RECOMMENDED CLINICAL/REHABILITATION STANDARDS OF PRACTICE

FOR
CULTURALLY COMPETENT SERVICES IN
PENNSYLVANIA

DEPARTMENT OF PUBLIC WELFARE
OFFICE OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

Edward G. Rendell, Governor
Estelle B. Richman, Secretary
Joan L. Erney, JD, Deputy Secretary

OMHSAS CULTURAL COMPETENCY ADVISORY COMMITTEE
JUNE 2003

Second Edition

DEDICATION

VISION STATEMENT

"Every person with a serious mental illness and/or addictive disease, and every child and adolescent who abuses substances and/or has a serious emotional disturbance will have the opportunity for growth, recovery and inclusion in their community, have access to treatment and supports of their choice, and enjoy a quality of life that includes family and friends."

MISSION STATEMENT

"The Office of Mental Health and Substance Abuse Services, in collaboration with other appropriate state offices, will ensure local access to a comprehensive array of quality mental health and substance abuse services that are reflective of the needs of Pennsylvania citizens, effectively managed and coordinated and responsive to a dynamic and changing healthcare environment."

MISSION FOR CULTURAL COMPETENCE

"Ensure that all programs, policies, program standards, special or new initiatives promote cultural competency in the public behavioral health system in order to guarantee the availability and access to services and supports that adapt to each individual's culture."

TABLE OF CONTENTS

INTRODUCTION

The Cultural Competency Advisory Committee works to advise the Office of Mental Health and Substance Abuse Services (OMHSAS) on many issues including access, effective delivery of services, and related administrative issues. This Committee was formed at the request of Charles Curie, deputy secretary of OMHSAS in 1998 in recognition of the importance and extraordinary complexity cultural issues give the current behavioral health service system. The members of this Committee are dedicated to the mission of OMHSAS and respectfully submit this document to Mr. Curie in fulfillment of its charge to develop operational standards integrating cultural competency into the behavioral health service delivery system. Within the body of this document is the outline for a sweeping philosophical change in the delivery of behavioral healthcare. While the document capitalizes on the existing service delivery structure, it proposes to set into motion a set of expectations regarding care delivery that is effective within the framework of the individual's cultural context. It does this by providing a single integrative set of standards definitive in their requirement of culturally competent staff, provider agencies, and clinical services as well as cultural competence within county and state governmental agencies.

While these standards build a broad conceptualization of cultural inquiry and the adaptation of care to the cultural context of the individual into the process, the standards also form the basis for effective policy development, regulation, evaluation and planning and clinical practice. These standards are grounded in guiding principles that assert basic beliefs and values regarding a highly effective healthcare system. While the changes are broad in scope, they set the fundamental standards for raising the quality of clinical practice. Some mistakenly, believe cultural competence is designed to assure that only certain racial groups are to be better served. Intended here is the assurance that _all_ Pennsylvanians will be fully and best served, regardless of race, class, religion, gender, ethnicity, immigration status or sexual orientation. These standards assure that all social groups representing the diversity that exists in each community across the Commonwealth are fully served by high-quality behavioral healthcare services. Our further hope is that other states will see these standards as a model to continue what we believe to be the growing enlightenment of clinical practice.

A Need for Action

Every person has an ethnic or multi-ethnic heritage. Perhaps it can be said that every person belongs to an ethnic/cultural grouping but it is certain that many people through their heritage identify with a particular group, perhaps more than one. These groupings vary in their degree of assimilation or integration into the mainstream of America's changing culture. Some groups fit well into this effervescent mainstream and find they are quite compatible with our current healthcare system. Members of various ethnicities and cultures may also fully embrace American mainstream values, lifestyle, healing traditions, worldview and social culture; but this is not a prerequisite for compatibility with the healthcare system, a parallel cultural style and social organization compatible with the structural assumptions of the healthcare system is. Mainstreaming ethnic groups have a strong sense of national belonging and fully participate in the opportunities and rewards of society. They may have members who struggle with mental illness, drug abuse, poverty and isolation, but

they readily view their existing social supports and community services as a source of sustenance. Since the original Community Mental Health Act in the early 1960's, America has made considerable efforts to assure all of its citizens have access to high-quality public behavioral healthcare services. Embedded in this effort was an assumption about effective healthcare delivery that did not affectively address issues of access and intervention arising from cultural variation. Generally, mainstream ethnic/cultural groups are able to best take advantage of this massive public health effort. The question of how to serve those in need that refuse services, or who are unaware of their availability or for whom service is ineffective, has lingered.

Over the past three decades, there has been a widening awareness of the underserved and identifiable groupings with a poor history of access to the public behavioral healthcare system. Variously the isolated poor, single women, women with children, particularly women and children with few social and familial supports, ethnic groups in general, sexual minorities, and recent immigrants form the collection of those underserved. Those who are underserved may indeed include people of all categories. The reasons they are underserved, beyond those of a purely economic nature, will differ. For many ethnic groupings the unrecognized significance given to their life experiences, worldviews, values, languages, traditions, customs and traditional healing practices in the mainstream behavioral healthcare system has lead them to question the value of the services offered. Often, though people know public behavioral healthcare services are available, the "compatibility gap" between the delivery system and the cultural differences between these individuals and needed service, create barriers and limit real access to existing services. The result ranges from no service to ineffective service with corresponding poorer health and substantially reduced quality of life for large pockets of citizens. Ultimately this limitation increases the cost to our economy and compromises the value and credibility of our healthcare system.

Under-served groups are often isolated, disenchanted and separate from mainstream America for numerous and complicated reasons. Some individuals hold closely to their traditional cultures and resist full integration into American mainstream culture. Some experience social alienation due to the effect of their social and cultural differences on mainstream response to the unfamiliar. Others experience outright discrimination and oppression. In response to these alienating affects, it is common for individuals to create a buffer from the mainstream to protect themselves from pain and harm. Homeless women and children who avoid public scrutiny serve as a dramatic example of those who require focused outreach and particular encouragement to be fully engaged and receptive to all the health services. Inability to speak English, English as a second language, and immigration status may all serve respectively as powerful barriers making full participation difficult. Sexual orientation also divides into mainstream and alternative lifestyles with those who differ from the mainstream identifying as "sexual minorities." Alienation of sexual minorities caused by biased and commonly hostile social responses has resulted in their development of a fairly cohesive social and politically active sub-culture. This helps to shield individuals in sexual minorities from the rejection they typically experience outside of their group. Others are differentiated by physical challenges that require special accommodations, and conventional services have insufficient resources to manage their behavioral healthcare needs.

Ethnic/cultural groups are disproportionately represented among persons of low-income. Along with low income comes high risk of illness and disease. Their behavioral health status is jeopardized by stresses related to adverse social conditions such as poverty, discrimination, social isolation, poor schools, immigration status, and no health insurance coverage. Often associated with these stresses are lives marked by chronic traumas triggered by internal personal, family and social

upheaval and not uncommonly, by violence, which may be experienced in the home, community or school. It is ironic that services are created to serve those at greatest need, but those at greatest risk of illness, persons of color and varying ethnicities, experience the greatest barriers to these same services.

Evidence of the questionable quality of behavioral healthcare experienced among ethnic/cultural groups is reflected in research findings. Studies illustrate how ethnic/cultural groups are under-served and the serious impact this has had on the healthcare they receive and their quality of life. Social conditions and healthcare community biases with respect to the effective delivery of care may ultimately be to blame for the lack of progress in addressing the decreased effectiveness and value of the healthcare system for these groups. Reports on biased prescription practices, misdiagnosing and the proportionally higher use of hospitalization illustrate a few of the serious problems that emerge when a behavioral health system fails to incorporate an understanding of ethnic/cultural experience and worldview for the people it serves. Ethnic/cultural groups often have different causes for and responses to illness that must be integrated into the informational and educational basis of the behavioral healthcare system if we are to avoid bias, discrimination and harm and promote effective, meaningful interventions. Below is a review of studies indicating different patterns in prescribing medication and in tendencies to apply more severe diagnoses to individuals in ethnic/cultural groups, than are accurate.

◊ Medication
- Segal, Bola, and Watson (1996) examined prescription practices of clinicians in psychiatric emergency services to determine if there was a difference in prescription practices between African Americans and other patient groups. The results found that clinicians, most of whom were Caucasian, in the four emergency service areas prescribed more psychiatric medications to African Americans than to other patients and devoted less time to patient evaluations. An interesting finding was that the tendency to overmedicate African American patients was lowered when the clinicians placed more efforts on engaging patients in their treatment.

◊ Diagnoses
- Ethnic/cultural rates of involuntary hospitalization, for both criminal and non-criminal commitments, were more than two times higher than rates for whites. (Snowden, L.R. & Cheung, F.K., 1990).
- A study of teen admissions to state mental hospitals found psychotic disorders were misdiagnosed three times higher in African American teens than for Caucasian teens. (Kilgus, M.D. et al., 1995)
- Another study, Mukherjee, Shukla, Woodle, Rosen, and Olarte (1983) reviewed the records of 76 bipolar patients to determine any history of a previous misdiagnosis of schizophrenia. Fifty-two of the 76 in the study, about 68.5 percent, were first misdiagnosed, attesting to the overall frequency of errors in diagnosing bipolar disorder. Of these variables significantly associated with the misdiagnosis in bipolar patients, ethnicity stood out over the others although misdiagnosis of Caucasians was also very high. African American and Latino patients, seen and treated by psychiatrists who were respectively African American or Spanish speaking had a similar occurrence of misdiagnosis. Therefore the difference was attributed to what appears to be a bias

within the analytic system, the *routine use of structured interviews…and …strict adherence to operationally defined diagnostic criteria.*

- Kates, Blow, Bingham, Copeland, and Mellow (2000) closely examined the issue of race and differential diagnosis in a national sample of almost 24,000 military veterans, aged 60 and over, who were admitted to acute inpatient care units in VA hospitals. The results show marked differences in rates of clinical psychiatric diagnoses by race. A much lower proportion of elderly African American patients were diagnosed as having mood and anxiety disorder diagnoses as compared with elderly Caucasian patients and even a bit lower when compared to Latino patients. Less striking than the proportional differences in mood disorders between ethnic populations, but nevertheless significant, is the higher proportion of African Americans diagnosed with cognitive disorders and substance abuse disorders. The proportional difference withstanding, about one third of each population, give or take about 2.5 points, reported a substance abuse disorder, making this the highest reported diagnosis for each. Latino and African American patients both had significantly higher rates of psychotic disorder diagnosed than Caucasian patients. This study presents the differences indicating that further study is needed to understand why, but it also provides an overview of possible reasons for differences including the possibility of misdiagnosis.

Illustrating variation in ethnic and cultural responses to illness is the first study below on differences found in help-seeking behaviors. The next study below shows the differences in referral patterns by ethnicity, of the service providers.

- Lin, Tardiff, Donetz, and Goresky (1978) analyzed the help-seeking pathways followed by severely disabled mental patients of different ethnicities in Canada. This research compares Chinese with Anglo-Saxons, Middle Europeans and Native American Indians and how they became involved in mental health services. Ethnicity is clearly shown as a prime factor in differentiating the patterns of help-seeking behavior. This study demonstrates the need for adjusting current mental health practices to make services more readily available and acceptable to people of certain cultures, markedly the Chinese and the Native Americans.

- Akutsu, Snowden, and Organista (1996) found markedly different referral patterns of African Americans, Latino, Asian Americans, and Caucasians in a public mental health system. The authors emphasize that a major barrier to service utilization is the lack of bicultural and bilingual staff at existing mental health facilities. This study shows significant differences in the referral patterns for ethnic-specific versus mainstream programs for ethnic/cultural populations.

Cultural differences in help-seeking behaviors are just one indication of the complexities in reaching, and effectively serving diverse groups. Behavioral healthcare systems with a *one-size-fits-all approach* are at risk of poorly treating and perhaps even injuring ethnic/cultural persons. These negative qualities foster poor access to healthcare services in ethnic and cultural communities and the isolation of individuals who are ethnically distinct. The result of poor healthcare and ineffective use of valuable resources is higher system costs to intervene in crises and treat emergencies, and to treat the broad increase in severity of symptoms found and the attendant difficulty in achieving remission. Under-served groups thus become over-represented in institutional settings and residential treatment facilities.

An urgent need for action locally is based on the increasing ethnic/cultural diversity of the population in the Commonwealth of Pennsylvania. Between 1980 and 1990, the Caucasian population in Pennsylvania increased by just one percent, however, each of the ethnic/cultural populations currently forming the minorities in the state increased substantially: Asian Americans increased by 114 percent; Native Americans by 56 percent; and African Americans by 40 percent. In addition, the population category of *other*, which includes primarily those of mixed race or ethnicity, increased by 31 percent (Pennsylvania County Planning Data Kit, 1991 Supplement). African Americans remain the dominant racial minority in the state, and with increases in the other racial and ethnic populations, Pennsylvania's overall population is fast becoming more multicultural in nature. This extraordinary growth continues to challenge our conventional behavioral healthcare system.

The changing population trend in Pennsylvania combined with service inadequacies for ethnic/cultural groups emphasizes the need for culturally competent behavioral healthcare. Beginning a discussion on what constitutes culturally competent healthcare requires agreement on a definition of Cultural Competence. The definition used by the OMHSAS Cultural Competency Advisory Committee is from M.R. Isaacs, & M.P. Benjamin (1991). They define cultural competence as *a set of congruent behaviors, attitudes and policies that come together in a system, agency or among professionals, enabling them to work effectively in cross-cultural situations…. the word culture is used because it implies the integrated patterns of human behavior that include thoughts, communications, actions, customs, beliefs, values and institutions of racial, ethnic, religious or social groups. The word competence is used because it implies having the capacity to function within the context of culturally integrated patterns of human behavior defined by the group.* The definition is not specific to behavioral health services but broad based and generally applicable, denoting a need for an overarching cultural change in all American institutions providing employment, services and goods.

In its application to behavioral health services, cultural competence is more than assuring equal access and non-biased traditional behavioral healthcare services. Culturally competent services are creative, imaginative and innovative solutions and responses to the problems and needs of individuals, families and communities. It discourages rote and repetitive services that give an illusion of compliance and responsiveness. Cultural competence fosters service system flexibility that is guided by the needs of consumers, children, adolescents and families. Services uniquely designed for each person are integrated within a flexible system of care that embraces ethnic/cultural worldviews.

Unfortunately, cultural competence in theory or practice has not been embraced and integrated in the private or public mental health sectors or by managed behavioral healthcare organizations that operate in both. The prevailing conceptualization of accommodating care to cultural distinctions is simply to have a clinician who speaks the same language and who is of the same gender, race, or ethnic background as the patient. Perhaps this is an improvement, and undoubtedly particular individuals stand out by their dedication and insight, but it is an illusion that services so delivered will improve access and effectiveness systematically. Without any further development, this is insufficient attention to cultural diversity.

Creation of a Cultural Competency Advisory Committee

As a part of an initiative to assure that a culturally competent system of care is established throughout the Commonwealth of Pennsylvania's behavioral healthcare system, a Cultural Competency Advisory Committee was established within OMHSAS. This committee is comprised of individuals who are consumers, advocates, providers, and other professionals involved in government, training and multiple areas of the mental health system. Committee members are also representative of the wide ethnic diversity found in Pennsylvania. Creation of the advisory committee reflects the State's sincere commitment to ensure high quality healthcare for all of its residents. The committee advises the Deputy Secretary of OMHSAS on the implementation and application of cultural competence in order to enhance the level of quality practice in the public behavioral health system. One of its goals was to develop and recommend a set of clinical and rehabilitative standards for statewide use. This document is the committee's achievement of that goal.

Davis (1997) describes a *standard* in the context of the health practices, as a set of criteria or rules that describe the expected levels of both clinical and system behavior, as well as courses of action that are based on research and experience. Following this definition, ***Recommended Standards for Cultural Competency,*** the Cultural Competency Committee provides standards that serve as guideposts for creating new policy, regulation and practice guidelines across a very diverse state. These standards are designed to ensure inclusion, access and full participation of cultural and ethnic groups in our behavioral healthcare and substance abuse system of services. They ensure consideration of individual health and quality of life as defined by the individuals' worldview, cultural context and experience, their families and communities, including their unique history, language, social experience and ethnic traditions. Finally, while these standards focus on ethnic groups and culture, they also address differences in age, gender, language, immigration status, sexual orientation, religious/spiritual beliefs, social class, and physical abilities as aspects of life that differentiate and isolate, but also group and identify individuals. In this way, a broader and more inclusive perspective of culture is considered.

The full set of standards below is based on a set of guiding principles and consensus by the broad spectrum of representation that the Cultural Competency Committee provides. This is our foundation for high-quality behavioral healthcare services. Many of these standards were found in other state behavioral healthcare initiatives and incorporated. They establish a vision and conceptual framework for serving populations least reached by current services, and most at-risk of debilitating behavioral and physical illness, overly restrictive care, and death. These principles compel a shift in the locus of control over services from professionals to consumers and communities. This subtle, but radical, change in the balance of power between providers and consumers is at the core of creating services that are culturally competent, high quality and accessible. For more than 40 years, studies of ethnic and cultural healthcare reveal a lack of access to quality care resulting in major health differences. Illness, death and disease rate discrepancies between the general population and ethnic/cultural groups result in enormous pain, suffering and cost, that effects all residents of Pennsylvania. Full access by those most at-risk will not occur without empowering cultural groups to influence and instruct the provider industry at all levels from government and corporate oversight to service implementation. This is essential to determine the individualized healthcare people need, consistent with their values, traditions and worldview.

For each standard, there are recommended outcomes and performance measures. Implementing groups and organizations should identify benchmarks for each recommended outcome to reflect the level of compliance required to foster change. Directional compliance is indicated by the use of the terms: *increasing* or *decreasing*. These directional terms should be rendered into specific targeted amounts of change when the recommended outcome is applied regionally as a goal for change. Attaining a level of outcome can be defined by using accumulating goals over several years. For example, *increasing the use of services by cultural groups to levels proportional to use by the general population* as a benchmark could translate into the *enrollment of Asian consumers will increase 20 percent each year for the next three years.* The regional or individual provider adaptation of these outcomes to meaningful benchmarks is intended to ensure that the application of standards is relevant to the diversity found in the various regions of the state. The performance indicators associated with each standard describe the expected results of implementation. These indicators provide an *outcomes* basis of evaluation, which is also useful for regulatory functions.

Intended as a *living document*, these standards are viewed as an introduction of a process of quality review that requires continuous study and periodic enhancement over time. Like the services identified here for assessment and improvement, the evaluation instrument itself must be open to improvement and responsive to changing ideas on achieving high quality, cost-effective, equitable delivery of care. Implementation of these standards will require a multi-step process in each region, consistent with the spirit of the guiding principles behind the standards and the recommendations within them.

The following steps are recommended:

- **Obtaining the Commitment of Key Leaders.** Making cultural competency *standards of practice* an integral part of county service systems requires key regional leaders to buy into its significance and create and promote partnerships with the many stakeholders. Major partners in this change include consumers, representative organizations, cultural communities, providers, and government staff and managed care organizations.

- **Establishing a Cultural Competence Task Force.** A standing task force persists over time to evaluate local needs and to organize and oversee changes. Membership of the task force should include representatives of providers, consumers, child and adolescent advocates, state officials, local government officials, managed care organizations, community groups and family organizations.

- **Identifying Needs and Engaging Cultural Communities.** A comprehensive assessment by cultural groups of their needs for mental/emotional health and substance abuse services is required to fully understand how to best provide access and appropriate service. Language barriers, historic patterns of discrimination and their causes, geographic isolation and immigration status are just a few of the challenges to be specifically identified in a thorough identification of needs. National resources and identification models for addressing these needs exist and are available and should be utilized. Basic for engaging communities in planning and design activities is the need to identify the problem areas. To be effective the plan must ensure ethnic/cultural communities are engaged and included in developing the comprehensive plan.

- **Developing a Comprehensive Plan of Action.** The Cultural Competence Task Force, in conjunction with local and state officials, develops a comprehensive cultural competence plan of action based on ethnic community need identification. The plan addresses the many levels of change: policy, clinical practice, funding, training, and evaluation. Further, the plan creates action steps for recruiting and hiring qualified staff who reflects the diversity of cultural groups to be served. Also developed in the plan are strategies for linking behavioral healthcare (inclusive of substance abuse services) with schools, physical health providers and other community services. Finally, the plan develops ways to create a support network for consumers, children, adolescents, the family and the community to advocate within the established system of care.

- **Implementing and Continually Evaluating Plan.** Key leaders with the Cultural Competence Task Force oversee and ensure the implementation of the plan and its evaluation. The implementation, evaluation procedures and outcomes are incorporated in the annual planning processes counties currently submit to the state. In most cases, these plans will be multi-year efforts, with multiple steps and goals.

- **Providing Ongoing Training.** Continual training and education of professional staff, and community groups, as well as policy-makers and government officials, is required for long-term success. The momentum necessary to sustain change over time is based in altering the fundamental assumptions, knowledge and skills of professionals and community members

These steps for change will require state leadership and statewide plans of action. Change will also require new and innovative funding and supports. Yet, this is an investment in our Commonwealth that will reduce health costs, promote and assure the health and welfare for many of our most vulnerable citizens.

ACKNOWLEDGEMENTS

I. GUIDING PRINCIPLES

1. Principle of the Universality of Ethnicity and Culture. Each person is aging and therefore has an age and an age cohort. Each person has: a gender, therefore a gender orientation; abilities, therefore limitations; resources deriving from social constructs, therefore a socioeconomic status; a family history and a legacy that precedes by many generations, therefore an ethnicity and a culture. Identification with others by all these means helps provide a sense of security, belonging and identity. It is the power of this that drives "Honk if you own a Volkswagen", or "the wave" at ballparks to work so effectively. Each human encounter, in so far as it crosses some boundary of age, belief or practice, is, in a sense, a cross-cultural encounter, but we have many bridges to facilitate the crossing. Culture is more than just membership in one's racial/ethnic group. Culture is a dominant force arising within us from our parental and community upbringing, serving to shape behavior, values, cognition and social institutions.

In the treatment setting, every individual must be valued within his/her cultural context. Observed differences are to be appreciated as sources of strength and enrichment and resources of reconnection and reintegration. Within each individual's thinking, personal history and family culture lay the defining attributes of his or her problems and the solutions. The wholeness of the individual is important for a complete evaluation and effective intervention.

2. Principle of Cultural Competence. Treatment, recovery and rehabilitation are more effective when consumers, children, adolescents and families fully engage in services compatible with their cultural values and worldviews. Services that are culturally competent are provided by individuals who have the skills to recognize and respect the behavior, ideas, attitudes, values, beliefs, customs, language, rituals, ceremonies and practices characteristic of a particular group of people (Child and Adolescent Service System Program Principles). These skills are used to determine wellness/illness, establish individualized and consumer-driven plans and goals, and create unique services that are community-based and integrate natural supports. Cultural competence entails knowledge of literacy level, native languages, levels of acculturation and assimilation, and cultural healthcare beliefs, customs and practices. This body of knowledge guides the service system to increase access to services, and to better design, implement and evaluate services tailored to particular cultural groups. The principle entails vigorous integration of cultural competency principles and standards of practice throughout all levels of behavioral health and substance abuse planning, policy-making, research, evaluation, training and service delivery.

3. Principle of Social and Environmental Influences. Social conditions of poverty, unemployment, discrimination, class rank, immigration status, and isolation greatly impact all aspects of behavioral healthcare, and contribute deleterious effects and exacerbate symptomatology. Effective service outcomes and quality of life are achieved when the consequences of these social experiences are identified and incorporated into healthcare planning and service delivery. Services are designed and funded to assure these conditions are not barriers to healthcare. The service system assures services do not merely reach the most motivated, educated and socially mobile. Service evaluations entail assessing the prevalence of these social conditions in communities, and engaging people at the highest risk of illness. Planning processes recognize social conditions and their impact on health and interventions. Professionals avoid assigning fixed diagnoses and characteristics to individuals who are merely responding to stressful social conditions. Service systems adopt a "*no-reject/no-eject*" standard of practice ensuring that no one is rejected or ejected from services because of behavior that is necessary to survive and cope in their social conditions.

4. Principle of Consumer-Driven Services. Consumer-driven services include activities that individualize plans, assessments and services to center on the priorities, values and goals of individuals and families. Whenever possible, self-help services are created and utilized. Consumer-driven services foster self-determination and choice. Cultural groups are fully engaged when they are actively involved in the design, implementation and evaluation of services that fit their unique worldview. For many cultural groups, this entails services that heal the wounds of bias and discrimination. It entails establishing linguistically appropriate services, assuring availability of culturally competent advocates and education as to the workings of the service system. Individuals, their families and the community, fully participate in determining the kind of services that best achieve goals for attaining high quality and meaningful lives. Systems of care must have a goal of empowering people, during the course of treatment, to be self-determining in all domains of their lives.

5. Principle of a System of Care. Systems of care are consumer-driven, highly coordinated service responses to multiple needs of consumers, families, children and adolescents. They require professional willingness to engage, interact and communicate in effective partnerships with culturally diverse populations, encouraging and valuing an active role in the service planning process. In a system of care, services focus on all domains of life (e.g., mental health, education, medical, housing, social rehabilitation, employment) and integrate healthcare needs into a single coordinated plan of services that are individualized and culturally relevant. Services are community-based, involve natural supports, strength-based, and are least restrictive. Cultural and non-traditional ways of healing are integrated in case management and treatment/rehabilitation plans. All planning processes are consumer-driven and family-focused. Family and community members are engaged and invited into the planning and service delivery processes. This entails planning meetings that are community-based and convenient to consumer availability. These strength-based, comprehensive plans are designed to enhance achieving high quality and meaningful lives.

6. Principle of Access. Access occurs when cultural groups perceive services are relevant to their life experience and worldview, and use them. Linguistic, geographic and cultural barriers to services are identified and removed. Service systems use culturally relevant media to inform and educate cultural groups, and the general public, about services and supports. Full access to services is determined by evaluating both the use of services by cultural groups as compared to the general population, and by evaluating the prevalence of concerns and problems in specific cultural communities. Increasing access results in less use of crisis and emergency services. Problems and concerns are identified early, and prevention and support services reduce the severity and prevalence of chronic illnesses. This principle entails identifying and overcoming transportation, poverty and community safety barriers to services. Whenever possible, services are community-based.

7. Principle of Quality of Life Outcomes. Consumers and families evaluate outcomes of services, and the service system, by their ability to enhance and improve quality of life. Quality of life is achieved when individuals reach and accomplish self-defined meaningful life goals. It involves having meaningful social roles within family and community. It involves empowerment and self-determination to make decisions in all domains of ones' life. Case management and treatment/rehabilitation plans encompass all domains of a persons' life to foster growth and development of necessary personal, social, employment and interpersonal skills to achieve fulfillment and well being. Holistic approaches to healthcare are essential to assure a high quality of life.

8. Principle of Managed and Integrated Healthcare. Costs of public healthcare are best managed and contained by providing high quality, effective mental health and substance abuse services tailored to each individual and family culture that integrate and coordinate medical, mental health and substance abuse. In this way, engagement may be maximized, and use of more costly emergency services reduced. Primary healthcare that engages people in preventative healthcare throughout life development best reduces costs and improves the overall health of our communities. Integrating physical and emotional health in assessments, plans and services is essential. The service system emphasizes managing care, and not dollars, by assuring individuals are in least-restrictive treatment settings, and gain access to services early.

Prevention is a key goal for managed and integrated systems of care. Prevention includes community education about mental illness, substance abuse, family support services, early identification programs and services, and social marketing campaigns to de-stigmatize mental illness. Prevention and early intervention necessitate behavioral health providers to link with physical healthcare providers and other community-based services. Assuring a high quality of life is considered an important aspect of prevention. Subsequently, increasing community employment and job skill training are examples of prevention activities.

9. Principle of Data Evaluated/Driven Systems of Care. Traditional ways of collecting information, planning and evaluating services, do not reach isolated and high-risk populations. Many currently existing information systems and planning processes do not attain information about communities and only focus on those currently and traditionally served. Assuring services are culturally competent requires engaging communities to gather information about the prevalence of problems, stressful social conditions, substance abuse and mental illness. Data and findings are always interpreted in the context of each cultural community, and not merely compared to the general population as a normative standard. Consumer, family, child and adolescent and community outcomes are projected as an aspect of county planning processes. Storytelling, testimonials, and oral accounts of needs and satisfaction are considered data sources. In consumer-driven systems of care, feedback regarding service satisfaction and outcomes are most important data for future planning and system re-design.

Outcomes and effectiveness of services are evaluated based on the prevalence of illness and problems in the cultural community, and not merely by comparing rates to the general population. This principle assures professionals and community members avoid using the dominant culture as a normative standard of health. Rates of illness are impacted by cultural, social and historic differences among social groups. Behavior that seems aberrant to the general population may be healthy responses to social conditions. Services target the unique patterns of illness and problems in cultural communities, and develop unique community-based health standards to evaluate services.

10. Principle of Least Restrictive/Least Intrusive Services. Services occur in settings that are the most appropriate and natural for the consumer and family and are the least restrictive and intrusive in impacting the right of self-determination by consumers, families and communities. (CASSP) This means community-based, in-home and natural support services being first utilized, unless there are assessed indications that other services are necessary to assure outcomes and quality of life. Justification for more restrictive and intrusive services occurs at all levels of planning: initial assessment through discharge. Consumer, family and community members are included in determining the least restrictive/intrusive setting and service. As "minorities" are over-represented in restrictive settings, and as recipients of behavioral controlling treatments, service systems regularly collect data and monitor these services. Plans of action are created and implemented when evaluation finds cultural groups are over-represented in restrictive treatments.

II. STANDARDS AND IMPLEMENTATION GUIDELINES

ACCESS AND SERVICE AUTHORIZATION STANDARD

Consumers, families, and natural support persons (self-defined family), have access to services in a respectful and welcoming manner. Services are provided in timely, convenient and easily accessible ways. Protocols exist to assure services are available to persons who are disinclined to accept treatment. Bilingual and bicultural providers, and trained interpreters, are available across the entire service system. Service availability and determination encompass a holistic rehabilitative approach that includes psychiatric, medical, social, vocational, behavioral, cultural, spiritual, familial and community supports.

PERFORMANCE OUTCOMES

1. Persons of diverse cultures and linguistic differences are served based on their preference and actual need.

2. Service systems use a variety of formats to disseminate culturally relevant information regarding mental health and addiction services, as well as non-traditional and self-help resources.

3. A written plan guides action that engages and encourages individuals in need of services but who are disinclined to accept treatment.

4. Service systems demonstrate timeliness in member access and authorization of services.

5. Service systems adopt flexible service hours to maximize the availability of services.

6. Service systems authorize cultural-based alternative and complementary treatment approaches that assure engagement, retention and follow-up.

7. Service systems staff and managed care organizations have culturally and linguistically competent staff available 24 hours a day, and seven days a week.

8. Service agencies have a milieu and physical environment that reflects diversity and the surface cultures of people being served.

1. Service utilization rates of traditionally under-served and over-represented persons are comparable to the prevalence of illness and problems that occur in the ethnic/cultural group. Cultural/ethnic community residents use behavioral healthcare providers as a community resource for all health concerns. In highly restrictive services, utilization rates are comparable to all other groups in the general population.

2. Service providers have a list available in each facility of culturally and linguistically accessible services.

3. Service descriptions for culturally sensitive programs are available for individuals in their community and other natural gathering places. Providers develop ethnically/culturally relevant ways of disseminating information that make services widely known in ethnic/cultural communities.

4. Educational and information materials reflect the languages and cultures of persons served.

5. Service systems track the utilization rates of persons who are traditionally disinclined to accept treatment. These systems develop studies on the prevalence of illness and problems in ethnic/cultural communities, and identify the barriers they experience in seeking help. Service systems create correction plans, implement actions, and measure improvements in help-seeking behavior. Indicators of positive impact include: decreased use of emergency rooms, decreased use of crisis services, increased number and use of advocacy groups, decreased arrest rates of persistently ill individuals, increased referral follow-through rates and increased voluntary use of self-help and prevention services.

6. Service systems track the increase in availability of services. Availability is indicated by services occurring in settings that various ethnic/cultural groups define as comfortable, appropriate, consistent with their values and worldview and complementary to their natural healing practices.

7. Service systems track the number and type of alternative and complementary treatment approaches for various cultural groups. High performance is indicated by an integration of traditional healing practices and treatment approaches with professional models that capture the best of each.

8. Service systems determine consumer and family satisfaction and increase access because of flexible hours, and alternative and complementary treatment.

9. Waiting area and offices display magazines, art, music, etc., reflective of the cultures and ethnic groups of individuals being served.

Case Management Standard

Case management shall be central to the operation of the multidisciplinary team. It reflects an understanding and appreciation of the values, norms and beliefs of cultures, and knowledge of resources in the communities. Case management recognizes the unique mental/emotional health and substance abuse issues associated with economic conditions, social class, and experience of bias, discrimination and racism. Case management recognizes the impact of these issues on behavioral health, and takes these into account when considering the cultural appropriateness of all services that are coordinated and managed. Case management advocates for the consumer, family, child and adolescent, assures knowledge of service options, and assists in consumer and family choice. These activities are individualized to the diverse culture, race, ethnicity and language differences. Case management services participate in ongoing assessments of their service system to determine and assure that they are responsive to diverse needs and experiences.

PERFORMANCE OUTCOMES

1. Consumer, family, child and adolescent access to a comprehensive array of services that are compatible with their culture.

2. Consumers receive culturally competent services that are coordinated within multiple domains, i.e., vocational, social, educational and residential settings.

3. Culturally competent services are continually created and adapted to meet the needs of adult consumers, children, adolescents and their families.

PERFORMANCE INDICATORS

1. Service utilization data and information are utilized to increase enrollment of under-served populations. Ethnic cultural group enrollment in less restrictive services (outpatient, self-help and social rehabilitation) increases to levels comparable to the general population. Enrollment in restrictive services (inpatient, involuntary commitments, jail treatment settings and court-ordered outpatient) decreases to levels comparable to the general population.

2. Service systems document culturally competent services and resources received by consumers and families. Individual and family definitions of culture, ethnicity and need guide the development of indicators for high levels of performance. Merely providing culturally competent services to persons of color, or persons who are perceived different from mainstream culture, is not an indicator of compliance.

3. Service systems document family and community contacts/visits, and visit locations. High levels of compliance are system-wide supports for family and community member advocacy and full participation in all aspects of case planning. Parent led support/advocacy groups naturally develop and influence decision-making throughout the delivery system. Merely having record of family member attendance at meetings is not an indicator of compliance.

4. Service systems document improved relationships within the family, and within social networks of their cultural group. High levels of compliance are indicated by less estrangement from the natural family and high levels of family involvement in planning processes and support services.

5. Service systems document that consumers, families, children and adolescents achieve the greatest degree of independence and self-determination. The use of restrictive services by ethnic/cultural groups is reviewed annually for higher use than the general population. Each provider implements a plan of correction until usage levels are comparable. Restrictive care includes the use of psychotropic treatment with no complementary clinical/rehabilitative services.

6. Revised care plans and services demonstrate inclusion of ethnic, social and cultural factors.

7. Cultural competence training for all case managers is incorporated in reviews for regulation compliance. Training is designed for the ethnic/cultural groups that exist in the service community. Levels of training and competence are established.

8. Community resources and natural supports are included in all care plans.

TREATMENT/REHABILITATION PLAN STANDARD

All persons served receive a treatment/rehabilitation plan that is holistic, and incorporates the individual's choice of attainable goals, culturally compatible treatment modalities, and consumer driven alternative strategies of healthcare. These strategies include the use of family, community supports, spiritual leaders and folk healers. Plans are consumer driven, based on individual strengths, and developed within the context of family and social networks so as to create a consumer-professional partnership. Plans are formulated and reviewed by culturally competent professionals and culturally competent consultants in full collaboration with consumers and families of children and adolescents.

PERFORMANCE OUTCOMES

1. Identification and creation of culturally relevant goals.

2. Use of culturally compatible modalities and alternative strategies.

3. Consumers and families fully participate and share in the development of goals and wishes, and express satisfaction with their role and participation.

1. Plans document consumer wishes and goals. These may be related to employment, education, training, personal appearance, health, family relationships, social activities and social relationships. Plans specify ethnically/culturally relevant wishes and goals.

2. Service systems document consumer and family satisfaction with their participation in the treatment/rehabilitation planning process. Low levels of satisfaction trigger plans of correction, implementation of these plans and re-evaluation.

3. Plans outline culturally relevant treatment and rehabilitation modalities and strategies.

4. Service systems document that culturally competent professionals create and review plans. The definition of a high level of performance depends on the ethnic/cultural groups in the service community, and not merely completion of training. Training, staff skills and cultural competence will be greatly impacted by the kinds of ethnic/cultural groups in the service area. A high level of performance is indicated by professional standards for competence for each ethnic/cultural group, and not a generalized declaration of professional competence due to completion of a generalized cultural competence training program.

5. Service systems create all written planning materials and documents in plain and simple text that are readily comprehended by consumers and families.

RECOVERY AND SELF-HELP STANDARD

Recovery and self-help groups are readily available, and function as an integral part of a seamless continuum of care. Recovery and self-help groups are culturally diverse and culturally compatible, incorporating consumer-driven goals and objectives that are oriented toward rehabilitation and recovery outcomes. Culturally competent providers and individuals in recovery are enlisted as consultants and educators to assist in the creative development of alternative treatment services, models and supports that are compatible with the lifestyles, values and beliefs of various cultures.

PERFORMANCE OUTCOMES

1. Services are accessible and available in a variety of settings, including churches, neighborhood facilities, and places of residence.

2. Service systems create more integrated, culturally and linguistically specific, recovery groups.

3. Community groups, individuals in recovery and other natural support groups are recruited in the development and design of recovery and self-help service models.

PERFORMANCE INDICATORS

1. Service systems document the increased use of recovery and self-help programs by various cultural groups. As families and communities are engaged in services, the number of ethnic/cultural self-help, advocacy and recovery groups increase. A strong performance

indicator is demonstrated by a high level of self-determination concurrent with inclusion and retention in the system of care.

2 Service systems document an increase in the variety of ethnically/culturally relevant recovery and self-help programs. The array of ethnic/cultural services increases as the service system better engages and empowers families and communities.

3. Providers make available a list of recovery and self-help services in locations that are readily accessible to individuals and their communities.

CULTURAL ASSESSMENT STANDARD

A cultural assessment is conducted by competent staff for each individual, within the context of their culture, family and community. The assessment is individualized, multidimensional and strength-focused. The components of the assessment include functional, psychiatric, social status, cultural milieu, social and economic stresses, discrimination, and family supports.

PERFORMANCE OUTCOMES

1. A cultural assessment is the basis for a culturally relevant diagnosis, goals and rehabilitation/treatment plans.

2. A cultural assessment tool and guide exists to determine cultural factors that impact treatment/rehabilitation services.

3. On-going cultural assessment occurs at each phase of treatment and rehabilitation.

4. Cultural assessment includes personal preferences, and differentiates pathology from cultural factors.

PERFORMANCE INDICATORS

1. Bilingual staff are available to assess consumers, children, adolescents and families in their language of preference.

2. Qualified cultural interpreters are utilized when bilingual staff are not available. To protect the rights and confidentiality of individuals, family and friends are not to be used as language/communication interpreters. Participation of these persons should be welcomed in the treatment planning process at the request and/or consent of the consumer.

3. Psychological assessment and measurement tools are culturally valid and reliable, and administered, scored and interpreted by culturally competent providers.

4. All persons receive an ethnic/cultural assessment. The rates of chronic, anti-social and other serious diagnoses for all ethnic/cultural groups are comparable to the general population. The use of restrictive treatments for all ethnic/cultural groups is comparable to the general population.

5. Providers document the inclusion of family members, and significant community support persons, in the initial and on-going assessment process. An indicator of high level performance is community-based, consumer-driven assessments and service planning that are inclusive of family members.

6. The assessment includes cultural factors that are important to the treatment process. These factors include, but are not limited to, the following:

   a) Preferred language;
   b) History of indigenous/immigration/migration/generation behavior patterns;
   c) Degree of acculturation and adaptation;
   d) Cultural, social, economic and discrimination stresses and traumas;
   e) Learning and cognitive styles;
   f) Family organization and relational roles;
   g) Extent of family support;
   h) Social network composition;
   i) Ethnic identity;
   j) Consumer/family's perception/belief of presenting problems and explanations for symptoms;
   k) Consumer/family's belief systems regarding mental illness/substance abuse;
   l) Sexual identity and sex role orientation in cultural group;
   m) Coping strategies utilized within the cultural group;
   n) Help-seeking behavior;
   o) Previous attempts at relieving, managing and treating symptoms (including healers, traditional medicine, etc.).

Communication Style and Linguistic Support Standard

Consumers, families, children, adolescents and other support persons receive cross-cultural and communication-support, such as assistive devices and qualified language interpreters and professionals interpreters. These supports are available at each entry point to services, and continue throughout the treatment and rehabilitation services. Staff is knowledgeable in the use of professional interpreters, and telephone interpreters are only utilized in emergencies. Orally presented information, and written materials and documents, are translated in the consumer's preferred language. Examples include consumer rights information, orientation packets, consent forms and treatment plans.

To protect the rights and confidentiality of individuals, family and friends are not to be used as language/communication interpreters. Participation of these persons should be welcomed in the treatment planning process at the request and/or consent of the consumer.

PERFORMANCE OUTCOMES

1. Consumers, children, adolescents and family members receive cross-cultural communication supports at each point of entry in the service system.

2. Consumers, children, adolescents and family members report satisfaction with communication supports.

3. Staff is knowledgeable in the use of communication supports.

4. Interpreters are qualified, competent, and demonstrate knowledge of the individuals' cultural experience; including deaf, hard of hearing and deaf blind.

5. Communication supports demonstrate culturally accurate assessments, treatment/rehabilitation plans and service delivery.

6. Cross-cultural communication supports are available and comparable across all cultural groups.

PERFORMANCE INDICATORS

1. Service systems increase the number of bicultural and bilingual staff, competent in the communication styles of the diverse cultures, as to minimize the use of interpreters.

2. A resource list of trained and qualified interpreters, updated annually, is maintained by facilities. Consumers, children, adolescents and families are aware of the availability of interpreters through service advertisement efforts.

3. Certified qualified interpreters are available within 24-hour notice for routine situations, and within one hour for emergencies.

4. Service systems document consumers' satisfaction with communication supports. A plan of correction and implemented action occurs when consumers are not satisfied with communication supports.

5. Service systems document that staff receives training in the use of interpreters.

6. Service systems document that interpreters are certified (sign language interpreters), qualified and competent.

7. Service systems document that communication supports are comparable across cultural groups.

CONTINUUM OF SERVICE/DISCHARGE

PLANNING STANDARD

Service and discharge planning begin at all points of entry along the continuum of services. It is provided by culturally competent providers in cooperation and collaboration with the consumer,

family, community support persons and social networks. Service and discharge planning are done consistent with the values, norms and beliefs of the individual. These plans incorporate pertinent information from the cultural assessment, and include service/discharge factors that are culturally relevant and important to recovery.

Plans identify personal, family, social environment, social network and cultural resources necessary for treatment and rehabilitation services that assure recovery.

Performance Outcomes

1. A culturally compatible continuum of service/discharge planning is developed for each individual.

2. Plans include clear goals and recommendations for necessary services in the post-discharge continuum of care.

3. Plans use the resources of family and social networks.

4. Plans assure individuals remain connected to treatment/rehabilitation recovery services as needed.

Performance Indicators

1. Service systems document that service/discharge plans involve consumers, family members, community resources, and social supports. High levels of performance occur when family and community members are partnered with consumers and drive the planning process. Family and community members merely attending meetings is not an indicator of adequate performance.

2. Plans list the resources, services utilized and accomplishments.

3. Individual values, norms and beliefs are documented in the plan and drive the planning process.

4. Service systems document future treatment and rehabilitation goals.

5. Service systems document recommendations for the use of family, social networks and cultural resources in any subsequent treatment/rehabilitation setting.

QUALITY OF LIFE STANDARD

Quality of life is achieved through a holistic integration of symptom reduction, family and community support, and spirituality, which maximizes the consumer and family's sense of personal meaning, fulfillment and well-being. Assuring consumers, children and adolescents and their families have a high quality of life enhances recovery for adult consumers and increases community

inclusion for children and adolescents and their families. Quality of life is determined by an individual's freedom to make choices and enjoy the benefits of those choices.

PERFORMANCE OUTCOMES

1. Service systems develop ways of assessing the quality of life for all individuals.

2. Individuals and families report improved quality of life through services.

3. Individuals and families direct the recovery planning and treatment process.

PERFORMANCE INDICATORS

1. Assessments, treatment/rehabilitation plans and services incorporate the goals, preferences, hopes and wishes of consumers.

2. Service systems compile, collect and interpret quality of life measures.

3. Service systems utilize quality of life information and data to evaluate and improve service delivery, and to develop new services.

SERVICES ACCOMMODATIONS STANDARD

Programs respond to the needs of individuals and families from different cultures by ensuring the best cultural fit between persons' beliefs, their cultural/behavioral styles and the services provided. Based on information derived from cultural assessments (re: family styles, gender roles, sexual orientation, spirituality/religion, worldview, traditions, work ethic, communication styles, leadership and organizational styles, cognitive and learning styles) services, interventions, modalities, and strategies are adapted or developed in order to better promote program engagement, treatment/rehabilitation, and retention. Particular consideration is given to the visible presence of different cultures throughout the program's physical environment. Culturally competent strategies are utilized to attract and recruit consumers and families. Varied induction methods that orient persons to types of services offered, as well as how to utilize and participate in these services, are available. Service outcome expectations, as well as clarification of both staff and consumer roles and responsibilities, are reviewed.

PERFORMANCE OUTCOMES

1. Program services, interventions and modalities are modified and developed in order to enhance engagement, treatment/rehabilitation, or retention.

2. Varied program induction methods are available.

3. Varied outreach and recruitment strategies are utilized.

PERFORMANCE INDICATORS

1. Information derived from cultural assessments is collated and summarized.

2. Programmatic needs to ensure responsiveness to persons from different cultures have been identified and prioritized.

3. Selected, prioritized services, interventions and modalities, that have been modified, are documented.

4. Examples of varied culturally compatible, program outreach and recruitment strategies are documented.

5. Examples of varied program induction methods utilized to engage consumers and families from different cultures are documented.

III. APPENDICES

Glossary

Access: The degree to which services are quickly and readily obtainable. It is determined by the extent to which needed services are available, information about these services is provided, the responsiveness of the system to individual, cultural and linguistic needs of persons and the convenience and timeliness with which services are obtained.

Assessment: Activities that determine the individual's current need for services. In addition there are assessments to determine the current availability and quality of such services. Assessment efforts include data collection through surveys, studies, and various means of evaluation. For example, assessment may be conducted to determine the demographic characteristics of the clients/consumers, provider and staff capacity, service quality, client/consumer satisfaction, provider satisfaction, appropriate utilization of services and techniques (standard and alternative) to facilitate healing.

Cultural Assessment: The process initiated by individual service providers, that occurs between the person served, and may include one or more significant others, and the service provider(s), which identifies the range of cultural factors and determines those that are significant to the treatment and continuing care process.

Cultural Competence: A set of congruent behaviors, attitudes and policies that come together in a system, agency or among professionals, enabling them to work effectively in cross-cultural situations … the word culture is used because it implies the integrated patterns of human behavior that include thoughts, communications, actions, customs, beliefs, values and institutions of racial, ethnic, religious or social groups. The word competence is used because it implies having the capacity to function within the context of culturally integrated patterns of human behavior defined by the group (M.R. Isaacs & M.P. Benjamin, 1991).

Culture: The aspects of identity that individuals share and which identify them as a group. To the extent that this incorporates physical attributes and group identification as a "race", physical attributes contribute to cultural identity. Culture incorporates the concept of embedded-ness of smaller group identities within larger. Cultural descriptions include, but are not limited to characterizations of shared values, norms, traditions, customs, arts, history, folklore, religion, and healing practices and beliefs. Cultural institutions such as religious beliefs, social organization, and customs are generally transmitted to succeeding generations and define the ethnicity of the group.

Family: Within the broader system of social relations, this is the subsystem of relationships to the individual. Biological affiliation and relations commonly define it, but how these relationships are organized vary by culture. Also, varying by culture and practice is the incorporation of others into the individual's identification of *family* by their relationship of special significance and fulfillment of functions identified with, and expected of, a family member.

Holism: The theory of systems as interacting wholes, one affecting the other. In medical application it is the use and integration of different methods, practices and modalities to address the needs of persons and their families in multiple arenas: biological, psychological, social, medical and spiritual.

Holistic: Emphasizes the interdependence of theoretically independent systems and the view that full and effective understanding requires an approach to examine the complete systems interaction. In medical application (see also *holism* above) this approach incorporates the importance of a broader cultural and alternative treatment perspective.

Interpreter: An individual trained and certified in facilitating oral, written, or manual communication between two or more people of different languages. Interpreters should have an in-depth knowledge not only of the language including non-verbal expressions, but also of cultural values and beliefs.

Natural Supports: Individuals recognized by persons, their family members and local communities, as being able to provide help and assistance when needed. Examples of such supports include family, friends, lay healers, co-workers, peer support groups, religious and community organizations.

Principles: Rules of conduct or action accepted as a fundamental truth or cause, by an individual, group, agency or governing body.

Qualified Interpreter: A person trained in oral translation who also serves to bridge the cultural gaps arising in cross-cultural communication. An ideal interpreter is someone who is not only trained in cross-cultural interpretation, but also trained in the healthcare field, proficient in both the culture of the client and that of healthcare professionals. The interpreter should have an understanding of the significance of the particular health matter being discussed and must have an understanding of the importance of confidentiality.

Standard: A set of criteria or rules that describes the expected behavior at both the clinical level and the system level. A *standard* often represents courses of action that are based on research and experience.

Values: Principles, qualities, standards, or beliefs intrinsically valued by a set of individuals or a group, and considered vital to their well-being and psychosocial survival.

References

Akutsu, P.; Snowden, L.; Organista, K.(1996). Referral patterns in ethnic-specific and mainstream programs for ethnic minorities and whites. Journal of Counseling Psychology, 43 (1), 56-64.

Isaacs, M.R. & Benjamin, M.P.(1991). Toward a Culturally Competent System of Care: A Monograph on Effective Services for Minority Children Who Are Severely Emotionally Disturbed, Volume II. Washington, DC: Georgetown University Child Development Center.

Kates, H.; Blow, F.; Bingham, C.; Copeland, L.; Mellow, A.(2000). Race and inpatient psychiatric diagnoses among elderly veterans. Psychiatric Services, 51 (6), 795-800.

Kilgus, M.D., Pumariega, A.J., & Cuffe, S.P.(1995). Influence of race on diagnosis in adolescent psychiatric inpatients, Journal of American Academic Child Psychiatry, 34, 67-72.

Lindsey, K., Gordon, P.(1989). Involuntary commitments to public mental institutions: Issues involving the overrepresentation of Blacks and assessment of relevant functioning. Psychological Bulletin, 106 (2), 171-183.

Lin, T.; Tardiff, K.; Donetz, G.; Goresky, W.(1978).Ethnicity and patterns of help seeking. Culture, Medicine and Psychiatry. 2, 3-13.

Lucksted, A.(2000). Experiences of LGBT people with serious mental illness: Raising issues. University of Maryland. Center for Mental Health Services Research.(Presentation Summary)

Mollica, R.; Blum, J. Redlich, F. Equity and the psychiatric care of the black patient, 1950-75. The Journal of Nervous and Mental Disorders, 168 (5), 279-286.

Mukherjee, S.; Shukla, S.; Woodle, J.; Rosen, A.; Olarte, S.(1983)Misdiagnosis of schizophrenia in bipolar patients: A multiethnic comparison. American Journal of Psychiatry, 140 (12), 1571-1574.

Paniagua, F. (1998). Assessing and treating culturally diverse clients. London: Sage Publications.

Pennsylvania Data Planning Kit, (1991 Supplement). Commonwealth of Pennsylvania

Segal, S.; Bola, J.; Watson, M. (1996). Race, quality of care, and anti-psychotic prescribing practices in psychiatric emergency services. Psychiatric Services, 47 (3),282-86.

Snowden, L.R. & Cheung, F.K. (1990). Use of inpatient mental health services by members of ethnic minorities, American Psychologist, 45, 347-355.

United States. Bureau of Census. (1995) Statistical Abstract of the United States. Washington, DC: U.S. Government Printing Office, 19.

The OMHSAS CULTURAL COMPETENCE ADVISORY COMMITTEE

STANDARDS SUB-COMMITTEE MEMBERS

Karen Garrison

Walter Smith, Ph.D. (Chair)

Michael Tickner, Ph.D.

Sharon Potter

Ronald Sullivan, M.Ed., MPA

Wendy Wood

CURRENT COMMITTEE MEMBERS

Veral Adair, Jr., MA, MS, MSW

Lonnie Barnes

Heidi Becker-Share, MSW, LSW

Laree Beilharz

Adreinne Dixon, MSW

AnkHang Doan

Heather Flournoy

Karen Garrison

Maria Givens, MSW

Herbert Horikawa, Ph.D.

Anthony House

Deborah Moser, MS, M.Ed.

John Mwaura, M.Ed.

Olie Nasir

Truong N. Phoung, Ph.D.

Arlene Prentice, MS, CAC

Iraina Salaam

Susan Schaffer

Jane Schmidt, M.Ed.

Robert Scott, Ph. D.

Walter Smith, Ph.D.

Wendi Taylor

Brenda Weaver

Sarah Werner-Callahan

Wendy Wood

Consultant: Laurene Y. Finley, Ph.D.

Staff Cultural Competence Coordinator: Maria del Carmen-Perez, M.Ed., CAC

OMHSAS STAFF MEMBERS

Ron Bennett, MA

Michael Tickner, Ph.D.

Margaret Butts, RN

Anita Thiemann

John O'Connor

Carol Ward-Colasante

OMHSAS SUPPORT STAFF

Gayle Goodling

Susan Ulsh

EX-OFFICIO MEMBERS

Joseph W. Powell

Harry Kao

DECEASED MEMBERS

Ronald Gibson

Ronald Sullivan, M.Ed., MPA