and c) being in becoming (i.e., a search for understanding about one's self). While doing is an important value in western culture, that is we define ourselves through what we do, in Hispanic culture individuals often define themselves by what family or region they come from (being). In our work with Hispanics we found that discussions of "la preciosidad" inherent in Hispanic values was a key component of many joining maneuvers (Perez-Vidal, A., personal communication, 1994). "Preciosidad" refers to the inherent quality of being, of who you are, which gives the individual value that is not attached to what they have achieved. Conversely, achievement oriented parents, often only value their children by what they achieve and not for who they are. One of the potential negative consequences of achievement orientation is that children may learn to value their parents, not for their inherent value, but for what they achieve. This can be particularly destructive among the poor, in which children sometimes de-value their parents for their lack of material achievement. Finally, it should be noted that many of our models of therapy have the goal of bettering the person (promoting growth) by achieving a deeper level of understanding about the self, a concept that may seem alien to persons who do not share the values that would give this type of endeavor its worth.

2d. The Time Orientation Dimension refers to the emphasis placed on a particular time period in one's life — with a range of a) present, b) past, and c) future. An understanding of time orientation of our client has considerable value for the planning of interventions. A therapist implementing a prevention intervention

(which is by definition future oriented) may be much more effective when working with a client that has a future orientation rather than with families that are present oriented and focused on “today’s” issues. It should be noted that socio-economic conditions may have much to do with a present orientation, such as when a family must struggle to survive day to day. With the present-oriented client, the discussion might be more effective when it focuses on how the intervention will impact current circumstances or difficulties such as important immediate precursors to the main problem to be prevented. For example, it may be more effective to frame an intervention as targeting current behavior problems rather than saying it is designed to prevention future drug use by targeting risk factors. Perhaps because of Confucianism, some far east cultures place great value in the past, in the form of ancestry worship and reverence toward parents and other elders. Native Americans also call up their ancestors to help them deal with life. African Americans are formally embracing their African Ancestry as indicated by the growing number of families celebrating the holiday Kwanza. The principles of Kwanza are based on the African tradition and provide guidelines for healthy families and communities. Consequently, when planning interventions, the role of honoring ancestors or the aversion to dishonoring ancestors, may be integrated into the intervention. These principles have been incorporated into prevention projects for African American youth at risk for substance abuse (Cherry et al., 1998).

2e. The Relational Orientation Dimension refers to the nature of a person's relation to other people -- with a range of a) hierarchical (vertical relationships), b) collateral (i.e. horizontal network) and c) individualistic (i.e., autonomy). Having a *hierarchical orientation as opposed to an individual orientation* is critical in the extent to which clients will be comfortable with family therapy. Those who view themselves primarily through their connection to family will be most in line with the assumptions of a family model. Problems can be discussed in family terms and it is expected that family will be involved. One of our first clear findings was that Hispanic parents were offended when individually oriented interventions

meant that therapists would most often see the youth alone therapists informed parents that due to confidentiality, family participation would be minimal.

The extent to which parents have a markedly hierarchical view of family relations has powerful implications for the process of family therapy. When parents view good family functioning as consisting of marked levels of authority, they can perceive open disagreements between parents and adolescents as disrespectful and unacceptable. One of the critical implications of this world view is that therapy interventions that openly encourage the youngsters to "speak their mind" and "tell parents what they really think" may be seen as incompetent or misguided therapy. The "intervention" may be seen as making the problem worse than it was originally, by encouraging what is perceived to be the dysfunctional behavior (disrespectful challenging). From the point of view of understanding the link between process and outcome, the impact can be profound because the types of family interactions that may be hypothesized to be therapeutic (e.g., direct negotiation and problem solving between adolescents and parents) may not lead to good outcomes for families who are highly hierarchical.

One of the constructs directly related to a preference for hierarchical relations, is familism, because of the focus on vertical relationships. Familism has been an often cited core construct among Hispanics and other ethnic cultures and has been shown to consist of three types of values orientation: 1) perceived obligations toward helping family members, 2) reliance on support from family members, and 3) the use of family members as behavioral and attitudinal referents (Sabogal, Marin, Otero-Sabogal, Marin & Perez-Stable, 1987). When there is a high familism, it is not uncommon to see individuals motivated to behave in more adaptive ways, by the potential benefit to the family and not merely by the benefit to themselves.

A related and commonly identified pattern among Hispanics is *Allocentrism* (Hofstede, 1980) which refers to the orientation toward collectivism as opposed to individualism. Allocentrism refers to being connected with, interdependent upon,

interested in the well-being of, a particular in-group and not just the self interest of the individual (Marin & Triandis, 1985). A powerful driving force is being in harmony with the in-group and may drive relationships to be less confrontational than an individualistic orientation may generate.

It is important to note that issues of hierarchy are not unique to intrafamily relations. Using the theory of *Power-Distance*, Hofstede (1980) describes how some societies favor marked power differentials in which some (highly intelligent or educated, high social class, high moral status) may be looked up to and should elicit intense respect, conformity and deference. We have found that this orientation can have a very powerful impact in two key areas. First, families characterized by this orientation often favor hierarchical doctor-patient relationship (expert-patient) in which the doctor tells the patient what to do and the patient complies with little or no questioning. This is not uncommon among many of our Hispanic families but is very different from our experience with African Americans who have a history of being wronged by so called experts, are more skeptical, and may prefer to interact in a more egalitarian fashion. Secondly, when programs include multisystemic interventions that attempt to help parents become partners with the school or juvenile justice systems for the sake of their children involved in these systems. Hispanic parents often look upon these institutions with such a high level of respect and awe that it impedes their sense that parents can and should seek to impact these systems. Research on the optimal doctor patient relationships and on programs that involves modification of interactions between ethnic parents and large institutions, would do well to consider the influence of Hofstede's power-distance orientation in their work.

Adding to the complexity of working with ethnic families is the fact that the original values, beliefs, and behaviors of an ethnic culture do not remain static. Perhaps the greatest challenge to understanding an individual or family, is understanding how these core values change over time. As an individual/family

spends time in a host culture that shares a different configuration of values, the values and behaviors of the immigrant will, in most instances, be modified. Acculturation has been defined as “the complex process whereby the behaviors and attitudes of a migrant group change toward the dominant group as a result of exposure to a cultural system that is significantly different” (Rogler, Malgady and Rodriguez, 1989). The natural changing of the original ethnic culture is one big reason why an ethnic label or nation of origin does not tell you all you need to know about the values of the individual consumer.

Recommended Cultural Competency Construct Regarding *Values Orientation*:

Does the service system consider the nature of a person's Values Orientation along each of the dimensions and understand the compatibility or incompatibility between these sets of assumptions and those of the service delivery system and treatment model? Do they understand the specific ways in which these orientations may affect therapy outcome?

3. Understanding Major Life Experiences that are Keys to Working which Ethnic Families. – Not all changes in people’s ways of seeing the world result from acculturation. Many ethnic families have major life experiences that directly produce powerful attitudes and beliefs and are crucial to consumer responses to treatment. Among African American families or other black families, a major issue is racial prejudice and the many forms that it takes in daily life. Black families will often be skeptical about a therapists ability to address such powerful and painful issues. Among immigrant families, they may be issues of atrocities and trauma that occurred during the actual immigration process or about the stress of deportation that still exist. Among immigrants it may also be about the stress of acculturation and adjusting to the new society or about the weak “minority” status that they have come to know for the first time in a society that looks down upon them. These powerful life experiences are important to know because the clinician gains credibility by being able to inquire about, understand how these stresses affect

daily life, and intelligently and sensitively process these with the client. Work by Jackson (1998), for example, has shown that alliance is improved in the treatment of African American adolescents when issues such as anger/rage/alienation and the journey of boyhood to manhood can be directly processed. Not surprisingly, Sue & Zane (1987) identified “credibility” as a key factor in succeeding with ethnic clients, particularly when the clinician does not belong to the client’s ethnic/racial group.

Recommended Cultural Competency Construct Regarding The Family’s Major Life Experiences.

Does the service system consider the powerful impact of major life experiences linked to ethnicity/race and can they process these experiences, linking them directly to their intervention?

4. **Ease in working with culturally diverse individuals.** An important but difficult to measure aspect of working with people of diverse cultures is the ease with which a system interacts with the client. At the practitioner level there are varying degrees to which he/she may feel comfortable, at ease, relaxed, and show flexibility when faced with ethnic diversity and diversity of habits, customs, and forms of expression. At the agency level, there are also varying degrees to which the agency can have flexible operating procedures that make ethnic individuals and families feel at home. This can include such things as the decorations and artwork that hang on walls, the reading material offered to clients, and the accommodations for children for cultures who are very nuclear and extended family oriented and may want to bring children or relatives.

Recommended Cultural Competency Construct Regarding The Ease with which the system works with diverse ethnic characteristics.

Does the service system show ease/comfort in working with people of diverse cultures and do their practices demonstrate that they have made adaptations to meet the expectations of the cultures of their clients?

Conclusions

In this paper we have argued the measurement of cultural competence is a complex but critically important endeavor because without cultural competence, a service delivery system cannot be expected to effectively engage into services, or effectively treat, consumers of different ethnic and racial backgrounds. We have also outlined four constructs that should be included in any measure of cultural competence: 1) Overall Competence, 2) Understanding of basic values orientations endorsed by consumers of diverse cultures, 3) Knowledge of the major life experiences (immigration and acculturation stress, racial prejudice and discrimination, the socio-political standing of the consumer's ethnic group within the host society) that shape the consumer's everyday lives, and 4) the "ease" with which practitioners and systems work with people of diverse ethnicity. Throughout we have attempted to explain how it is that these important dimensions interact with efficacy of treatment.

Table 1
Recommendations of Four Constructs To Be Measured
In an Instrument on a MH Service's Cultural Competency

1. **Recommended Cultural Competency Construct Regarding Basic Competence in the Treatment Model:** *Does the service system have the technical expertise to deliver their core treatment model competently? Do they understand the theoretical assumptions on which their models are based?*

2. **Recommended Cultural Competency Construct Regarding Values Orientations:** *Does the service system consider the nature of a person's Values Orientation along each of the dimensions (Human Nature, Person-Nature, Activity Orientation, Time Orientation, and Relational Orientation) and understand the compatibility or incompatibility between these sets of assumptions and those of the service delivery system and treatment model? Do they understand the specific ways in which these orientations may affect therapy outcome?*

3. **Recommended Cultural Competency Construct Regarding The Family's Major Life Experiences:** *Does the service system consider the powerful impact of major life experiences linked to ethnicity/race and can they process these experiences, linking them directly to their intervention?*

4. **Recommended Cultural Competency Construct Regarding The Ease with Which the System Works with Diverse Ethnic Characteristics:** *Does the service system show ease/comfort in working with people of diverse cultures and do their practices demonstrate that they have made adaptations to meet the expectations of the cultures of their clients?*

References

Alexander, J.F., Holtzworth-Munroe, A., & Jameson, P.B. (1994). The process and outcome of marital and family therapy: Research review and evaluation. In A.E. Bergin, & S.L. Garfield (Eds.), *Handbook of Psychotherapy and Behavior Change*. New York: N.Y: John Wiley and Sons, Inc.

Boyd-Franklin, N. (1989). *Black Families in Therapy*. New York, NY: Guilford Press.

Cherry, V., Belgrave, F., Jones, W., Kofi Kennon, D. & Phillips, F. (1998). NTU: An Afrocentric approach to substance abuse prevention among African-American youth. *Journal of Primary Prevention*, 18, 319-339.

Hofstede, G. (1980). *Culture's Consequences: International Differences in Work related Values*. Beverly Hills, CA: Sage Publications.

Jackson, A. (1998). The relationship of cultural theme discussion to engagement with acting out African American male adolescents in family therapy. Unpublished doctoral dissertation, University of Miami.

Kluckhohn, F. R. & Strodtbeck, F. L (1961). *Variations in Value Orientations*. Evanston, IL: Row, Peterson.

Marin, G. & Marin, B. V. (1991). *Research With Hispanic Populations*. Newbury Park, CA: Sage Publications.

Marin, G., & Triandis, H.C. (1985) Allocentrism as an important characteristic of the behavior of Latin American and Hispanics. In R. Diaz-Guerrero (Ed.), *Cross-cultural and National Studies in Social Psychology* (pp.85-104). Amsterdam:Elsevier Science Publishers.

Rogler, L.H., Malgady, R.G., & Rodriguez, O. (1989). *Hispanics and Mental Health: A Framework for Research*. Malabar, FL: Krieger

Sabogal, F., Marin, G., Otero-Sabogal, R., Marin, B.V. & Perez-Stable, E. J. (1987). Hispanic familism and acculturation: What changes and what doesn't?. *Hispanic Journal of Behavioral Sciences*, 9, 397-412.

Santisteban, D., Muir-Malcom, J., Mitrani, V. B. & Szapocznik, J. (In

preparation). Integrating the study of ethnic culture and family psychology intervention science.

Sue, S. & Zane, N. (1987). The role of culture and cultural techniques in psychotherapy: A critique and reformulation. *American Psychologist*, 42, 37-45.

Szapocznik, J., Rio, A.T., Hervis, O.E., Mitrani, V.B., Kurtines, W.M. & Faraci, A.M. (1991). Assessing change in family functioning as a result of treatment: The Structural Family Systems Rating Scale (SFSR). *Journal of Marital and Family Therapy*, 17 (3), 295-310.

**Defining and Measuring Cultural Competence in the Evaluation of Mental
Health Services**

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RACE, ETHNICITY, AND CULTURE

It is necessary to make distinctions between race, ethnicity, and culture, in order both to define cultural competence and to devise methods of bringing it about. Problems abound in the inconsistent ways the terms are used; all three are useful, but they should not be thought interchangeable.

Race is best confined to uses indicative of biological implications of genetic origin. We do not have to take any stance one way or the other about the ultimate scientific legitimacy of the idea of race, but it is useful to mark those occasions when genetic variations are intended. Race does enter into the operations of mental health service systems at times, perhaps not always in the ways intended. For example, pressures for diversity in staffing of organizations are almost always couched in terms of race (more blacks, more Asians) or pseudo-race (more Hispanics).

Ethnicity is a useful term when it refers to sense of identity with or belongingness in relation to some social group. Some black (race) persons may be of Hispanic ethnicity, and some persons with Hispanic surnames (quasi-race) may have only a weak sense of being Hispanic (ethnicity). Ethnicity is often very important for political purposes as it enables the establishing of bonds between persons that are useful for achieving power and political aims. We think that ethnicity as a concept may be extended to cover some identifications beyond those represented by racial, geographic, and linguistic characteristics, the more usual bases for ethnic identification. For example, Page (1993) notes that deaf Hispanics in New Mexico appear to have a much stronger view of themselves as deaf than as Hispanic. It is important to recognize that ethnicity may be assigned as well as adopted. Thus, a person may be regarded by others as a member of some ethnocultural group even though the person may not at all so regard him or herself.

Culture, then, refers to a complex and interrelated set of forces operating on

individuals so as to direct their energies and responses along certain lines of thought and action from among the myriad possibilities. Culture is learned and may be thought of generally as the way of life of a group of people with some common and enduring bond among them. Race is not culture, nor is ethnicity. People with highly similar racial background or a common ethnic identification may represent quite different cultures. Some black persons (race) with a strong black identification (ethnicity) may, nonetheless, have much more in common culturally with a white group, say upper middle-class, than with other black groups, e.g., inner-city black culture.

It may be very difficult to specify in particular cases just what is meant by cultural competence, in part because there may be confusion about exactly what is meant by “culture.” For example, some investigations have shown that racial-ethnic “matching” of clients and service providers may produce outcomes different from those with unmatched pairs. It seems unlikely that racial (biological) matching could have any effect on characteristics of service encounters. Ethnicity could be important, however, if clients feel more comfortable with someone “of their own kind,” and, therefore, respond differently than with persons not having the same identity. It should be clear, however, that even in that case, it would be possible that a client might feel an ethnic affinity that did not exist if the service provider, in fact, had no particular allegiance to the ethnic group of the client. Culture, on the other hand, might be the important determinant of the encounter if the latter depended on a particular understanding of some feature of the client’s way of life. If culture were the critical factor in matched interactions, then it should not matter whether the matching reflected racial or ethnic characteristics. Cultural competence cannot substitute for ethnic identity, but the latter may not always be a good cue to culture.

Defining Cultural Competency

It is likely to be difficult to distinguish cultural competency from general

sensitivity to individual differences. Any given person or group has multiple “social addresses” (Bronfenbrenner, 1986). Which of those identities will be salient or important at any given time will be dependent on the particular circumstances or context of a situation or interaction. Thus, a person might be culturally sophisticated but not in the way made regnant by a particular interaction. For example, a black, female, small business owner might not be helped at all by being “matched” to a black, male service provider from a working class background. In addition to black ethnicity, it might be that sex, socio-economic status, or business orientation might be important in the example described. In our own work with male veterans, it is veteran identity rather than ethnic identity (Hispanicity) that seems to be the more important "ethnic" identification.

Having said that, there is value in being sensitive to the specific needs, values and experiences of ethnically and culturally diverse clients. What may be required is not so much specific cultural knowledge as a developed sensitivity to and tolerance for the fact that people are different in many interesting ways, some of which are moderately predictable from group characteristics (social addresses). If that is so, then training for cultural competence may be better if it is broadly conceived and directed rather than oriented to the acquisition of specific knowledge about cultural habits and traditions. Even if it is believed that specific training in culture is desirable, cultural competence needs to include awareness of the possibility that for any given person at any given time, one or more of many social identities may be more important than what is usually termed culture.

Incorporating cultural values in programs may increase the credibility and perceived relevance of those programs for some participants (Terrell, 1993). Potential increases in “self-esteem and ethnocultural pride” may be particularly important for groups that face discrimination and negative stereotyping. We thought it interesting in our work with Hispanic veterans that they were greatly pleased with printed

materials in Spanish even though none of them chose to use the Spanish versions. Again, cultural competence may be manifested more in terms of general sensitivity than specific knowledge or skills.

Cultural competence requires a thorough understanding of the local population being served by an organization and ascertainment of what cultural factors are likely to be at issue. It is not likely that cultural competence can be broadly "manualized." For example, we are acquainted with one American Indian case manager who presents to her co-workers a slide show demonstrating the living conditions of veterans on the reservation and practical considerations limiting access to services. Providing effective mental health services requires developing a unique and complex relationship with each client. Replacing individual evaluations with group-based generalizations can be limiting and promote stereotyping. Lopez and his colleagues (Lopez, Blachar, & Shapiro, in press) have referred to group-based generalizations as the "cultural elements" approach, in which cultural elements are assumed to correlate highly with reports of ethnicity. Yet ethnic groups are by no means homogenous and treating them as such is rarely justified. The empirical evidence for such an approach is weak (Lopez, et al., in press; Phinney, 1996) and may promote fixed, stereotypic views of ethnic groups (Lopez, et al., in press).

Cultural Issues in Overall Quality of Care

A number of factors involving cultural issues may be identified as important to consider in the assessment of the overall quality of care delivery (adapted from WICHE/ AHCPR, 1998; Terrell, 1993).

Language barriers are the most obvious potential impediment to the delivery of good quality mental health services, which depend far more than other health services on accurate understanding of nuances of feelings, values, preferences, and so on. Yet, we are reluctant to designate language competence as a critical feature of

cultural competence. One reason is that language facility is to a great extent a fairly straightforward technical skill. Surely the ability to communicate accurately and efficiently should be taken for granted in the delivery of mental health services. Moreover, when language barriers do exist, they are, probably unlike many other cultural barriers, likely to be fairly evident to one or both parties to a transaction so that they can be allowed for. Nonetheless, persons working in mental health service arenas should take care to prepare themselves by acquiring the vocabulary necessary for effective communications, including becoming informed about intricacies of meaning that may be peculiar to particular cultural settings.

Communication expectations have to do with cultural patterns related to the conditions under which communications are undertaken and their preferred forms. For example, it is the current widely accepted practice in the United States to affect a kind and degree of familiarity in interactions, especially by use of informal forms of address such as first names, that is unsuitable, perhaps even offensive in other cultures. On the other hand, professionals are often so accustomed to having legitimacy and authority of their advice taken for granted that they may be disinclined to engage in explanation or justification and may seem presumptuously abrupt.

Health care beliefs and practices are culturally determined, and those of any given subcultural group may or may not be consonant with those of the broader, “science-oriented” society. If a cultural group from which a patient comes is known to believe that mental illness is the result of spirit possession, it is important for clinical personnel working with that patient to know of that belief, but it is also essential that they come to terms with the belief and devise ways of providing effective intervention in light of a belief that they themselves may reject. Mental disorder may be much more stigmatized in some cultures than in others, and understanding both the stigma and how to deal with it in treatment may not be a

simple matter. A notable example is the stigma that attaches to mental disorder in the police community. That stigma requires special concern for confidentiality and may even rule out the use of civilian mental health services. When clinical personnel must deal with behaviors that are accepted in another culture but “intolerable” in their own, the limits of cultural competence may be encountered. Cultural competence is often be manifest in the ability of clinicians to engage patients on their own terms and still be effective. Building that sort of competence into organizations is a challenge.

Family organization and relational roles also vary across cultural and subcultural groups and may result in differences in the ways in which mental health services can or ought to be carried out. For example, some cultures may have family systems characterized by patriarchal or matriarchal rule that require elaborate consultations before any decisions are made. Some mental health service providers have been surprised to discover cultural expectations that entire families be present at interviews or treatment sessions. Variations in the ways in which in-law relations are treated are very large.

Sources of stress and coping skills are also important and differ between groups. Both may reflect ethnic as well as cultural differences. For example, discrimination, inadequate employment and educational opportunities, poverty, and a pervasive sense of powerlessness may stem from ethnic identity (Terrell,1993), perhaps even if ethnicity is ascribed to a person rather than being adopted. It is critically important to recognize, however, that two persons of the same apparent racial and ethnic background may differ substantially in, for example, the sense of having suffered from discrimination. Ethnic identification may, of course, also be a source of strengths, e.g., from engendering a sense of social support and belonging.

Coping mechanisms may be fostered by some cultural features or suppressed

by others. The approaches taken in mental health services facilities need to be sensitive to the characteristics of the cultures of clients. For example, training in assertiveness should be based on a sense of community and respect for others' experiences to be culturally appropriate for American Indians, who may not share the dominant culture's emphasis on individualism (Terrell, 1993). Enhancing social support resources in clients should also take into account variations in sources of support for different ethnic communities. Some cultures encourage turning to other family members for help rather than seeking treatment from outside the family, let alone from strangers.

Measuring the Facets of Ethnicity and Culture

No characteristic or facet of ethnicity or culture is an invariable consequence of either. In fact, many of the relationships are of modest size, reflecting the fact that nearly all persons are members of numerous subsets or groups and, hence, subject to widely varying influences. It follows, then, that if we are to take account of ethnicity and culture, including assessing competence of service providers to deal with them, we need to undertake the daunting task of identifying the critical variables and locating or developing measures of them. The foregoing list of ethnic and cultural features is a beginning place for initiating a focus on quantifying their effects, but only a beginning place. We wish to emphasize that the measures we list later for potential use in ethnic and cultural studies is only a beginning point.

Theory to guide the understanding of ethnic and cultural factors is underdeveloped. That is especially so if we try to specify the factors that will be central to the development and delivery of effective mental health programs. At present a basis does not exist for anticipating the ethnic and cultural barriers to or facilitators of effective service delivery programs. Consequently, it will be difficult to propose with much confidence any culturally specific mechanisms or programs aimed at preventing or treating the wide array of troubling behavioral and mental disorders.

Mental Health Delivery Systems and Cultural Competence

Attempts at improving the effectiveness of mental health services through increasing cultural competence may address the characteristics of individual providers, settings, or systems. For example, individual providers may be trained to listen for certain cultural themes during early contacts with clients, settings may adjust their ways of operating, such as hours open, to meet the needs of different cultural groups, and systems may adapt their service philosophies so as to become more hospitable, e.g., by coordinating efforts with those of native healers or taking account of family structures.

Many different aspects of service facilities and systems may be the focus of efforts to improve cultural competence. Some of the more important include the following:

Organization of Services

Access

- Barriers to access

- Structure

- Efficiency (carved out)

Delivery of Services

Utilization

- Level of service use

- Appropriateness of use

- Drop out rates

Quality

- Satisfaction with services

- Duration and termination

- Perception of counselor effectiveness

Effectiveness

- Outcomes (noncompliance, self-esteem, inferiority or personal inadequacy,

anxiety, perceived discrimination)

Financing

Cost containment (co-payments, high deductible amounts, limits on services covered)

Organizational Issues

Efficiency

Building structure

Team diagnosis

Centralized (versus decentralized)

Personnel substitution

Measuring Cultural Competency for Evaluation of Mental Health Service Systems

Just how one might measure cultural competency is not clear. Presumably it ought to be reflected in understanding of cultural issues, which might include both general and specific sensitivities. That is, part of cultural competency should be a general sensitivity, and part of it should be knowledge of and sensitivity to local cultural concerns. A question of no small importance is how and to what extent cultural competence should be related to outcomes of services. There tends to be an assumption that cultural competence should result in increasing access to and satisfaction with services, as well as more appropriate diagnosis and treatment. Presumably those are mediators by which there will be increasing compliance and subsequent improved outcomes. In that case, successful service delivery programs, i.e., as manifested by good outcomes, may be taken to be by definition culturally competent. If, however, service outcomes are less successful than seems acceptable, then issues of cultural competence and the necessity to measure them come to the fore.

We have taken note of the WICHE outcome measures and benchmarks to assess "cultural competence," which include the following:

- Consumer, family and stakeholder satisfaction with services (90%)
- Consistency of service authorizations (benchmark: comparable across ethnic groups; increasing over time)
- Frequency of diagnostic revisions resulting from failure to respond to treatment (benchmark: comparable across ethnic groups and decreasing over time)
- Clinical and functional assessment scales that are validated across cultural boundaries and that can be considered equivalent (see Canino and Bravo, 1994)

Measures we have identified that are likely to be particularly useful in studies of ethnic and cultural factors in mental health services research are given in an appendix to this paper.

References

- Bronfenbrenner, U. (1986). Ecology of the family as a context for human development: Research perspectives. *Developmental Psychology*, 22, 723-742.
- Fox, J., Merwin, E., and Blank, M. (1995). De facto mental health services in the rural south. *Journal of Health Care for the Poor & Underserved*, 6, 434-468.
- Lopez, S. R., Blacher, J. B., & Shapiro, J. (in press). The interplay of culture and disability in Latino families. In I. Tan Mink, M. L. de Leon Siantz, & P. Berman (eds.) *Ethnically Diverse Families and Childhood Disability: Theory, Research, and Service Delivery*. Washington, D. C.: American Association of Mental Retardation.
- Page, J. M. (1993) Ethnic identity in deaf Hispanics of New Mexico. *Sign Language Studies*, 80, 185-222.
- Terrell, M. D. (1993) Ethnocultural factors and substance abuse: Toward culturally

sensitive treatment models. *Psychology of Addictive Behaviors*, 7, 162-167.

WICHE. (1997). *Cultural Competence Standards in Managed Mental Health Care For Four Underserved/Underrepresented Racial/Ethnic Groups*. Boulder: WICHE Publications.

APPENDIX
SCALES FOR MEASURING ETHNIC AND CULTURAL VARIABLES

Ethnic identification and acculturation

1. Acculturation Rating Scale for Mexican-Americans (ARSMA)

(Cuellar, Harris, & Jasso, 1980)

What theory (if any) does the scale test? What is the purpose?

The scale attempts to measure the adaptation of Mexican Americans into the dominant American culture.

Examine the Face Validity of Subscales and Individual Items:

The ARSMA consists of items assessing (1) preferences for language usage, relationships, entertainment, and food, (2) ethnic identification and origin, (3) generational proximity and (4) bilingual abilities.

Cuellar, I., Harris, L. C., & Jasso, R. (1980). An acculturation scale for Mexican-American normal and clinical populations. *Hispanic Journal of Behavioral Sciences*, 2, 199-217.

2. Suinn-Lew Asian Self-Identity Acculturation Scale (SL-ASIA)

(Suinn, Rickard-Figueroa, Lew, & Vigil, 1987)

What theory (if any) does the scale test? What is the purpose?

The scale attempts to measure the adaptation of Asian Americans into the dominant American culture.

Examine the Face Validity of Subscales and Individual Items:

The SL-ASIA consists of 21 items in a multiple choice questionnaire format. The scale contains topics related to language, identity, friendships, behaviors, generational/ geographic background, and attitudes.

Suinn, R. M., Richard-Figueroa, K., Lew, S., & Vigil, P. (1987). The Suinn-Lew Asian Self-Identity Acculturation Scale: An initial report. *Educational & Psychological Measurement*, 47(2), 401-407.

3. Multidimensional Measure of Cultural Identity for Latino and Latina Adolescents

(Feliz-Ortiz, Newcomb, & Myers, 1994)

What theory (if any) does the scale test? What is the purpose?

Collecting information along several dimensions provides a better understanding about individual acculturation, in which individuals affiliate and identify with one or more groups. This scale quantifies the individual's sense of familiarity with both

American and Latino(a) cultures.

Examine the Face Validity of Subscales and Individual Items:

The *cultural identity scales* contain items that assess (1) language use, (2) behavior and familiarity with aspects of American and Latino(a) culture, and (3) specific Latino(a) values and attitudes.

Feliz-Ortiz, M., Newcomb, M. D., & Myers, H. (1994). A multidimensional measure of cultural identity for Latino and Latina adolescents. *Hispanic Journal of Behavioral Sciences*, 16(2), 99-115.

4. Multidimensional Scale of Cultural Difference

(Martinez, Martinez, Lomedo, & Goldman, 1976)

What theory (if any) does the scale test? What is the purpose?

constructed to measure level of “acculturation” to predict group membership, i.e. Hispanic or Anglo.

Examine the Face Validity of Subscales and Individual Items:

Items measure language familiarity and usage, nationality, and occupational status

Martinez, J. L., Martinez, S. R., Lomedo, E. L., & Goldman, R. D. (1976). The semantic differential technique: A comparison of Chicano and Anglo high school students. *Journal of Cross-Cultural Psychology*, 7(3), 325-333.

5. Cultural Information Scale (CIS)

(Saldaña, 1988)

What theory (if any) does the scale test? What is the purpose?

The CIS provides an assessment of demographic and psychological factors associated with acculturation.

Examine the Face Validity of Subscales and Individual Items:

The 23-item scale consists of two subscales aggregated to measure acculturation. Questions in the *demographic index* assess generation level in the U.S., current language preference, fluency in Spanish, and ethnicity of childhood friends. The *psychological index* includes items tapping behavioral preferences, cultural integration and ethnic loyalty.

Saldana, D. H. (1994). Acculturative stress: Minority status and distress. *Hispanic Journal of Behavioral Sciences*, 16(2), 116-128.

6. Cultural Adaptation Pain Scale

(Sandhu, Portes, & McPhee, 1996)

What theory (if any) does the scale test? What is the purpose?

The scale is constructed to assess cultural adaptation and psychological pain associated with the acculturation process.

Examine the Face Validity of Subscales and Individual Items:

Scale consists of 55 counterbalanced statements, reporting on a 5-point Likert scale. The items measure pain and distress: sense of being alienated; learned helplessness: pessimism concerning limited options in life; positive adaptation: sense of belonging, identity, functioning; bigoted: promotion of ethnic stereotypes and slurs.

Sandhu, D. S., Portes, P. R., & McPhee, S. A. (1996). Assessing cultural adaptation: Psychometric properties of the cultural adaptation pain scale. *Journal of Multicultural Counseling and Development, 24*, 15-25.

7. Ethnic Self-Identification

(Phinney, 1990)

What theory (if any) does the scale test? What is the purpose?

The conceptual framework is drawn from research review and attempts to capture self-definition with a particular group.

Examine the Face Validity of Subscales and Individual Items:

Items measured include sense of belonging; positive and negative attitudes toward one's ethnic group; social participation and cultural practices; language use and preference; importance and percentage of in-group friends and dating partners; religious affiliation and practice; structured ethnic social groups; political ideology and activity, e.g. commitment to in-group politics and political runners; area of residence, e.g. proportion of in-group members within neighborhood; miscellaneous ethnic/cultural activities and attitudes, e.g. music and food preferences.

Phinney, J. S. (1990). Ethnic identity in adolescent and adults: Review of research. *Psychological Bulletin, 108*(3), 499-514.

8. Multidimensional Racial Identity Scale (MRIS)-Revised

(Thompson, V.L., 1995)

What theory (if any) does the scale test? What is the purpose?

The scale attempts to provide an assessment of African American ethnic identity along several dimensions.

Examine the Face Validity of Subscales and Individual Items:

The MRIS-R consists of four subscales, or factors: a *psychological* factor, a *physical*

factor, a *cultural* factor, and a *sociopolitical* factor. Items within the *psychological* factor address issues related to (1) commitment to, (2) attachment to and (3) concern for black people and the African American community. Items that make up the *physical* factor assess the acceptance of physical features typically associated with blacks and African Americans. Items from the *cultural* factor measure attitudes toward black and African literature, music, and art. Items within the *sociopolitical* factor measure the individual's awareness of and beliefs about the caste of blacks and African Americans.

Thompson, V. L. (1995). The multidimensional structure of racial identification. *Journal of Research in Personality, 29*, 208-222.

9. African self-consciousness Scale

(Baldwin & Bell, 1985)

What theory (if any) does the scale test? What is the purpose?

The scale attempts to provide an assessment of African American ethnic identity along several dimensions.

Examine the Face Validity of Subscales and Individual Items:

The 42 items in this scale are designed to measure awareness/ recognition of one's African identity and heritage; general ideological and priority of activities based on Black survival, liberation and proactive/ affirmative development; preference of Africentric values, customs and institutions; attitude of resistance toward "anti-black" forces, and threats to black survival.

Baldwin, J. A., & Bell, Y. (1985). The African self-consciousness scale: An Africentric personality questionnaire. *The Western Journal of Black Studies, 9*, 61-68.

10. Black Racial Identity Attitude Scale—Form B

(Helms, 1990)

What theory (if any) does the scale test? What is the purpose?

Within-group and intracultural variance exists in racial-ethnic minority groups (i.e., groups are not homogeneous). The BRIAS-Form B attempts to operationalize Cross' 5-stage model of "Nigrescence", or Negro-to-Black conversion. In his model, Cross explains different levels of racial identity among members of the black community according to stages: Preencounter, Encounter, Immersion-Emersion, and Internalization.

Examine the Face Validity of Subscales and Individual Items:

Items from each subscale relate to the defining features of each stage. Items in the Preencounter subscale measure the degree of adoption of Euro-American world views and behaviors and devaluation of black culture. Items from the Encounter subscale assess the extent to which (1) a critical personal experience has challenged an individual's current world view and (2) an individual has become receptive to new world views and has begun to search for a new identity. The Immersion-Emersion subscale estimates psychological withdrawal and immersion into black experiences and culture (i.e., how much the individual discredits "Whiteness" and idealizes "Blackness"). The Internalization subscale the individual's self-confidence and security with his or her Black identity.

Helms, J. E. (1990). *Black and White Racial Identity: Theory, Research, and Practice*. New York: Greenwood Press.

11. White Racial Identity Attitude Scale

(Helms & Carter, 1990)

What theory (if any) does the scale test? What is the purpose?

The WRIAS attempts to operationalize Helms' (1984) theory of White racial identity. According to her theory, as Whites become racially conscious, they progress through two phases of development: Phase I (Abandonment of Racism), which includes the Contact, Disintegration, and Reintegration stages and Phase II (Defining a Nonracist White Identity), which consists of the Pseudo-independence, Immersion/ Emersion, and Autonomy stages .

Examine the Face Validity of Subscales and Individual Items:

The WRIAS is a self-report measure consisting of 50 items, each rated on a five-point Likert scale. They measure the attitudes associated with 5 of the 6 stages in Helms' model of racial identity development. The Contact subscale consists of items related to naivete about Blacks and racial differences. The Disintegration subscale assesses the amount of anxiety, depression, and guilt resulting from conflict between internal moral standards about past injustices against Blacks and fear of exclusion by White peers. The Reintegration subscale measures hostility and anger toward Black culture and positive biases toward White culture. The Pseudo-independence subscale identifies the degree of genuine curiosity about cross-racial relations, intellectualized acceptance of Blacks, and positive identification with one's Whiteness. Finally, the Autonomy subscale indicates the amount of appreciation for racial differences and involvement in cross-racial interactions.

Helms, J. E. (1990). *Black and White Racial Identity: Theory, Research, and Practice*. New York: Greenwood Press.

12. Jewish Rating Scale

(Dor-Shav, 1990)

What theory (if any) does the scale test? What is the purpose?

This scale attempts to measure children's ethnic identification as Jewish.

Examine the Face Validity of Subscales and Individual Items:

This scale is administered as a structured questionnaire with criterion questions "Why are you a Jew? What makes you a Jew?" It discriminates between eight-levels of children's modes of self-identification as Jewish.

Dor-Shav, Z. (1990). Development of an ethnic self-definition: The ethnic self-concept "Jew" among Israeli children. *International Journal of Behavior Development, 13*(3), 317-332.

13. Multigroup Ethnic Identity Measure

(Phinney, 1992)

What theory (if any) does the scale test? What is the purpose?

Groups share common elements of ethnic identity. This measure assesses similarities and differences in ethnic identity so that researchers can study and compare ethnic identity and its correlates across all ethnic groups.

Phinney, J. (1992). The Multigroup Ethnic Identity Measure: A new scale for use with diverse groups. *Journal of Adolescent Research, 7*, 156-176.

Exposure to Discrimination

14. Scale for the Effects of Ethnicity and Discrimination (SEED)

(Cardo, 1994)

What theory (if any) does the scale test? What is the purpose?

The scale is designed to measure ethnicity and discrimination (35 items, unknown point scale).

Examine the Face Validity of Subscales and Individual Items:

Items measured include those tapping valence of ethnicity for self (VES), dealing with individual's own ethnic identity; valence of ethnicity for others (VEO), dealing with knowledge of and reaction toward other ethnic groups; and perception of discrimination (PD), dealing with perceived effects of selective, differential treatment based on one's ethnic group membership.

Cardo, L. M. (1994). Development of an instrument measuring valence of ethnicity

and perception of discrimination. *Journal of Multicultural Counseling and Development*, 22, 49-59.

15. Cultural Mistrust Inventory

(Terrell & Terrell, 1981)

What theory (if any) does the scale test? What is the purpose?

The scale was developed to measure the degree of mistrust of Whites and White related institutions by individuals (assumed to be a result of exposure to discrimination).

Examine the Face Validity of Subscales and Individual Items:

CMI is scored on a 7-point Likert scale with 48 items with items tapping mistrust in education and training; mistrust in law and politics; mistrust in work and business; mistrust in interpersonal and social settings

Terrell, F., & Terrell, S. L. (1981). An inventory to measure cultural mistrust among Blacks. *Western Journal of Black Studies*, 5(3), 180-184.

Deprivation

16. Index of Multiple Deprivation

(Townsend, 1987)

What theory (if any) does the scale test? What is the purpose?

The questionnaire attempts to capture indicators of deprived conditions, experiences and behaviors.

Examine the Face Validity of Subscales and Individual Items:

Subscales measured include Material Deprivation (dietary, clothing, housing, home facilities, environment, location, work) and Social Deprivation (rights to employment, family activities, integration into community, formal participation in social institutions, recreation, education)

Townsend, P. (1987). Deprivation. *Journal of Social Policy*, 16(2), 125-146.

SES Measures

The following are not developed scales, but suggestions of a variety of areas that may be important to examine in assessing the socio-economic status of the population of clients one is working with.

A. Poverty

Items to consider measuring:

- neighborhood poverty, i.e. Tract & Block-group U.S. census (Bureau of Census, 1990)
- social class and employment status.
- composite of household income, education and occupational status (Knupfer & Room, 1970).
- work history, autonomy, and decision-making authority (suggested additions by Schneider, 1986)

Items to consider measuring:

- Earned school diplomas (high school, BS, graduate or professional, etc)
- Patterns of schooling (i.e. only during non-harvest time, or year round schooling)

B. Private or Public Insurance

C. Social environment (Suggested by Lillie-Blanton & LaViest, 1996)

Items to consider measuring:

- Socio-economic (e.g. employment, education)
- Physical surroundings (e.g. neighborhood and work conditions, resources available)
- Social relations (e.g. within a community or workplace, i.e. segregation)
- Power arrangements (e.g. political empowerment, individual and community control and influence)

Lillie-Blanton, M., & LaVeist, T. (1996). Race/ethnicity, the social environment, and health. *Social Science & Medicine*, 43(1), 83-92.

Measuring Cultural Competency: Issues and Dilemmas

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I think all of us agree on the importance of cultural competency in the provision of mental health care because of the changing and increasingly diverse population and the fact that cultural competency may underlie any kind of care. What will it take for us to establish measures of cultural competency? In devising measures, we must engage in at least four tasks. First, we must define what cultural competency is. Second, we must find measures that tap into our definition. Third, the measures must demonstrate adequate psychometric properties and, most importantly, validity in assessing cultural competency. Fourth, the measures must be useful.

The purpose of this paper is not to try to answer these issues. Rather, I am hoping to delineate certain tasks that are necessary to address, if we are to devise measures of cultural competency. These tasks and issues can serve to stimulate further discussion.

Definition of Cultural Competency

We must develop a definition of cultural competency. The problem is not the lack of conceptually based definitions. A number of definitions exist. The one that underlies several constructed measures was articulated by Sue, Ivey, & Pedersen (1996). The real problem is to understand the parameters covered by various definitions and to come to a reasonable consensus of the nature of the term.

1. What is the level of analysis: A culturally competent system vs. provider?
2. Do different competencies exist for different groups or does cultural competency reside in individuals (e.g., clinicians) independent of groups?
3. Is it possible to "know" all cultures? How much knowledge is necessary and what are the contents of this knowledge?
4. Are different cultural competencies required at different times in the treatment process? In other words, can cultural competency be measured at one time and assumed to be in effect for all times?

5. Are the definitions based on theory or on empirically based research?
6. Is a culturally competent counselor or clinician effective with all groups?
7. Is cultural competency a skill or can manualized and scripted standard behaviors or procedures be considered culturally competent?
8. Is cultural competency a uni-dimensional versus multi-dimension phenomenon; if it is multidimensional, are certain dimensions more important than others?

Because each of us has definition, let me indicate what my definition is (Sue, 1998). There appears to be skills that enhance work across different cultural groups and skills that may be specific to particular groups. This is why we have a very difficult time devising measures of cultural competency – because we may tend to assess culture specific skills rather than more general skills or visa versa. We really need to account for general and specific skills.

I would like to advance several propositions in trying to uncover the essence of cultural competency. First, three characteristics are critical in cultural competency: (1) having good general skills (especially being scientifically minded), (2) having skills in dynamic sizing, and (3) being proficient with a particular cultural group. Second, these characteristics are orthogonal in that it is possible to be proficient in none, one, two, or all of them. Third, there are degrees of cultural competency and to adequately measure it, we must consider all three characteristics.

Good General Skills

There probably are some skills that are beneficial to have in culture competency – characteristics or skills that cut across culture. While examples can be found where some time-honored skills, such as an empathic therapist or a good listener, may not be culturally appropriate, on the whole, there are some characteristics that are important to possess.

I believe one of those characteristics is scientific mindedness. By scientific mindedness, I am referring to therapists who form hypotheses rather than make premature conclusions about the status of culturally different clients; who develop creative ways to test hypotheses; and who act on the basis of acquired data. In cross-cultural relationships, many mistakes are made because we apply theories or assumptions that are developed in one culture and applied to clients from different cultures. By forming hypotheses rather than by making the sameness myth, therapists can then test their clinical inferences. The point is that culturally competent therapists will try to devise means of testing hypotheses about their clients. This scientific mindedness may also help to free us from ethnocentric biases or theories.

Dynamic Sizing

The second characteristic is dynamic sizing – a phrase used in computer circles to indicate a fluctuating cache size. I use it to mean that the therapist has appropriate skills in knowing when to generalize and be inclusive and when to individualize and be exclusive. That is, the therapist can flexibly generalize in a valid manner. One of the major difficulties in interpersonal and interracial or interethnic relationship is the stereotyping of members of a group. While therapists may avoid the overt expression of stereotypes (e.g., beliefs that African Americans are lazy, Chinese are shy, Mexican Americans are family oriented, etc.), stereotypes may, nevertheless, exist in their belief systems and affect their behaviors. On the other hand, the opposite mistake can be made such as the ignoring of cultural group characteristics that may be affecting that individual. The prejudices, stereotypes, and failures to consider culture among therapists or service providers are frequently no different from those found among the general population.

Appropriate dynamic sizing is a critical part of cultural competency. It allows one to avoid stereotypes of members of a group while still appreciating the

importance of culture. In dynamic sizing, the therapist is able to place the client in a proper context--whether that client has characteristics typical of, or idiosyncratic to, the client's cultural group.

Culture Specific Elements

The third characteristic is culture specific expertise. We know that different cultures may have culture specific experts--a shaman, witchdoctor, fortune teller, acupuncturist, folkhealer, etc. These experts presumably are effective in their own cultures because they know the culture and have the skills to translate this knowledge into effective intervention. The culturally skilled helping professional has good knowledge and understanding of his or her own worldview, has specific knowledge of the cultural groups he or she works with, understands sociopolitical influences, and possesses specific skills (intervention techniques and strategies) needed in working with culturally different groups. The person is also able to use culturally based interventions and has the ability to translate interventions into culturally consistent strategies. These characteristics have been extensively discussed in the literature as being important in effective psychotherapy and counseling with members of minority groups (D. Sue, Ivey, & Pedersen, 1996).

The three characteristics--scientific mindedness, dynamic sizing, and culture specific expertise are orthogonal. That is, the three are independent. It is possible to be scientific minded and yet, naive about the cultural background of the client (i.e., have good general skills but no knowledge of the culture of a particular client); to be able to appropriately generalize and individualize and yet fail to engage in hypothesis testing; and to understand and work effectively in a particular culture and yet use stereotypes of individuals in another culture.

Thus when we try to measure cultural competence, we should not confine ourselves just to the knowledge that one has about one particular culture. Rather, we

also have to assess general skills such as scientific mindedness and dynamic sizing abilities. I believe that they are among the most important characteristics that define cultural competency.

Measures of Cultural Competency

A number of instruments are available to assess cultural competency. The most widely cited are:

1. Cross-Cultural Counseling Inventory (CCCI) of LaFromboise, Coleman, and Hernandez (1991) counseling effectiveness. Observer rates 20 items.
2. Multicultural Counseling Awareness Scale (MCAS) by Ponterotto, Reiger, Barrett, & Sparks (1994). Self-report 45 items, assessing cultural awareness, knowledge, and skills.
3. Multicultural Counseling Inventory (MCI) by Sadowski, Taffe, Gutkin, & Wise (1994). Assessment of awareness, knowledge, skills, and relations using 43 self-report items.

These have been reviewed by Ponterotto & Alexander (1996) and have been found to have good psychometric properties. However, several issues are important to consider in evaluating the measures. First, the measures are largely limited to self-report strategies. Even in the observer ratings of the CCCI, the kinds of behaviors that constitute cultural competency are hypothesized, and not empirically determined, to be related to outcomes (see next section). Absent are criterion or performance based behavioral measures. Second, the measures may be particularly pertinent to one profession (e.g., counseling) rather than other professions. Third, as mentioned earlier, if the measures tap into multidimensional phenomenon, which dimensions are particularly important?

Validity of Measures

If there is gold standard to evaluate cultural competency, it is treatment outcomes for clients from different cultures. Currently, measures are not based on outcomes. Most use proxy or distal variables, such as therapist knowledge of culture. This is understandable because rigorous outcome studies for ethnic minority clients are lacking. For example, in two major reviews of the literature (Chambless et al., 1996; Sue, Zane, & Young, 1994), my colleagues and I found not a single rigorous study examining the efficacy of treatment for any ethnic minority population. By rigorous, I am referring to: research in which (a) pre- and post treatment outcomes are assessed for clients from one or more ethnic group(s), (b) clients are randomly assigned to conditions, and control groups (e.g., no treatment, attention-placebo, or different ethnic groups matched on demographic characteristics other than ethnicity, etc.) are used when appropriate, (c) type of treatment and ethnicity are crossed when comparisons of outcomes by ethnicity and treatment are made, (d) multiple, culturally cross-validated assessment instruments are employed, (e) outcomes are assessed over time, and (f) findings are replicated. Many of these criteria have been used by the APA Division 12 Task Force on Psychological Interventions to evaluate empirically validated treatments (Chambless et al., 1996).

Given the lack of outcome research, any measure of cultural competency will always be suspect.

Usefulness of the Measures

Finally, cost, ease of administration, ability to use the measure in different situations, etc., must be considered. If measures demand too much effort or cost too much, they will not be used.

All of the current measures fail to adequately address the critical issues under the four tasks. This does not mean that we cannot proceed to define and use measures and that progress has not been made. Rather, our efforts must be more strongly guided by the questions raised by the four tasks.

References

Chambless, D. L., Sanderson, W. C., Shoham, V., Bennett-Johnson, S., Pope, K. S., Crits-Christoph, P., Baker, M., Johnson, B., Woody, S. R., Sue, S., Beutler, L., Williams, D. A., & McCurry, S. (1996). An update on empirically validated therapies. *The Clinical Psychologist, 49*, 5-18.

LaFromboise, T.D., Coleman, H.K., & Hernandez, A. (1991). Development and factor structure of the Cross-Cultural Counseling Inventory-Revised. *Professional Psychology: Research and Practice, 22*, 380-388.

Ponterotto, J.G., & Alexander, C.M. (1996). Assessing the multicultural competence of counselors and clinicians. In Suzuki, L.A., Meller, P.J., & Ponterotto, J.G. (Eds.), *Handbook of Multicultural Assessment: Clinical, Psychological, and Educational Applications* (pp. 651-672). San Francisco: Jossey-Bass.

Ponterotto, J.G., Rieger, B.P., Barrett, A., Harris, G., Sparks, R., Sanchez, C.M., & Magids, D. (1996). Development and initial validation of the Multicultural Counseling Awareness Scale. In G. R. Sodowsky & J.C. Impara (Eds.), *Multicultural Assessment in Counseling and Clinical Psychology* (pp. 247-282). Lincoln, NE: Buros Institute of Mental Measurements.

Ponterotto, J.G., Rieger, B.P., Barrett, A., & Sparks, R. (1994). Assessing multicultural counseling competence: A review of instrumentation. *Journal of Counseling and Development, 72*, 316-322.

Sodowsky, G.R., Taffe, R.C., Gutkin, T., & Wise, S.L. (1994). Development of the Multicultural Counseling Inventory: A self-report measure of multicultural competencies. *Journal of Counseling Psychology, 41*, 137-148.

Sue, S. (1998). In search of cultural competence in psychotherapy and counseling. *American Psychologist, 53*, 440-448.

Sue, D. W., Ivey, A. E., & Pedersen, P. B. (1996). *A Theory of Multicultural Counseling and Therapy*. San Francisco: Brooks/Cole Publishing.

Sue, S., Zane, N., & Young, K. (1994). Research on psychotherapy with

culturally diverse populations. In E. Bergin & S. L. Garfield (Eds.), *Handbook of Psychotherapy and Behavior Change*, 4th edition (pp. 783-820).

**Cultural Competence Prerequisites for Managed Behavioral Health Care
Programs**

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Introduction

The primary purpose for the strategic implementation of the national Core Cultural Competence Standards for Managed Mental Health Care Programs is to promote the systematic development of culturally competent public and private systems of care. The projected implementation of the proposed cultural competence standards will require public and managed care organizations to develop strategic cultural competence implementation plans. Additionally, the systematic implementation of the cultural competence plan will concurrently require the development and implementation of a supportive and dynamic program evaluation plan to measure the progress and effectiveness of the cultural competence plan. The gradual development of an effective cultural competence evaluation plan will require a continuous linking and active collaboration of specialists with cultural competence and specialists with program evaluation expertise. The evaluation plan will include appropriate cultural competence indicators or outcome measures and the appropriate methodology to assess any progress in the implementation of the cultural competence plan and its effectiveness over a specified period of time.

An Overview of Cultural Competence Standards

The Americans with Disabilities Act of 1990 and Title VI of the Civil Rights Act of 1964, as amended, both mandate accessibility to programs and the facilities at which services are dispensed. It is therefore critical for public and private agencies to be staffed with culturally competent and appropriately qualified bicultural and bilingual personnel. To help meet this requirement, the Cultural Competence Standards recommend that cultural competence training be provided to all direct care staff and those with management oversight responsibilities. The goal of the training program is to promote the systematic development of culturally competent systems of care.

The national Core Cultural Competence Standards were developed through

the collaboration of national African American, Asian and Pacific Islander American, Latino, and Native American Behavioral Health Workgroups with the recognition that, in order to provide individualized mental health services, consumers must be viewed within the context of their cultural group and their experiences from being part of that group. Consequently, training of staff to enable them to understand the cultural background and need of a consumer is a critical element of a culturally competent system of care. Cultural competence training is intended to help the service provider from another culture become better able to understand and communicate with the consumer who is from one of many national origins or ethnic backgrounds. It will not, of course, permit an individual to take two or three courses and become totally competent in understanding and treating someone with different life experiences, language and cultural background. Acquiring cultural competency is a long-term developmental process from an individual, professional, and organizational level.

The "ideal" culturally competent system of care demonstrates a value for diversity, has the capacity for cultural self-assessment, shows awareness of the dynamics inherent when culture interacts, institutionalizes cultural knowledge, and develops adaptations to diversity. Ultimately, the culturally competent system incorporates the concept of equal and nondiscriminatory services and further includes the concept of responsive services matched to the unique cultural and linguistic needs of consumers.

The Program Evaluation Plan

The Program Evaluation Plan and the Cultural Competence Plan should be concurrently developed and implemented to insure that the essential principles and values which generated the cultural competence standards are accurately represented by the evaluation protocols. The preferred approach to develop the Evaluation Plan would be to utilize specialists with expertise in cultural competence and also in

program evaluation to develop and implement both plans. Most likely, however, it will be necessary to utilize a collaborative planning process which allows different specialists to integrate their expertise in the area of cultural competence with expertise in the area of program evaluation competence. Regardless of the planning process utilized, the emphasis should be on flexibility, strategic planning and the practical use of available resources.

The national Core Cultural Competence Standards primary interest areas for evaluation planning are listed in Table I below. These cultural competence standards and primary interest areas should be used as the basis or key factors for determining the cultural competence performance indicators and the outcome measures for the evaluation plan.

Similar to the Cultural Competence Standards which need to be systematically validated and refined through appropriate pilot testing, the initial phase of program evaluation should place emphasis on an assessment of behavioral impacts that does not depend on experimental research design or random assignment. Emphasis should be placed on assessment of operational procedures which focus on services delivery to cultural and linguistic groups and on quality assurance measures and utilization reviews. More rigorous experimental research evaluation should be done on a limited basis when the cultural competence system in an organization is more firmly established.

Table I
National Core Cultural Competence Standards
Primary Interest Areas For Evaluation Planning

Core CC Standards Primary Interest Areas	Cultural Competence Performance Indicators	Outcome Measures
Cultural Competence Planning		
Governance		
Benefit Design		

Quality Monitoring & Improvement		
Decision Support & MIS		
Staff Training & Development		
Provider Competencies		
Access & Service Authorization		
Triage & Assessment		
Care Planning		
Treatment Services		
Case Management		
Linguistic Support		

The Cultural Competence Plan

A Cultural Competence Plan for both public and private sectors should be developed and integrated within the overall organization or provider network using an incremental strategic approach to implement elements of cultural competency and to assure attainment of cultural competence within manageable but foreseeable time frames. The Plan should be developed by a team involving representation from top and middle management, direct care staff, consumers, families, and community stakeholders. The Cultural Competence Plan should designate a culturally competent executive level manager who will have the necessary authority to implement and monitor the implementation of the cultural competence plan. Each individual manager in the system of care should be accountable for the success of the Cultural Competence Plan.

Cultural Competency Basic Requirements

Some of the essential elements which are required in a culturally competent mental health care delivery system and which must be reflected system-wide include:

1. An unbiased attitude and organizational policy that values cultural diversity in the population served.
2. A fundamental belief that all services and service providers must be culturally competent.
3. An awareness that cultural differences may impact the effectiveness of mental

health care delivery.

4. Skills to communicate effectively with diverse populations and application of those skills in cross-cultural interaction to ensure equal access of quality health care.
5. Knowledge of disease prevalence in specific cultural populations whether defined by race, ethnicity, socioeconomic status, physical or mental ability, gender, disability or age.
6. Programs and policies that address the mental health needs of diverse populations.
7. Ongoing evaluation of the effectiveness of programs and policies that address the health needs of diverse populations and cultures.

Administrative Requirements to Develop Cultural Competency

Organizational culture and behavior are learned by staff through attitudes communicated by key level administrators. To insure clear communication to staff about the importance of cultural and linguistic competency, an organization such as a State Department of Mental Health (DMH) should integrate throughout their administrative policies these priorities:

1. Cultural competency must be evident in the DMH mission and values.
2. DMH must establish and maintain a system-wide process to evaluate and determine the need for special initiatives related to cultural competency
3. DMH must include recruitment and retention initiatives to ensure organization-wide staffing that is reflective of the communities served.
4. DMH must assess the cultural competence of its staff and contract providers on a regular basis.
5. DMH should establish a special Office or designated staff to develop, direct and coordinate the integration of cultural competency standards throughout the Department. Responsibilities should include establishing mechanisms to appropriately meet the cultural and linguistic needs of DMH consumers. The office or designated staff should also coordinate these services with cultural competence efforts by other State or Federal agencies.

6. DMH must have an array of communication tools to distribute information to staff relating to cultural competency issues (e.g., those tools generally used to distribute other operational policy-related issues.)
7. DMH must participate with government, community and educational institutions in matters related to best practices in cultural competency in managed health care to ensure that the Department maintains current information and an outside perspective on its policies and practices.
8. DMH must have information systems capable of identifying and profiling cultural and linguistic specific client data (e.g., eligibility criteria, client tracking, diagnostic services, treatment outcomes etc.).
9. DMH should evaluate the effectiveness of its strategies and programs in improving the health status of culturally defined populations.

These guidelines should be used by DMH to establish performance measures and initiatives throughout the Department to support integration of cultural and linguistic differences in mental health care delivery and operations.

Education and Training Concepts

Active and ongoing staff training and education regarding cultural competency further communicate the priority the organization places on this issue. Quality Improvement (QI) feedback and assessment measurements should be used on an ongoing basis to assess the effectiveness of the cultural competency education and training initiatives. A comprehensive staff training and education program includes components for orientation sessions, ongoing education and training, assessment of the educational program, sharing of ideas and resources and dissemination of materials.

Continuity of Planning For the Cultural Competence Standards:

The National Latino Behavioral Health Workgroup has continued the strategic planning process to refine the Latino Cultural Competence Standards through pilot testing and by developing methods for implementation of the standards

in an inclusive manner with other multicultural groups and mental health authorities. The ongoing planning and implementation effort emphasizes the use of culturally competent total quality management approaches and public managed care principles of quality care.

The following additional priority issues and problems in mental health care services delivery were identified as significant for Hispanic consumers:

Cultural Competence: Requires a highly specialized developmental, long term, multi-stage process to implement. Should be viewed as a way to improve quality, not penalize staff.

Representative Participation in Workforce: A major issue is the recruitment, employment, retention and promotion of qualified bilingual and bicultural Hispanic professionals to plan, staff and manage appropriate mental health services for Hispanic consumers.

Quality and Design of Programs: Existing mental health treatment resources are often limited and frequently inappropriately designed and inadequately staffed to respond to the special needs of Hispanic consumers.

Qualified Interpreters: Mental health programs, services and activities must use, in the absence of appropriate bilingual/bicultural staff, qualified interpreters to facilitate communication at all levels between consumers and providers of mental health services.

Quality Care: A requirement under the Civil Rights Act of 1964, as amended. The following are critical issues and concerns :

1. Accessibility of services.

2. Models of Care and Components of Care.
 - Integrated primary care, mental health, substance abuse, etc.
 - Community based organizations
 - One stop shopping / single entry point into system
 - Design and development of appropriate systems of care
 - Gate-keeping
3. Service utilization and outcome data
4. Meet needs of special populations (children, geriatric, rural, dual diagnosis, disabled, undocumented persons)
5. Quality of translators

Community Improvement and System Change: Use Total Quality Management.

The following are critical issues and concerns:

1. Ensure culturally competent managed care systems through regulation and enforcement.
2. Responsiveness of local health care system to community needs.
3. Empowerment of Hispanic community to impact significantly the development and formulation of managed systems of care.
4. Consumer empowerment and activism.
5. Discrimination and lack of parity in services for Hispanic persons.

**Issues Pertinent to the Selection of Cultural Competence Measures in
Performance Measurement Systems**

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Interest in performance measurement of the behavioral managed care delivery system has increased considerably. The expansion of managed care organizations for providing state funded behavioral health care has contributed to the need to identify if purchased services are delivered and the quality of care provided. A major goal of managed care practices is the reduction of health costs (Beaudin, 1998). To achieve this goal treatment strategies have been impacted by eliminating unnecessary treatments and procedures. Service providers are held accountable for treatment decisions. Demonstration of need for services has been identified as critical for determining access to care (Abe Kin and Takeuchi, 1996).

Ethnic minorities although an increasingly growing segment of the population report a lower use of mental health services in comparison with non-minorities (Hu et al., 1991). An increasing concern is that cost containment strategies under managed care systems negatively impact access to mental health care for minority populations. To increase access and quality care to underserved culturally diverse populations increased attention has been focused on the culture-related aspects of care. The importance that managed care environments develop a system of care that addresses ethnic and cultural factors has been widely acknowledged (Lavizzo-Mourey and Mackenzie, 1996; Dana, 1998).

Significant efforts in the health community have been geared towards the identification of relevant elements for the implementation of culturally competent systems of care. Most recently, joint work of four national racial/ethnic panels formulated a set of viable performance indicators aimed at improving the ability of managed care organizations to meet cultural competence standards that translate into measures of accountability. Particular emphasis is placed on the relevance of viewing mental health service consumers within the context of their cultural group recognizing that people develop different approaches in response to their life circumstances. The

need for new approaches in the delivery of mental health services to address cultural variations among consumers from diverse ethnic populations is recognized.

The document *Cultural Competence Standards in Managed Care Mental Health Services for Four Underserved/Underrepresented Racial/Ethnic Groups* (1998) presented by the Consensus Panel members, specifies core cultural competence standards applicable to diverse ethnic/racial populations. The cultural competence standards developed address system, clinical and provider aspects of care. The expected outcome of the effective implementation and use of cultural competence standards is that managed care systems achieve progress in the development of a culturally competent work force and increase high-quality care for culturally diverse populations. For each standard relevant performance indicators and outcomes are also specified for use in measuring adherence.

Table 1 lists system, clinical, and provider areas for which cultural competence standards were identified. Implementation guidelines, performance indicators and outcomes are recommended for each standard. Table 2 presents, as an example, recommended performance indicators and outcomes for the standard on access and service authorization.

The effective implementation of cultural competence standards present significant challenges. As evidenced in the *Cultural Competence Standards in Managed Care Mental Health Services (CCSMC)* report (Tables 1 and 2 present an outline and example), the evaluation of cultural competence of health care delivery systems involves multiple aspects of care that address system, clinical, and provider issues.

The first set of standards and performance indicators addressed in the CCSMC document focuses on the health plan overall system, with particular emphasis on the

cultural competence of the organization and managed practices (see Table 1). A basic premise is that the commitment of the organization to culturally competent care as reflected in its philosophy, mission, strategic planning, and organizational analysis sets the tone for the delivery of care. The organization of a health care system holds a major role in responding to the culture-driven needs of patients.

Providers acceptance of clinical standards is a major obstacle for performance based systems. Lack of time, poor understanding of appropriateness of intervention, uncertainty of measurement procedures are stated as reasons for provider failure to adopt standards. The socialization process of the health care provider is also identified as having a significant influence on the therapeutic interventions with culturally different patients (Jones et al., 1998). The document CCSMC emphasizes the need to address providers' knowledge, understanding, skills, and attitudes to ensure cultural competence among clinical staff.

The identification of appropriate measures of cultural competency that address diverse elements involved in the health care process (organizational, clinical and provider) is essential. The CCSMC document provides recommendations of performance indicators relevant for each standard. These indicators should provide the basis for guiding the identification of relevant measures.

A review of various measures of cultural competence revealed that while initial instruments focused mostly on the measurement of knowledge, attitudes and skills, most recent assessments respond to a more comprehensive perspective addressing both provider and organizational elements. The instrument Self-Assessment of Cultural Competence, from the National Public Health and Hospital Institute (1997) addresses several cultural competence standards included in the CCSMC document. The areas assessed are the following:

1. Ethnic/Cultural Characteristics of the Staff and Organization - Board, Staff & Patient/Community Profiles; Diversity Training; Database Systems & Data Development; Human resource Programs; and Union Presence.
2. Institutional Approaches to Accommodating Patient Needs and Attributes - Organizational Adaptation to Diversity, Managed Care & Quality Issues.
3. Institutional Links to the Communities Served by the Healthcare Organization.
4. Language & Communication Needs of Ethnic/Cultural Patient & Staff - Service Provision, Communication Issues, Patient Issues.

The Cultural Competence Self-Assessment Tool (Missouri Department of Mental Health, 1998) is a recent adaptation of a previous measure developed by James Mason. The content areas include: Knowledge of Diverse Communities, Personal Involvement/Awareness, Resources and Linkages, Staffing, Organizational Policies and Procedures, Reaching Out to Communities, and Staff-Client Interactions. Both measures strongly contribute to provide relevant information for the assessment of performance indicators included in the CCSMC document.

Information for the measurement of performance indicators can also be obtained from other sources: administrative data (enrollment/encounter data, claims files); program and medical records; and consumer self reports. Several factors must be considered when examining data sources for the selection of performance measures. The quality of the performance measure is highly dependent on the quality of the data set from which it is derived. Information from existing databases and records may be incomplete, inaccurate or misleading. Recruitment requirements and training of data collectors are identified as crucial elements to achieve high quality data. An established quality control program should guide data collection efforts; particular attention on ongoing editing and reviews of accuracy of data is essential.

The volume and complexity of data collection will also have a strong impact on the selection of performance measures. Computerized record keeping and integrated information systems facilitate the use of complex and large data sets for the selection of performance measures. Other desirable properties of performance measures are that they must be reliable and valid for their intended purpose providing similar results in comparable situations. Data collection procedures need to be clearly specified since decisions made have implications for the accuracy and credibility of the data.

Table 1. Overall system, clinical and provider areas for which cultural competence standards were developed

-
- A. Overall System Standards
 - Cultural Competence Planning
 - Governance
 - Benefit Design
 - Prevention, Education, and Outreach
 - Quality Monitoring and Improvement
 - Decision Support and Management Information Systems
 - Human Resource Development
 - B. Clinical Standards
 - Access and Service Authorization
 - Triage and Assessment
 - Care Planning
 - Plan of Treatment
 - Treatment Services
 - Discharge Planning
 - Case Management
 - Communication Styles and Cross-cultural Linguistic and Communication Support
 - Self Help
 - C. Provider Competencies
 - Knowledge, Understanding, Skills, and Attitudes
-

Table 2. Sample standard, indicators and outcomes

Access and Service Authorization

Standard

Service shall be provided irrespective of immigration status, insurance coverage, and language. Access to services shall be individually- and family-oriented (including client-defined family) in the context of racial/ethnic cultural values. Access criteria for different levels of care shall include health/medical, behavior, and functioning in addition to diagnosis. Criteria shall be multi-dimensional in six domains: psychiatric, medical, spiritual, social functioning, behavior, and community support.

Recommended Performance Indicators

1. Procedures for access in place with specific provisions for consumers from the four groups.
2. Time from point of first contact through service provision for all levels of care are tracked by age, gender, ethnicity (i.e., particular subgroup and mixed origins), primary language, and level of functioning.
3. Rate and timelines of response to telephone calls by consumers from the four groups.

Recommended Outcomes

1. Tracking of authorization decisions including denials, rationale, and disposition by ethnicity.
Benchmark: Comparability across ethnic groups served.
 2. Tracking of access and utilization rates for populations of the four groups across all levels of care in comparison to the covered population.
Benchmark: Proportional to covered population.
 3. Consumer and family satisfaction with access and authorization services.
Benchmark: 90% satisfaction.
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References

Abe-Kim, J.S., & Takeuchi, D.T. (1996). Cultural competence and quality of care: Issues for mental health service delivery in managed care. *Clin Psychol Sci Prac*, 3, 273-295.

Beaudin, C.L. (1998). Outcomes measurement: Application of performance standards and practice guidelines in managed behavioral healthcare. *Journal of Nursing Care Quality*, 13, 14-26.

WICHE. (1998). *Cultural Competence Standards in Managed Care. Mental Health Services for Four Underserved/Underrepresented Racial/Ethnic Groups*. Western Interstate Commission for Higher Education (WICHE) Mental Health Program.

Dana, R.H. (1998). Cultural competence in three human service agencies. *Psychological Rep*, 83, 107-12.

Hu, T., Snowden, L.R., Jerrell, J.M., & Nguyen, T.D. (1991). Ethnic populations in public mental health: Services choice and level of use. *American Journal of Public Health*, 81, 1429-1434.

Jones, M.E., Bone, M.L., & Cason, C.L. (1998). Where does culture fit in outcomes management? *Journal of Nursing Care Quality*, 13, 41-51.

Lavizzo-Mourey, R., Mackenzie, E.R. (1996). Cultural competence: essential measurements of quality for managed care organizations. *Annals of Internal Medicine*, 15, 919-21.