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Abstract

Mental health services in the United States were designed for European American consumers, but with burgeoning multicultural populations these services have proven inadequate and underutilized. This paper examines research on cultural competencies of agencies and clinicians relevant to a mental health practice model, the Multicultural Assessment-Intervention Process model (MAIP). This model was modified for systematic application in a California agency, the Tri-City Mental Health Center, to provide a flexible blueprint for major alterations in agency practice and programs that affect the entire system of care. MAIP begins with intake process including client-clinician/ethnicity-language match, client acculturation/racial identity status, and clinician cultural competence, and proceeds to clinician in-service-training, cultural components embedded in services, and outcome measures.

Culturally Competent California Public Mental Health Services: Model and Example

Introduction

The mental health needs of burgeoning multicultural populations in the United States now require the development of culturally competent mental health services. At present, these populations provide approximately 40% of mental health consumers in the public sector nationally. Historically, competent services were available primarily in culture-specific agencies. As a consequence of managed care, integrated and cost-effective mental health services are now mandatory in California and increasingly necessary in all states.

This paper examines the history of mental health services for ethnic minority populations to document their current needs for access to culturally competent mental health services. The evolution of the term cultural competence is described and expanded to include contemporary definitions. As part of a comprehensive definition of cultural competence, the utility of the Multicultural Assessment-Intervention Process model as a vehicle to increase cultural competence is described. An application of this model within the Tri-City Mental Health Center serving Pomona, La Verne, and Claremont in California provides an example of how current research and practice knowledge can be incorporated within a service delivery system.

History

Ethnic minority populations in the United States have a long history of receiving fewer mental health services of lower quality provided by clinicians with less training than were available for European American consumers (Dana, 1993, 1998a, 2001a). A capsule presentation of this history documents the magnitude of need for culturally competent services. To begin with, immediately following World War II, inadequate public sector services for these populations were a direct consequence of discrimination and racism that resulted in under-

utilization of available services designed for the European American majority consumer population. During the 1960s, deinstitutionalization of chronic mental patients was coupled with the emergence of community mental health programs nationally. Benefiting from advocacy provided by the Civil Rights Movement, culture-specific programs and agencies were developed to provide services to the urban ethnic minority catchment areas in which they were located. These settings made community-based intervention programs available from clinicians of the same ethnic/racial origins as their consumers. Responsible efforts to provide acceptable services led to examinations of the ethnic responsiveness hypothesis regarding the desirability of matching consumers with clinicians to increase utilization of mental health services (Sue, Fujino, Hu, Takeuchi & Zane, 1991). This hypothesis has received positive empirical support, although the outcome effects are complex and differ by group and treatment modality (e.g., Gamst, Dana, Der Karabetian & Kramer, 2000). However, the availability of segregated services contributed to a continued presence of a European American service delivery system in mainstream community mental health facilities. This system was erroneously believed to be directly applicable to ethnic minority populations because cultural/racial differences were ignored, denied, minimized, and misunderstood.

Ethnocentrism has now replaced blatant discrimination as an impediment to culturally competent mental health services, although bias continues to adversely affect service providers as well as access to services, service delivery, standard tests, psychiatric diagnosis, and treatments for multicultural populations (Dana, 1998b, 2000a, 2001b). Clinician bias occurs as a consequence of stereotypy, cultural information deficits, lack of understanding the oppression histories of each ethnic minority population, and an unquestioned mantle of "White privilege" (Neville, Worthington & Spanierman, 2001). Bias occurs in the absence of a service delivery

etiquette that is credible and gift-giving (Sue & Zane, 1987). Diminished rapport and failure to develop a relationship of trust can curtail subsequent consumer visits. Bias also occurs in use of standard assessment instruments that often caricature, pathologize, or dehumanize ethnic minority consumers because they were constructed and standardized primarily on middle-class White populations. The diagnostic standards for psychopathology developed by in the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) (American Psychiatric Association, 1994) are assumed to be universal, although they are specific to mainstream European Americans for whom they were developed (Castillo, 1997). DSM-IV includes an outline for preparing cultural formulations and a glossary of culture-bound disorders. These embellishments certainly provide token recognition of distal cultural influences on psychopathology, but also require substantial augmentation from other sources for applications by diagnosticians (e.g., Dana, 2001c,d; Mezzich, Kleinman, Fabrega, & Parron, 1996; Paniagua, 1998).

Managed care has institutionalized another source of bias by requiring use of the most cost-effective interventions for mental illness in the absence of substantive empirical documentation. The consequences of failure to incorporate the medical offset literature (Fiedler & Wight, 1989) into managed care policy decisions has resulted not only in reducing the available treatment options for all consumers, but has ignored individual differences, particularly in the form of ethnic/racial differences (Dana, Conner, & Allen, 1996; Dana, 1998c). Furthermore, the pervasive presence of managed care and reduction to a small number of super-ordinate corporations has drastically reduced the numbers of culture-specific agencies in favor of integrated services. This dilemma provided a social justice incentive, mandated by legislation in

California, for embedding cultural competence within organizations to provide equity in mental health care for all ethnic/racial populations (Dana, Aragon, & Kramer, in press; Mock, 1999).

Cultural Competency

An emergent and immediate necessity for cultural competence has been acknowledged in recent articles addressing cultural incompetence and cultural malpractice in mental health research and clinical practice (e.g., Dana, 2000b, 2001a; Hall, 1997; Strickland, 2000; S. Sue, 1999). European American professional psychologists have been generally unable to achieve cultural competence as a result of the formal credentials provided by their training, supervision, and practice with multicultural populations. A recent national survey found that their self-perceived competence with African Americans, Asian Americans, Hispanics/Latinos, and American Indians/Alaska Natives was 38%, 26%, 16%, and 8%, respectively (Allison, Crawford, Echemendia, & Kemp, 1994). Another survey (Holcomb-McCoy & Myers, 1999) found that non-White counselors, one third of their national sample, perceived themselves as more competent than their White counterparts, perhaps as a consequence of life experiences and daily contact with culturally different persons. However, all counselors reported that their multicultural training was inadequate, particularly with regard to cultural knowledge and racial identity information.

This section begins with description of a comprehensive framework for agency cultural competence as well as the use of an instrument to evaluate agency cultural competence. The current status of cultural competency among service providers is described by an evaluation of self-report instruments constructed from a careful delineation of attitude, knowledge, and skill components.

Agency Cultural Competence

A comprehensive model for agency cultural competence (Issacs-Shockley et al., 1996) permeates all levels of agency function to affect every step in the assessment-intervention process. These levels include policy-making, administrative/ management, direct service provider/clinician, and consumer. Policy development should be initiated and accomplished by all persons responsible for planning services, including agency board members and administrators, local officials, state legislators, and ethnic minority community persons. Policy decisions can result in culturally competent executive orders and legislation, set standards and sanction training, lead to funding opportunities for access to services, initiate culturally competent programs, and promote the development of resources with and for the ethnic minority communities. At the management level, there is responsibility for personnel policy to assure staff composition representing the consumer population, agency self-assessment, in-service training, adapting physical facilities, adequate data collection, and alteration of existing interventions as well as creation of new services. Service providers are responsible for providing culturally competent services stemming from positive attitudes, sufficient cultural knowledge, and relevant, credible skills gained through training and experience. At the consumer level, families can become advocates for their children by informing the agency of their community helping networks, by mutual support in defining and articulating issues from their perspective as well as by collective responsiveness to insensitive services.

Two methods have been used to evaluate agency cultural competence, the Agency Cultural Competence Checklist (ACCC) (Dana, Gonwa & Behn, 1992) and intensive case studies of agencies. The ACCC was developed from a systematic compilation of published descriptions of cultural competence ingredients in agency services and service delivery and

provides reliable information on attitudes, services, community relationships, training, and evaluation. A revision of this checklist, the ACCC-R, was used during a two-day interview process with personnel in a number of agency settings to provide external evaluations (Dana, 1998; Dana & Matheson, 1992). The ACCC-R has been modified and reformatted to develop a questionnaire for agency employees, the Staff Perceptions Measure (SPM) (Hart, 2001). The SPM items were developed for use in residential treatment facilities for children but could be adapted for community agencies. An agency evaluation, in either interview or questionnaire format, can delineate areas in which improvement can occur, unresolved conflicts between cultural perspectives can be identified, and readiness for introduction of cultural competence training can be examined.

A more elaborate approach to agency evaluation involved preparation of detailed case studies of highly selected culture-specific agencies (Cross, Bazron, Dennis, & Issacs, 1989; Issacs & Benjamin, 1991). These case studies were accompanied by a definition of cultural competence and a model of agency cultural competence predicated on five essential elements (Issacs-Shockley, Cross, Bazron, Dennis, & Benjamin, 1996): (a) valuing/respecting diversity, (b) cultural self-assessment within the agency, (c) acknowledgement of the dynamics of difference, (d) institutionalizing cultural knowledge within the agency, and (e) adaptation to diversity. Cultural self-assessment by all agency personnel can provide a basis in self-knowledge for attitudes and behaviors toward persons with different cultural/racial origins. Such clinician self-knowledge should be coupled with knowledge of the cultural values and beliefs of consumers. An understanding the dynamics of difference refers to the recognition that divergent worldviews, or cultural perspectives, foster misunderstandings, stereotypes, and prejudice. Cultural knowledge becomes institutionalized within an agency by sanction and/or mandate

insuring the development of mechanisms to facilitate new learning, including in-service training. Finally, agency services and programs require continuous monitoring and adaptation to provide a culturally competent delivery system.

Cultural Competence of Service Providers

At the service provider level, 31 multicultural competencies were identified and organized in nine competency areas within a 3X3 matrix (D. W. Sue, Arredondo, & McDavis, 1992). These competencies included awareness of assumptions/ beliefs/ biases, the knowledge necessary for understanding client worldviews, and a variety of skills necessary for implementing beneficial interventions. The matrix clustered characteristics (awareness of own cultural values/biases, clients' worldview, appropriate interventions) and dimensions (beliefs/attitudes, knowledge, skills) (Ponterotto & Alexander, 1996).

Using an assessment-intervention context, I have proposed elaboration and specification of competencies in each area (Dana, in preparation). Knowledge should be available concerning a client's personal and group history and experiences with discrimination, health-illness beliefs, mind-body dualism, spirituality, individualism-collectivism, locus of control/locus of responsibility that is sufficient to permit description of identity and the cultural self. The development of relevant intervention skills include culture-specific service delivery styles, ability to describe acculturation status or racial identity status, ability to evaluate acculturation stressors and level of experienced distress, an understanding of how to prepare cultural formulations and cultural conceptualizations for DSM-IV diagnosis, and the acquisition of practice skills for interventions that are composed of standard and culture-specific components as well as interventions that are exclusively culture-specific (see also Dana, 1993, 1998a). The

cardinal attitude is respect for clients that includes an ethnorelativistic stance and empathy predicated on living experiences in various cultural contexts.

S. Sue (1998) has described scientific mindedness, dynamic sizing, and culture-specific knowledge as orthogonal ingredients of culturally competent skills. Scientific mindedness entails the knowledge to comprehend empirical research and especially the methodological and statistical limitations of this literature for multicultural populations. Dynamic sizing refers to the ability to be flexible in using cognitive styles in order to generalize inclusively and individualize exclusively. The dearth of relevant training for cultural competency among clinicians has been recognized and suggestions for improvement are now available (e.g., Pope-Davis & Coleman, 1997).

A Mental Health Practice Model for Cultural Competence

The Multicultural Assessment-Intervention Process model (MAIP) is a clinical practice derivative of Malgady's recommendation (1996, 2000) for a reversal of the Null Hypothesis in research examining cultural issues. Similarly, instead of the conventional assumption that cultural influences are usually minimal or absent in clinical practice, the MAIP model assumes cultural issues are always present at every step in mental health service delivery until it can be demonstrated otherwise by specific information and/or empirical demonstration. This model was originally presented as a stepwise flow chart to describe culturally competent assessment of multicultural clients (Dana, 1993, p. 218). Later developments of this model were derived from empirical literature over a period of years including service delivery behaviors leading, formulations for clinical diagnoses, and subsequent interventions either incorporating components relevant to the client's culture or designed exclusively for presenting problems that stem from cultural/racial issues (Dana, 1997, 1998a, 1998b, 2000d, 2001a,b,c). MAIP has been

independently evaluated as a qualitative tool for clinicians (Ponterotto, Gretchen, & Chauham, 2002).

The original MAIP provided an explicit representation of the assessment-intervention process with an emphasis on guidelines for using psychological tests and methods with multicultural client populations. The model suggested that relevant questions should be asked to inform decisions relevant to client care during each of seven points in the service delivery process designated as steps. These steps included (1) eventual development of universal instruments; (2) required acculturation or racial identity status information; (3) evaluation of the necessity for a DSM-IV diagnosis; (4) criteria for appropriateness of standard diagnostic instruments; (5) availability of alternative culture-specific, or emic instruments; (6) assessment of the impact of cultural interaction stressors/stress; (7) preparation of formulations/ conceptualizations resulting in DSM-IV clinical diagnoses or otherwise and leading to specified subsequent interventions for psychopathology or identity and oppression-related problems-in-living.

MAIP Usage at the Tri-City Mental Health Center (TCMHC)

Agency Description

TCMHC is a municipal joint powers authority formed in 1960 by the cities of Pomona, Claremont, and La Verne to provide mental health services to eastern Los Angeles county residents. The agency follows the guidelines for the state Department of Mental Health Necessity Criteria with a mission to identify the mental health needs of individuals and families in a diverse, urban community of 400,000 persons, and to assure the development, provisions, accessibility, and continuity of high quality mental health treatment and prevention services. The community ethnicity is 42% Latino, 21% African American, 26% European American, 2%

Asian, 1% American Indian, 2% other, and 7% unknown. Services to this population evaluated by state mandated outcome measures for adults and children have resulted in positive outcomes for consumers with high levels of consumer satisfaction (Gamst, 2001, October). These services are provided in three Medi-Cal certified sites in Pomona as well as by over 70 strategic offsite locations. Services include outpatient treatment, day treatment, school-based and in-home treatment, case management, substance abuse prevention and treatment, vocational training, outreach to the homeless, and medication support. The agency budget for FY 2000-2001 is nearly $27 million from a variety of funding sources in addition to Medi-Cal that include contracts with Los Angeles County Departments of Probation, Mental Health, Children and Family Services, Public Social Services, Community and Senior Services as well as agreements with local school districts. A mandate for culturally competent services is fundamental to the agency mission. A Cultural Competency Program ensures that all services follow guidelines to meet community and consumer needs. Continuous research on culturally relevant program characteristics ensures timely program modifications and staff competence training to foster a positive environment for multicultural, multilingual employees representative of the consumer communities. Initial agency preparation preceded the MAIP application because fundamental agency changes in policies and practices were necessary. The Human Resources, Accounting, Contracts, Compliance, Quality Improvement and Training, and Research and Evaluation departments, in addition to the clinical program managers and supervisors, provided infrastructure preparation.

Agency Application

A community mental health center application of MAIP cannot include the same emphasis on conventional assessment instruments and methods contained in questions for steps

1, 4, and 5 above. While these tests may be used on a limited referral basis, they are not used routinely in public agencies designed to serve large numbers of multicultural mental health clients. As a result, the MAIP model was revised as MAIP-R to substitute seven steps in the service delivery process instead of specific questions to designate information entry points (Figure 1). These steps at present include intake/access (Step 1), client-clinician match (Step 2), acculturation or racial identity status (A/RIS) (Step 3) of client and clinician, clinician cultural competence (Step 4), clinician training requirements (Step 5), cultural components required in services (Step 6), and outcome measures (Step 7) to provide pre-post evaluation.

These steps recognize that it is always necessary to gather specific information from clients using interview questions or content from moderators in tests administered during intake/access procedures (see Figure 1) in order to assure preparation, when necessary, of cultural formulations for DSM-IV diagnosis, and subsequent selection of credible, appropriate interventions. Examples of the intake or Step 1 procedures include demographic information concerning ethnicity/race, client history, Community Functioning Evaluation, DSM-IV diagnoses, and Global Assessment of Functioning (GAF). The Access and Authorization Unit developed a comprehensive intake questionnaire for gathering this information that provided an opportunity for clients to request preferred language and clinician characteristics. A psychosocial assessment includes client ethnic identity, acculturation status, community functioning level, history of presenting problem and problem explanation.

Since many clients do not use English as first language, or have inadequate English language skills, MAIP-R Step 2 pertains to client-clinician match for ethnicity/race and/or language. Client–clinician matching for ethnicity or race has received abundant research attention, particularly in Los Angeles county (Kurasaki, Sue, Chun, & Gee, 1999), and has also

been explored directly within agency research publications (e.g., Gamst, et al., 2000; Gamst, Dana, Der Karabetian, & Kramer, 2001; Gamst, Dana, Kramer, & Der-Karabetian, submitted). These large sample studies suggest for which clients, under specified diagnostic and intervention conditions, match is mandatory, or desirable, to maximize benefit from mental health services. However, in the absence of replication, the generality of these specific match findings across public mental health agencies is unknown.

A/RIS information (Step 3), or determination of client cultural/racial orientation status, is of primary importance to identify clients who are unacculturated or traditional (i.e., retain an original culture orientation), marginal (i.e., blend original and acquired culture characteristics), bicultural (i.e., maintain behaviors commensurate with both original and acquired cultures), and assimilated (for elaboration of these categories, see Dana, 1993, 1998a). In addition to the Step 2 English language deficiency or language preference for many Latinos, or racial preference for some Africentric African Americans, A/ARIS information is necessary to know whether or not there is need to match clients with clinicians for cultural or racial identity. Match is not required for European American or assimilated clients, but A/RIS information is necessary to know whether or not matching is necessary for the large majority of clients who are marginal in acculturation status and the much smaller number of traditional clients (base rate information on A/RIS categories is contained in Dana, 1998a). A/RIS information has to be available for decisions regarding the necessity for a clinical diagnosis for clients with a traditional cultural orientation status. A/RIS information is also relevant for interpretation of all pre and post measures used to evaluate the efficacy of mental health services.

For clients actively engaged in developing an Africentric racial identity, behaviors that constitute normal accompaniments of racial identity development are not considered to be

pathological within their cultural communities (Dana, 2001a). Nonetheless, these behaviors may be misidentified as a consequence of confounding racial identity development with psychopathology as defined by the Minnesota Multiphasic Personality Inventory (e.g., Whatley, Allen, & Dana, submitted). In the same vein, traditional acculturation status is misidentified as psychopathology for Mexican Americans (Montgomery & Orozco, 1985; Whitworth & McBlaine, 1993), Asian Americans (Sue, Keefe, Enomoto, Durvasula, & Chao, 1996), and American Indians (Dana, Hoffmann, & Bolton, 1985; Pollack & Shore, 1980).

Whenever clinical diagnosis is not required due to absence of psychopathology, beneficial interventions for these problems-in-living may be provided either within the agency or an external referral may be necessary. Moreover, traditional clients often suffer from culture-bound disorders responsive to culture-specific interventions using the client's first language. For example, it has been demonstrated that some of these disorders (e.g., Neurasthenia in Chinese Americans) occur with at least 20 times the anticipated frequency by psychiatrists in the United States (Zheng, Lin, Takeuchi, Kurasaki, Wang, & Cheung, 1997).

MAIP-R, Steps 4 and 5, clinician cultural competence, is known to be affected by training, although training programs in the United States remain deficient in the quality, amount, and intensity of this training and continuing education has not emphasized advanced training opportunities. This agency research program has taken the standard cultural competence measures described earlier and collected a large, statewide sample from clinicians, identified items common to instruments, and initiated a series of funded research studies leading to preparation of an in-service training program and manual.

Step 6, embedding cultural components in services, is currently in process of development within the agency. Culture-specific descriptions of the research basis for these

components as applied to services for major cultural/racial groups provide criteria for embedding cultural components and exemplar treatments (Dana, 1998a). As an agency beginning, all personnel are being training in the particular service delivery styles, or social etiquette, that facilitate development of a solid clinician-client relationship during intake and thereafter during treatment. The cultural rationales and the specified culture-specific interpersonal behaviors are mandatory for European American clinicians and are known to reduce drop-out of multicultural clients. This training is necessary for all cross-cultural services and preparatory to the development and utilization of combined culture-general and culture-specific treatments as well as to the design of culture-specific treatments. Step 7 in Figure 1 lists the outcome measures mandated by the state. These measures are routinely used with all clients and are included in the agency research data base.

Insert Figure 1 about here

Discussion

This description of a MAIP application to the implementation of a California mental health agency mission exemplifies the current research status of ethnic minority mental health services. The service needs of each ethnic minority population are now known to be affected by extreme within-group and between-group differences, although measurement of ethnic minority mental health status remains deficient and research concerning the impact of social, economic, political, and cultural factors is sparse (Williams & Harris-Reid, 1999). In addition, culturally responsive services are congruent with the cultures of their consumers by providing systems of care more adequately addressing the needs of these communities as has occurred in ethnic-specific programs evidenced by more adequate utilization rates (Takeuchi & Uehara, 1996). These findings suggested that responsive mainstream services also require ethnic professionals to

increase utilization as a direct result of genuine empathy communicated in the service delivery process coupled with clinician-client agreement on definitions of deviant behavior and therapeutic techniques for reducing symptomatic effects and simultaneously increasing quality of life. Consistent clinician-client matching is infeasible in practice and the complexity of matching effects on therapeutic outcomes is now known to be largely setting-specific and related to the variables present within an entire system of care. Moreover, as more mental health programs become exclusively mainstream as a direct result of managed care in the United States, the magnitude of alterations required for providing adequate services to a multicultural population increases dramatically.

It must be emphasized that there is pessimism that these alterations can be systematically introduced in the face of dwindling budgets and standardized operations (e.g., Takeuchi & Uehara, 1996). However, a democratic multicultural society is also morally obligated to deliberately nourish multiple visions of legitimate humanity, or "proper ways of being human" (Cushman & Gilford, 2000, p. 985). An approach is suggested by including cost-effectiveness and universal access as necessary components of a proposed 21st century health care system driven by the market approach of managed care competition in an increasingly multicultural society (Bingaman, Frank, & Billy, 1993). Nonetheless, reconciliation of these disparate components can conceivably occur by the establishment of equitable services that assume different rates of mental illness and treatment needs as the basis for allocation of funds (Tien, 1992). What is still lacking at present are demonstrations that equitable services for all ethnic minority clients can occur by "specific implementation of research programs, policy initiatives, and service programs that tackle the issues and diverse needs of .... those with serious emotional problems" (Casas, Pavelski, Furlong, & Zanglis, 2001, p. 193).

The agency example provided in this paper strongly suggests that a responsible aegis and enforceable mandate provided by a state department of mental health can result in systemic attempts toward culturally competent and equitable mental health services even during an era of managed care. The use of the MAIP model within a flexible research-driven system of care recognizes that tailoring the agenda of services and manner in which services are delivered on the basis of research findings is a legitimate approach to embedding cultural competence in a system of care for multicultural populations. The MAIP model, as an example of treatment theory, informs the measurement of service practice by problem definition, critical ingredients, stages in delivering treatment, and expected pattern of outcomes (Lipsey, 1990). As a consequence, it may become feasible to incorporate culturally competent mental health services into managed care on the basis of cost-effective outcome research (Hargreaves, Shumway, Hu, & Cuffel, 1998).

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Figure 1

MAIP-R Application to Tri-City Research Program

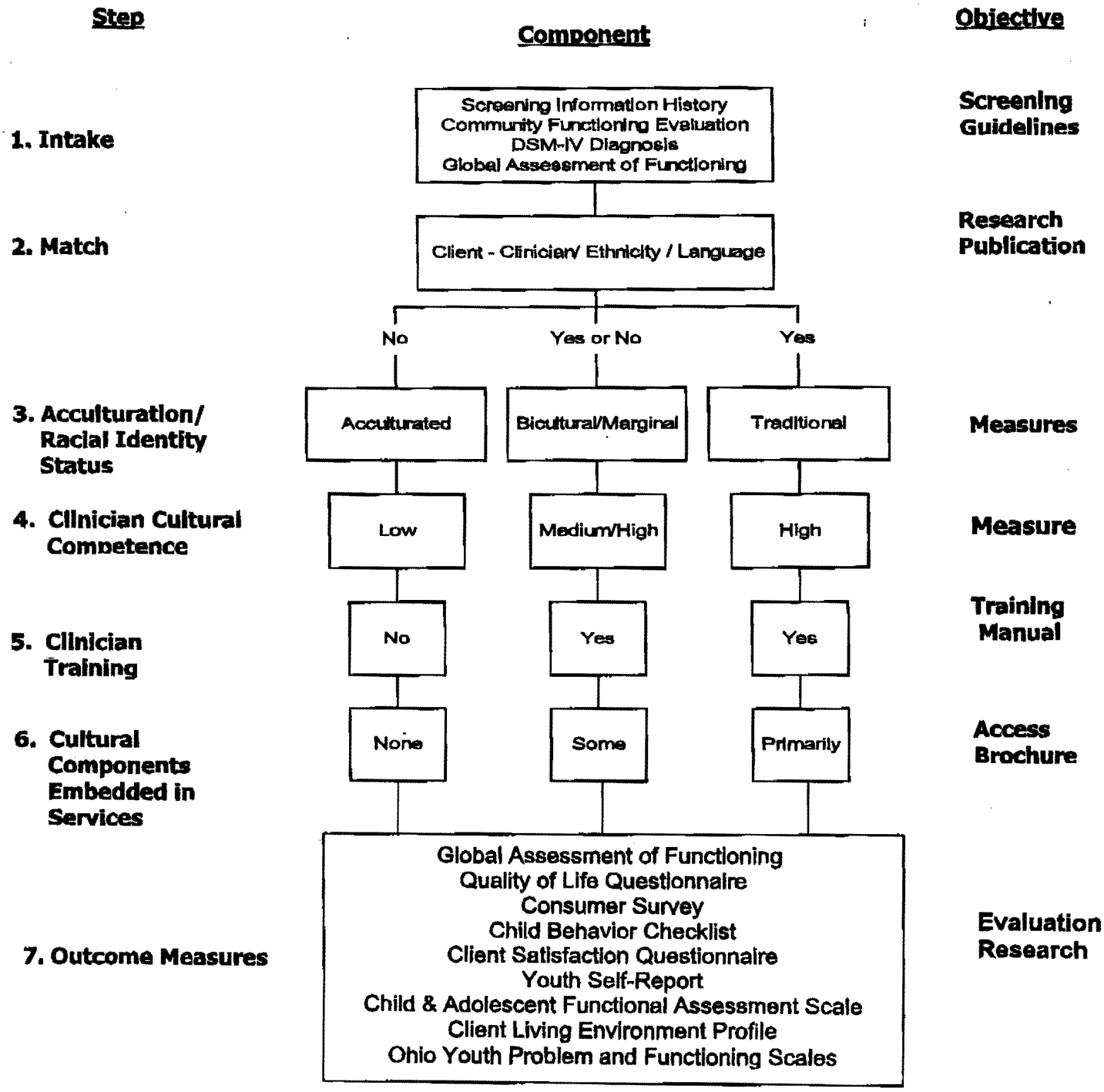

Figure 1

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