

Co-Occurring Disorders: Integrated Dual Disorders Treatment

Implementation Resource Kit



Statement on Cultural Competence

Cultural competence is about adapting mental health care to meet the needs of consumers from diverse cultures. One key aim is to improve their access to care. Others are to build trust and to promote their engagement and retention in care.

Above all, cultural competence aims to improve the quality of care and to help consumers recover quicker and better. Its broader societal purpose is to reduce or eliminate mental health disparities affecting disenfranchised groups.

This statement on cultural competence lays out ways for programs to tailor their evidence-based practices to the cultures they serve. It is meant as a guide, rather than a set of fidelity measures. The statement begins with the basics: what is culture, how does it affect care, what is cultural competence, and why is it important. It then gives examples of how cultural competence is translated into practice.

What is culture, and how does it affect care?

A culture is broadly defined as a common heritage or set of beliefs, norms, and values shared by a group of people. People who are placed, either by census categories, or through self-identification, into the same racial or ethnic group are often assumed to share the same culture; however, not all members grouped together in a given category will share the same culture. There is great diversity within each of these broad categories and individuals may identify with a given racial or ethnic culture to varying degrees. Others may identify with multiple cultures, including those associated with their religion, profession, sexual orientation, region, or disability status.

Culture is dynamic. It changes continually and is influenced both by people's beliefs and the demands of their environment. Immigrants from different parts of the world arrive in the United States with their own culture but gradually begin to adapt and develop new, hybrid

cultures that allow them to function within the dominant culture. This process is referred to as acculturation. Even groups that have been in the United States for many generations may share beliefs and practices that maintain influences from multiple cultures. This complexity necessitates an individualized approach to understanding culture and cultural identity in the context of mental health services.

The culture someone comes from influences many aspects of care, starting with whether the person thinks care is needed or not. Culture influences what concerns that person brings to the clinical setting, what language is used to express those concerns, and what coping styles are adopted. Culture affects family structure, living arrangements, and how much support someone receives in time of difficulties.

Culture also influences patterns of help-seeking? whether someone starts with a primary care doctor, a mental health program, or goes to a minister, spiritual advisor, or community elder. Finally, culture affects how much stigma someone attaches to mental health problems, and how much trust is placed in the hands of providers.

It's easy to think of culture as only belonging to consumers without realizing how it also applies to providers and administrators. Their professional culture influences how they organize and deliver care. Some cultural influences are more obvious than others, like the manner in which clinicians ask questions or interact with consumers. Less obvious but equally important are what hours a clinic has, the importance the staff attaches to reaching out to family members and community leaders, and the respect they accord to the culture of each consumer entering their doors.

Knowing how culture influences so many aspects of mental health care underscores the importance of adapting programs to respond to, and be respectful of, the diversity of the surrounding community.

Why cultural competence?

For decades, many mental health programs neglected the growing diversity around them. Often, people from non-majority cultures found programs off-putting and hard to access. They avoided getting care, stopped looking for care, or, if they managed to find care, they dropped out. The result was troubling disparities: many minority groups faced lower access to care, lower use of care, and poorer quality of care. Altogether, those disparities translated into millions of people suffering needless disability from mental illness.

Disparities are most apparent for racial and ethnic minority groups such as African Americans, American Indians and Alaska Natives, Asian Americans, Hispanic Americans, and Native Hawaiians and other Pacific Islanders. But disparities also affect many other groups, such as women and men, children and older adults, people from rural areas, and people with different sexual orientations, or with physical or developmental disabilities.

Starting in the late 1980's, the mental health profession responded with a new approach to care called "cultural competence." Cultural competence was originally defined as a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals and enables that system, agency, or those professionals to work effectively in cross-cultural situations.

What is cultural competence?

Cultural competence is an approach to delivering mental health services grounded in the assumption that services are more effective when they are provided within the most relevant and meaningful cultural, gender-sensitive, and age-appropriate context for the people being served. The Surgeon General defined cultural competence in the most general terms as “the delivery of services responsive to the cultural concerns of racial and ethnic minority groups, including their languages, histories, traditions, beliefs, and values.” In most cases, the term cultural competence refers to sets of guiding principles, developed to increase the ability of mental health providers, agencies, or systems to meet the needs of diverse communities, including racial and ethnic minorities.

While consumers, families, providers, policymakers, and administrators have long acknowledged the intrinsic value of cultural competence, insufficient research has been dedicated to identifying its key ingredients. Therefore, the field still struggles to define, operationalize, and measure cultural competence.

The word “competence” is somewhat misleading. Competence usually implies a set of criteria on which to evaluate a program. But this is not yet true for cultural competence, which is still under-researched. The term “competence,” in this context, means that the responsibility to tailor care to different cultural groups belongs to the system, not to the consumer. Every provider or administrator involved in delivering care? from mental health authorities down to clinical supervisors and practitioners? bears responsibility for trying to make their programs accessible, appropriate, appealing, and effective for the diverse communities that they serve. Many do it naturally.

How is cultural competence related to evidence-based practices?

Evidence-based practices are for every consumer who enters care, regardless of what culture they come from, according to the Surgeon General.¹ But programs often need to make adjustments to evidence-based practices in order to make them accessible and effective for cultural groups that differ in language or behavior from the original study populations. The adjustments should facilitate, rather than interfere with, a program’s ability to implement evidence-based practices using the fidelity measures in this toolkit.

In a nutshell, to deliver culturally competent evidence-based practices means tailoring either the practice itself or the context in which the practice is delivered to the unique communities served by a mental health program.

In time, there may be specific fidelity measures used to assess a program’s cultural competence. But this is not the case now. The concept of cultural competence is too new and the evidence base is too small. While the evidence is being collected, programs can and should take the initiative to tailor evidence-based practices to each of the cultural groups they serve,

¹ U.S. Department of Health and Human Services. (2001). *Mental health: culture, race, and ethnicity. A report of the Surgeon General*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health.

like translating their information brochures into the languages often used in their communities. Others steps are featured in the next section.

Many providers ask, how can we know if evidence-based practices apply to a particular ethnic, racial, or cultural group if the research supporting those practices was done on a very different population? The answer is that we will not know for sure until we try; but the limited research that does exist, suggests that evidence-based practices, with minor modifications or not, work well across cultures. Furthermore, because evidence-based practices represent the highest quality of care currently available, it is a matter of fairness and prudence to provide them to all people who may need them. Yet the question remains, how can we do this effectively?

How can cultural competence be put into practice?

All programs are encouraged to be more culturally competent, even though research has not yet generated a set of evidence-based practices to achieve cultural competence.

A variety of straightforward steps can be taken to make programs more responsive to the people they serve. The steps might apply to all facets of a program and need not be restricted to the evidence-based practice covered by this toolkit. The following steps are meant to be illustrative, not prescriptive:

- ↳ Understand the racial, ethnic, and cultural demographics of the population served
- ↳ Become most familiar with one or two of the groups most commonly encountered
- ↳ Create a cultural competence advisory committee consisting of consumers, family and community organizations
- ↳ Translate your forms and brochures
- ↳ Offer to match a consumer with a practitioner of a similar background
- ↳ Have access to trained mental health interpreters
- ↳ Ask each client about their cultural background and identity
- ↳ Incorporate cultural awareness into the assessment and treatment of each consumer
- ↳ Tap into natural networks of support, such as the extended family and community groups representing the culture of a consumer
- ↳ Reach out to religious and spiritual organizations to encourage referrals or as another network of support
- ↳ Offer training to staff in culturally responsive communication or interviewing skills.
- ↳ Understand that some behaviors considered in one culture to be signs of psychopathology are acceptable in a different culture
- ↳ Be aware that a consumer from another culture may hold different beliefs about causes and treatment of illness

Cultural competence is also important for planners and for mental health authorities. Here are a few examples of the ways a public mental health authority or program administrators can become more culturally competent.

- ?? Designate someone with part-time or full-time responsibility for improving and monitoring cultural competence
- ?? Create a strategic plan to incorporate cultural competence into programs throughout a system
- ?? Establish an advisory committee that includes representatives of all the major racial, ethnic, and cultural groups being served
- ?? Address barriers to care (cultural, linguistic, geographic or economic)
- ?? Provide staffing that reflects the composition of the community being served
- ?? Conduct regular organizational self-assessments of cultural competence
- ?? Collect and analyze data to examine disparities in services
- ?? Designate specific resources for cultural competence training
- ?? Include cultural competence in quality assurance and quality improvement activities and projects

Case studies of cultural competence

Vignette 1 – Dual Diagnosis

Kevin is a 40 year-old African-American homeless man in Chicago who, for a decade, has cycled between jail, street, and shelter. At the shelter, he refuses getting help for what the staff believe is a longstanding combination of untreated schizophrenia and alcoholism. He becomes so drunk one night that he walks in front of a car and becomes seriously injured. While in the hospital, he is treated for his injuries, as well as placed on anti-psychotic medications after the psychiatrists diagnose him with schizophrenia.

At the time of hospital discharge, Kevin is referred to an outpatient program for individuals with dual diagnoses. Realizing that Kevin needs aggressive treatment to avoid re-spiraling into homelessness, the head of the treatment team recommends concurrent treatment of the alcoholism and the schizophrenia. The team leader is an African American psychiatrist who has an appreciation for the years of alienation, discrimination, and victimization that Kevin describes as having contributed to his dual disorders. The clinician works hard to develop a trusting relationship. He works with the treatment team to ensure that, in addition to mental health and drug abuse treatment, Kevin receives social skills training and a safe place to live. When Kevin is well enough, and while he continues to receive group counseling for his dual disorders, one of his first steps toward recovery is to reconnect with his elderly mother who had not heard from him in ten years.

Vignette 2, Assertive Community Treatment

A minister in Baltimore contacts the city's ACT Program with an unusual concern: one of his congregants disclosed to him that another member of the congregation, an older woman from Jamaica, was beating her adult daughter for "acting crazy all the time." The Jamaican mother may even be locking her adult daughter in the basement, according to the congregant.

One year before, the ACT team's social worker had reached out to local ministers to tell them about the program. The ACT team had realized that better communication and referrals were needed. Stronger connections across organizations would improve chances for recovery

by enhancing social support and adherence to treatment. Some of the consumers believed that treatment was counter to their religion.

The ACT social worker managed to obtain a court order to allow authorities to enter the Jamaican mother's home. They discovered the traumatized 25-year old daughter locked in the basement, actively psychotic, and bearing marks of physical abuse. The ACT team diagnosed the daughter with schizophrenia and managed to find a group home for her. The team arranged for an intense combination of medications, individual and group therapy, including trauma care and social skills training. Through links to the church and the community, the ACT social worker helped the daughter to get clothing and spiritual support. The social worker discovered that the mother's ethnic group from Jamaica believed that her daughter's craziness was a sign of possession by the devil? the belief system behind her abuse. After all criminal charges were dropped, the social worker reached out to the mother to educate her about schizophrenia and to set the stage for the daughter's eventual return to her mother's household.

Vignette 3 – Supported Employment

Jing is a bilingual vocational worker at a mental health program in San Francisco. By informally surveying her caseload, she estimates that about 30 percent of her clients are Asian. But they come from vastly different backgrounds, ranging from Taiwan to Cambodia, with vastly different educational backgrounds. One of her clients with bipolar disorder is a recent immigrant from China. He has a high school education, but speaks Mandarin and very little English. Fluent in Mandarin, Jing is able to conduct a careful assessment of the client's job skills and a rapid, individualized job search. Because Jing is part of the treatment team, she's aware that the client has progressed to the point of being ready for full-time employment.

Jing identifies several import-export businesses in the area with monolingual Mandarin-speaking employees. She secures a position, but it pays less than one the client would qualify for if he spoke English. Jing succeeds in persuading the client to take the position while at the same time recommending a quick-immersion night program in English as a Second Language. Jing provides follow-along job support during the next few months. When the client's English is better, Jing searches for and manages to find a higher paying job for him. She stays in touch to be sure he can adjust to the greater demands of the new position, while continuing to receive treatment for his bipolar disorder.

Vignette 4 – Medication Management

A primary care doctor at a rural Indian Health Service clinic tentatively diagnoses John, a 65-year old American Indian man, with a severe depression. But he is unsure whether he might have bipolar disorder. John had relied on a native healer for years but he had become so debilitated and despondent in recent weeks that his family drove him on the 4-hour trip to the doctor from their frontier area of South Dakota.

Upon examination, the primary care doctor discovers numerous medical conditions, including diabetes and hypertension, which had gone untreated. Uncertain of the diagnosis of John's psychiatric illness, and the potential for interactions with the other medications he wishes to prescribe, the doctor arranges for a psychiatric consultation via telehealth.

Through video and other telecommunications equipment, John is interviewed by a psychiatrist 500 miles away at an Indian Health Service Facility. The psychiatrist is able to assess John's appearance and body language. Having been advised by a cultural competence advisory committee, the psychiatrist knew how and what types of questions to ask John about

his use of native healers and herbal remedies. She also is part of a program experienced in medication algorithms for mental disorders. She arrives at a diagnosis of bipolar disorder and recommends a medication regimen that would not interact with the diabetes and hypertension medications. Because of John's older age, she recommends extremely low doses of the psychiatric medications. But she recognizes that the longer length of time for the antidepressants to take effect in older people (8 weeks rather than 4), combined with the lower dose, might leave John vulnerable to suicide. She suggests that the doctor work to establish communication with John's native healer to monitor John carefully and to avoid giving him certain herbal therapies that might interfere with his medications.

Vignette 5— Illness Management and Recovery Skills

Lupita, a 17-year old high school senior, arrived in a San Antonio emergency room after a suicide attempt. The psychiatrist on call happened to be the same one who had diagnosed Lupita's bipolar disorder a year ago. He thought that she had been taking her medications properly, but blood tests now revealed no traces of lithium or antidepressant.

The psychiatrist tried to communicate with Lupita's anxious parents waiting in the visitor area, only to learn that they spoke only Spanish and no English. She had mistakenly assumed that because Lupita, a second generation Mexican American, was highly acculturated, so were her parents. She contacted the hospital's bilingual social worker who discovered that the parents felt powerless for months as they watched their daughter sink into a severe depression, all the while lacking the motivation to take her medications. The social worker, whose family had similarly emigrated from a rural region of Mexico, knew to gently ask the parents if they could read and understand the dosage directions for Lupita's medication. Finding that the parents had limited literacy in both English and Spanish helped the psychiatrist and social worker to tailor a treatment program that would not depend on the written word. Seeing the parents as essential to Lupita's recovery and knowing she lived at home, the psychiatrist encouraged the parents, through the interpreter, to accompany their daughter to an illness management and recovery program. The hospital had organized programs for Spanish-speaking families because Latinos are a majority group in San Antonio.

During the weekly sessions, the social worker translated for the family and helped them with scheduling Lupita's psychiatric visits and to apportion the correct combination of pills in a daily pill container. Understanding that the family had no phone, the social worker worked with them to find a close neighbor who might allow them use of the phone to relay messages from her and to contact her if Lupita stopped taking her medications.

Vignette 6— Family Psychoeducation

When Kawelo lost his job as an electrician, his therapist asked Kawelo if he had a family elder who knew of community elders familiar with traditional Hawaiian healing practices for personal and family problems. The therapist knew that Native Hawaiians, in times of difficulties, rely on their elders, traditional healer, family, and/or teacher to provide them with wisdom and cultural practices to resolve problems. One such practice is *ho`oponopono*, which is a traditional cultural process for maintaining harmonious relationships among families through structured discussion of conflicts. *Ho`oponopono* is also used by individuals for personal healing and/or guidance in troubled times.

Kawelo's therapist recognized the importance of tapping into this community support and suggested that his family seek out ho'oponopono. The therapist contacted the family and elders to arrange a meeting concerning Kawelo's problems with depression, for which he needed both medication and counseling. At the group meeting the therapist further explained that Kawelo was so ill that he lacked the motivation to receive treatment, and that his condition was so serious that he may be at risk for suicide. The therapist asked the elders how the group could help to encourage Kawelo to stick with his treatment and how they could watch Kawelo for suicidal signs. After lengthy deliberations, the family decided that one way to help Kawelo was to participate in ho'oponopono to understand the types of problems that he is experiencing and identify how the family could help him heal himself. Some members of the family also agreed to participate in a bi-weekly family psychoeducation group held at the community mental health center to learn more about his mental illness, coping skills and strategies, and pharmacological and psychosocial treatments. Through family psychoeducation the family would participate in structured sessions using a variety of educational formats. Because an important level of healing in Native Hawaiian culture involves sharing feelings and positive and negative emotions, in an open, safe, and controlled environment, the family's participation in a combination of ho'oponopono and family psychoeducation was ideal.

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Selected Resources on Cultural Competence

The resources listed below are for consumers and families, mental health authorities, administrators, program leaders and practitioners. They may be useful for all stakeholders in mental health services.

National Resources for Consumers and Families

Center for Mental Health Services
Substance Abuse and Mental Health Services Administration
National Mental Health Information Center
(800) 789-2497
www.mentalhealth.org

First Nations Behavioral Health Confederacy
(406) 732-4240 Montana
(505) 275-3801 Albuquerque, NM
pauletterunningwolf@hotmail.com

National Alliance for the Mentally Ill
Colonial Place Three
2107 Wilson Blvd., Suite 300
Arlington, VA 22201-3042
1-800-950-NAMI (6264)
Fax: (703) 524-9094
TTY: (703) 516-7227
www.nami.org

National Asian American Pacific Islander Mental Health Association,
1215 19th St. Suite A
Denver, Colorado 80202
(303) 298-7910
Fax: (303) 298-8081
www.naapimha.org

National Institute of Mental Health (NIMH)
Office of Communications

6001 Executive Boulevard, Room 8184, MSC 9663
Bethesda, MD 20892-9663
(866) 615-NIMH (6464)
Fax: (301) 443-4279
TTY: (301) 443-8431
www.nimh.nih.gov

National Latino Behavioral Health Association
PO Box 387
506 Welch, Unit B
Berthoud, CO 80513
(970) 532-7210
Fax: (970) 532-7209
www.nlbha.org

National Leadership Council on African American Behavioral Health
6904 Tulane Drive
Austin, Texas
(512) 929-0142
Fax: (512) 471-9600
tkjohnson@mail.utexas.edu

National Mental Health Association
2001 N. Beauregard Street, 12th Floor
Alexandria, VA 22311
(800) 969-NMHA
Fax: (703) 684-5968
TDD: (800) 433-5959
www.nmha.org

Resources for Mental Health Authorities

Aponte, C., Mason, J. "A Demonstration Project of Cultural Competence Self-Assessment of 26 Agencies" in M. Roizner, *A Practical Guide for the Assessment of Cultural Competence in Children's Mental Health Organizations* (Boston: Judge Baker Children's Center, 1996) 72–73.

California Mental Health Ethnic Services Managers with the Managed Care Committee. *Cultural Competency Goals, Strategies and Standards for Minority Health Care to Ethnic Clients* (Sacramento: California Mental Health Directors' Association, 1995).

Center for Mental Health Services, Substance Abuse and Mental Health Services Administration. *Cultural Competence Standards in Managed Mental Health Care Services: Four Underserved/ Underrepresented Racial/Ethnic Groups* (2000).

This is the final report from four working groups: African Americans, Asian Americans, and Pacific Islanders, Latinos, and Native Americans. It contains a series of standards for culturally competent mental health care and a plan for implementation. The report does not represent the official positions of the U.S. Department of Health and Human Services. A glossary is included.

Information and recommendations are provided on the following:

- ↴ ↴ guiding principles
- ↴ ↴ overall system standards and implementation guidelines
- ↴ ↴ clinical standards and implementation guidelines
- ↴ ↴ provider competencies

Dillenberg, J., Carbone, C.P. *Cultural Competency in the Administration and Delivery of Behavioral Health Services* (Phoenix: Arizona Department of Health Services, 1995).

Knisley, M.B. *Culturally Sensitive Language: Community Certification Standards* (Columbus, OH: Ohio Department of Mental Health, 1990).

National Implementation Research Network. *Consensus Statement on Evidence-Based Programs and Cultural Competence* (Tampa, FL: Louis de la Parte Florida Mental Health Institute, 2003).

New York State Office of Mental Health. *Cultural Competence Performance Measures for Managed Behavioral Healthcare Programs* (Albany, NY: New York State Office of Mental Health, 1998).

New York State Office of Mental Health. *Final Report: Cultural and Linguistic Competency Standards* (Albany, NY: New York State Office of Mental Health, 1998).

Pettigrew, G.M. *Plan for Culturally Competent Specialty Mental Health Services* (Sacramento, CA: California Mental health Planning Council, 1997).

Phillips, D., Leff, H.S., Kaniasty, E., Carter, M., Paret, M., Conley, T., Sharma, M.P. *Culture, Race and Ethnicity (C/R/E) in Performance Measurement: A Compendium of Resources; Version 1.* (Cambridge, MA: Evaluation Center@HSRI, Human Services Research Institute, 1999).

Siegel, C., Davis-Chambers, E., Haugland, G., Bank, R., Aponte, C., McCombs, H. "Performance Measures of Cultural Competency in Mental Health Organizations." *Administration and Policy in Mental Health* 28(2000): 91–106.

U.S. Department of Health and Human Services. *Consumer Mental Health Report Card. Final Report: Task Force on a Consumer-Oriented Mental Health Report Card* (Rockville, MD: Substance Abuse and Mental Health Services Administration, 1996).

U.S. Department of Health and Human Services. *Mental Health: A Report of the Surgeon General* (Washington, DC: U.S. Department of Health and Human Services, 1999).

Western Interstate Commission for Higher Education (WICHE) Mental Health Program and the Evaluation Center@HSRI (Human Services Research Institute). *Notes from a Roundtable on Conceptualizing and Measuring Cultural Competence* (WICHE, Mental Health Program and the Evaluation Center at Human Services Research Institute, 1999).

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

Resources for Mental Health Administrators

Center for Mental Health Services
Substance Abuse and Mental Health Services Administration
5600 Fishers Lane
Rockville, MD 20857
301-443-7790

Lopez, L., Jackson, V.H. "Cultural Competency in Managed Behavioral Healthcare: An Overview" in V.H. Jackson, L. Lopez (Eds) *Cultural Competency in Managed Behavioral Healthcare* (Providence, RI: Manisses Communications Group, Inc., 1999).

National Alliance of Multi-ethnic Behavioral Health Associations
Howard University, School of Social Work
601 Howard Place N.W.
Washington, DC 20059
202-806-4727
misaacs@howard.edu

National Center for Cultural Competence
Georgetown University Center
for Child and Human Development
3307 M Street, NW
Suite 401
Washington, D.C. 20007
Tel: 202.687.5387
TTY 202/687-5503
cultural@georgetown.edu

The Evaluation Center@HSRI
2336 Massachusetts Avenue
Cambridge, MA 02140
617-876-0426
www.tecenter@hsri.org

Western Interstate Commission for Higher Education (WICHE)
Mental Health Program
P.O. Box 9752
Boulder, CO 80301-9752

Resources for Program Leaders

Barrio, C. "The Cultural Relevance of Community Support Programs." *Psychiatric Services* 51 (2000): 879-874.

Issacs, M.R., Benjamin, M.P. *Toward a Culturally Competent System of Care: Programs Which Utilize Culturally Competent Principles* (Washington, DC: Georgetown University Child Development Center, 1991).

Leong, F. "Delivering and Evaluating Mental Health Services for Asian Americans." in *Report of the Roundtable on Multicultural Issues in Mental Health Services Evaluation* (Tucson, AZ: The Evaluation Center, Human Services Research Institute, 1998).

Musser-Granski, J., Carrillo, D.F. "The Use of Bilingual, Bicultural Paraprofessionals in Mental Health Services: Issues for Hiring, Training, and Supervision" *Community Mental Health Journal* 33 (1997): 51-60.

National Institute of Mental Health (NIMH) www.nimh.gov

Phillips, D. et al. *Culture, Race and Ethnicity (C/R/E) in Performance Measurement: A Compendium of Resources; Version 1* (Cambridge, MA: Evaluation Center, Human Services Research Institute, 1999).

Organizational names, contact names, websites, e-mail addresses and mailing addresses are included.

This publication has extensive lists of resources, standards, and selected readings. Information is provided on such topics as: training, language, service satisfaction and dissatisfaction, stakeholder involvement, social environments, community outreach, service planning, access and delivery, recruitment and retention, data collection and analysis, assessment, impact of practitioner identity, indigenous practitioners/services, attitudes, needs assessment, and additional readings on translated versions of instruments. Readings are included on African Americans, Hispanics/Latinos, Native Americans, and Asian Americans and Pacific Islanders. The compendium contains the following sections for diverse cultural, racial and ethnic groups:

- ↴ ↴ standards for behavioral health competence
- ↴ ↴ behavioral health disorder prevalence and service utilization
- ↴ ↴ measures of identity
- ↴ ↴ behavioral health diagnostic, assessment and outcomes measures
- ↴ ↴ instruments to assess behavioral health service competence

Ponterotto, J.G., Alexander, C.M. "Assessing the Multicultural Competence of Counselors and Clinicians" in L.A. Suzuki, P.J. Meller, J.G. Ponterotto (Eds.) *Handbook of Multicultural Assessment: Clinical, Psychological, and Educational Applications* (San Francisco: Jossey-Bass, 1996) 651-672.

Tirado, M.D. *Tools for Monitoring Cultural Competence in Health Care* (San Francisco: Latino Coalition for a Healthy California, 1996).

U.S. Surgeon General. *Mental Health: A Report of the Surgeon General* (Washington, DC: U.S. Department of Health and Human Services, 1999).

U.S. Surgeon General. *Mental Health: Culture, Race, and Ethnicity. A Supplement to Mental Health: A Report of the Surgeon General* (Washington, DC: U.S. Department of Health and Human Services, 2001).

Instruments for Program Leaders to Assess Cultural Competence

Cross-Cultural Counseling Inventory (CCCI).

LaFromboise, Coleman, and Hernandez (1991).

↴ ↴ Observer rates 20 items.

↴ ↴ Measures counseling effectiveness.

Multicultural Counseling Awareness Scale (MCAS).

Ponterotto, Reiger, Barrett, and Sparks (1994).

↴ ↴ Self-report of 45 items.

↴ ↴ Assesses cultural awareness, knowledge and skills.

Multicultural Counseling Inventory (MCI).

Sodowski, Taffe, Gutkin, and Wise (1994).

↴ ↴ Self-report of 43 items.

↴ ↴ Assesses awareness, knowledge, skills, and relations.

Resources for Practitioners

Aguirre-Molina M., Molina C.W., Zambrana R.E. (Eds.) *Health Issues in the Latino Community* (San Francisco, CA: John Wiley & Sons, Inc., 2001).

Alvidrez, J. "Ethnic Variations in Mental Health Attitudes and Service Among Low Income African American, Latina, and European American Young Women." *Community Mental Health Journal* 35 (1999): 515-530.

American Medical Association, Council on Scientific Affairs, Ad Hoc Committee on Health Literacy. *Health Literacy: Report of the Council on Scientific Affairs* (JAMA, Dec. 6, 1995): 1677- 1682.

Aranda, M.P. "Culture Friendly Services for Latino Elders." *Generations* 14 (1990): 55-57.

Atkinson, D., Morten, G., Sue, D. *Counseling American Minorities* (Dubuque, IA: Wm. C. Brown, 1983).

Atkinson, D.R., Gim, R.H. "Asian-American Cultural Identity and Attitudes towards Mental Health Services" *Journal of Counseling Psychology* 36 (1989): 209-213.

Baldwin, J.A., Bell, Y. "The African Self-Consciousness Scale: An Afrocentric Personality Questionnaire" *The Western Journal of Black Studies* 9 (1985): 61-68.

Bauer, H., Rodriguez, M.A., Quiroga, S., Szkupinski, S., Flores-Ortiz, Y.G. "Barriers to Health Care for Abused Latina and Asian Immigrants" *Journal of Health Care for the Poor and Underserved* 11 (2000): 33-44.

Belgrave, F.Z. *Psychosocial Aspects of Chronic Illness and Disability Among African Americans* (Westport, CT: Auburn House / Greenwood Publishing Group, Inc., 1998).

Berkanovic, E. "The Effect of Inadequate Language Translation on Hispanics' Responses to Health Surveys" *American Journal of Public Health* 70 (1980): 1273-1276.

Bichsel, R.J. "Native American Clients' Preferences in Choosing Counselors" *Dissertation Abstracts International: Section B: Science and Engineering* 58 (1998): 3916.

Branch C. Fraser, I. "Can Cultural Competency Reduce Racial and Ethnic Health Disparities? A Review and Conceptual Model" *Med Care Res Rev Suppl* 1 (2000): 181-217.

- Browne, C.T. "An Anguished Relationship: The White Institutionalized Client and the Non-White Paraprofessional Worker" *Journal of Gerontological Social Work Special Issue: Ethnicity and Gerontological Social Work* 9 (1986): 3-12.
- Bull Bear, M. Flaherty, M.J. *The Continuing Journey of Native American People with Serious Mental Illness: Building Hop* (Boulder, CO: WICHE, 1997).
- Carter, R.T., Qureshi, A. "A Typology of Philosophical Assumptions in Multicultural Counseling and Training" in J.G. Ponterotto, J.M. Casas, C.M. Alexander (Eds.) *Handbook of Multicultural Counseling* (Thousand Oaks, CA: Sage Publications, 1995) 239-262.
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Scales for Practitioners to Recognize Cultural Identity

Acculturation/Cultural Identity Scales

Acculturation Rating Scale for Mexican-Americans (ARSMA)

Cuellar, I., Harris, C., Jasso, R. "An Acculturation Scale for Mexican-American Normal and Clinical Populations" *Hispanic Journal of Behavioral Sciences* 2 (1980): 199-217.

Multidimensional Measure of Cultural Identity for Latino and Latina Adolescents

Feliz-Ortiz, M., Newcomb, M.D., Meyers, H. "A Multidimensional Measure of Cultural Identity for Latino and Latina Adolescents" *Hispanic Journal of Behavioral Sciences* 16 (1994): 99-115.

Short Acculturation Scale for Hispanics (SASH)

Marin, G., Sabogal, F., Van Oss Marin, B., Otero-Sabogal, R., Perez-Stable, E. "Development of a Short Acculturation Scale for Hispanics" *Hispanic Journal of Behavioral Sciences* 9 (1987): 183-205.

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

Suinn, R.M., Richard-Figueroa, K., Lew, S., Vigil, P. "The Suinn-Lew Asian Self-Identity Acculturation Scale: An Initial Report" *Educational and Psychological Assessment* 47 (1987): 401-407.

Group Identification/Cultural Identity Scales

African Self-Consciousness Scale

Baldwin, J.A., Bell, Y. "The African Self-Consciousness Scale: An Afrocentric Personality Questionnaire" *The Western Journal of Black Studies* 9 (1985): 61-68.

Black Racial Identity Attitude Scale-Form B (BRIAS-Form B)

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

Multidimensional Racial Identity Scale (MRIS)-Revised

Thompson, V.L. "The Multidimensional Structure of Racial Identification" *Journal of Research in Personality* 29 (1995): 208-222.

Multigroup Ethnic Identity Measure (MEIM)

Phinney, J. "The Multigroup Ethnic Identity Measure: A New Scale For Use with Adolescents And Young Adults From Diverse Groups" *Journal of Adolescent Research* 7 (1992): 156-176.

White Racial Identity Attitude Scale (WRIAS)

Helms, J.E. and Carter, R.T. "Development of the White Racial Identity Inventory" in J.E. Helms (Ed.) *Black and White Racial Identity: Theory, Research, and Practice* (New York: Greenwood Press, 1990) 67-80.

Value Orientation Scales

Chinese Values Survey

Chinese Culture Connection. "Chinese Values and the Search for Culture-free Dimensions of Culture" *Journal of Cross-Cultural Psychology* 8 (1987): 143-164.

Cultural Adaptation Pain Scale (CAPS)

Sandhu, D.S., Portes, P.R., McPhee, S.A. "Assessing Cultural Adaptation: Psychometric Properties of the Cultural Adaptation Pain Scale" *Journal of Multicultural Counseling and Development* 24 (1996): 15-25.

Cultural Information Scale (CIS)

Saldana, D.H. "Acculturative Stress: Minority Status and Distress" *Hispanic Journal of Behavioral Sciences* 16 (1994): 116-128.