

A TREATMENT IMPROVEMENT PROTOCOL

Improving Cultural Competence

TIP 59



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U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Treatment

1 Choke Cherry Road
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Consensus Panel

Note: Information given indicates each participant's affiliation during the time the panel was convened and may no longer reflect the individual's current affiliation.

Chair

Felipe González Castro, M.S.W., Ph.D.
Professor
Department of Psychology
Arizona State University
Tempe, AZ

Co-Chairs

Loretta J. Bradley, M.A., Ph.D.
Professor
Department of Educational Psychology
Texas Tech University
Lubbock, TX

**Jacqueline P. Butler, M.S.W., CCDC,
LISW**
Professor of Clinical Psychiatry
Substance Abuse Division
College of Medicine
University of Cincinnati
Cincinnati, OH

Flanders Byford, M.S.W., LCSW
Oklahoma City-County Health Department
Oklahoma City, OK

**Ting-Fun May Lai, M.S.W., CSW,
CASAC**
Director
Chinatown Alcoholism Center
Hamilton-Madison House
New York, NY

Workgroup Leaders

**Virgil A. Gooding, Sr., M.A., M.S.W.,
LISC**
Clinical Director
Foundation II, Inc.
Cedar Rapids, IA

Ford H. Kuramoto, D.S.W.
President
National Asian Pacific American Families
Against Substance Abuse
Los Angeles, CA

Harry Montoya, M.A.
President/Chief Executive Officer
Hands Across Cultures
Española, NM

Onaje M. Salim, M.A., NCAC-II, CCS
Director
Cork Institute Southeast Addiction
Technology Transfer Center
Morehouse School of Medicine
Atlanta, GA

Panelists

Barbara Lee Aragon, M.S.W.
Academic Fellow
Department of Health Services
North Highlands, CA

Debra A. Claymore, M.Ed.Adm.
D. Claymore & Associates, Inc.
Loveland, CO

E. Daniel Edwards, D.S.W.
Director
Ethnic Studies Program
University of Utah
Salt Lake City, UT

Tonda L. Hughes, M.S.N., Ph.D., FAAN
Associate Professor
College of Nursing
University of Illinois at Chicago
Chicago, IL

David Mathews, M.A., Ph.D.
Director of Adult Services
Kentucky River Community Care, Inc.
Jackson, KY

Anthony (Tony) Taiwai Ng, M.D.
Consultant
Washington, DC

Barry Pilson, Ph.D.
Adjunct Professor
School of Social Work
Tulane University
Metairie, LA

Rafaela R. Robles, Ed.D.
Director
Technology Transfer Center
Caribbean Basin/Hispanic Addiction
Centro de Estudios en Adicción
Universidad Central del Caribe
Bayamon, PR

Gloria M. Rodriguez, D.S.W.
Research Scientist
Division of Addiction Services
New Jersey Department of Health and Senior
Services
Trenton, NJ

Ann S. Yabusaki, M.Ed., M.A., Ph.D.
Director
Coalition for a Drug-Free Hawaii
Honolulu, HI

KAP Expert Panel and Federal Government Participants

Note: Information given indicates each participant's affiliation during the time the panel was convened and may no longer reflect the individual's current affiliation.

Barry S. Brown, Ph.D.

Adjunct Professor
University of North Carolina at Wilmington
Carolina Beach, NC

**Jacqueline Butler, M.S.W., LISW, LPCC,
CCDC III, CJS**

Professor of Clinical Psychiatry
College of Medicine
University of Cincinnati
Cincinnati, OH

Deion Cash

Executive Director
Community Treatment and Correction
Center, Inc.
Canton, OH

Debra A. Claymore, M.Ed.Adm.

D. Claymore & Associates, Inc.
Loveland, CO

Carlo C. DiClemente, Ph.D.

Chair
Department of Psychology
University of Maryland Baltimore County
Baltimore, MD

Catherine E. Dube, Ed.D.

Independent Consultant
Brown University
Providence, RI

Jerry P. Flanzer, D.S.W., LCSW, CAC

Chief of Services
Division of Clinical and Services Research
National Institute on Drug Abuse
National Institutes of Health
Bethesda, MD

Michael Galer, D.B.A.

Independent Consultant
Westminster, MA

Renata J. Henry, M.Ed.

Director
Division of Alcoholism, Drug Abuse and
Mental Health
Delaware Department of Health and Social
Services
New Castle, DE

Joel Hochberg, M.A.

President
Asher & Partners
Los Angeles, CA

Jack Hollis, Ph.D.

Associate Director
Center for Health Research
Kaiser Permanente
Portland, OR

Mary Beth Johnson, M.S.W.

Director
Addiction Technology Transfer Center
University of Missouri—Kansas City
Kansas City, MO

Eduardo Lopez, B.S.

Executive Producer
EVS Communications
Washington, DC

Holly A. Massett, Ph.D.

Academy for Educational Development
Washington, DC

Diane Miller, Ph.D.

Chief
Scientific Communications Branch
National Institute on Alcohol Abuse
and Alcoholism
National Institutes of Health
Bethesda, MD

Harry B. Montoya, M.A.

President/Chief Executive Officer
Hands Across Cultures
Española, NM

Richard K. Ries, M.D.

Director/Professor
Outpatient Mental Health Services
Dual Disorder Programs
Seattle, WA

Gloria M. Rodriguez, D.S.W.

Research Scientist
Division of Addiction Services
New Jersey Department of Health and Senior
Services
Trenton, NJ

Everett Rogers, Ph.D.

Center for Communications Programs
Johns Hopkins University
Baltimore, MD

Jean R. Slutsky, P.A., M.S.P.H.

Director
Center for Outcomes and Evidence
Agency for Healthcare Research and Quality
Rockville, MD

Nedra Klein Weinreich, M.S.

President
Weinreich Communications
Canoga Park, CA

Clarissa Wittenberg

Director
Office of Communications and
Public Liaison
National Institute of Mental Health
National Institutes of Health
Bethesda, MD

**Consulting Members of the KAP
Expert Panel**

Paul Purnell, M.A.

Social Solutions, L.L.C.
Potomac, MD

Scott Ratzan, M.D., M.P.A., M.A.

Academy for Educational Development
Washington, DC

Thomas W. Valente, Ph.D.

Director, Master of Public Health Program
Department of Preventive Medicine
School of Medicine
University of Southern California
Alhambra, CA

Patricia A. Wright, Ed.D.

Independent Consultant
Baltimore, MD

3 Culturally Responsive Evaluation and Treatment Planning

IN THIS CHAPTER

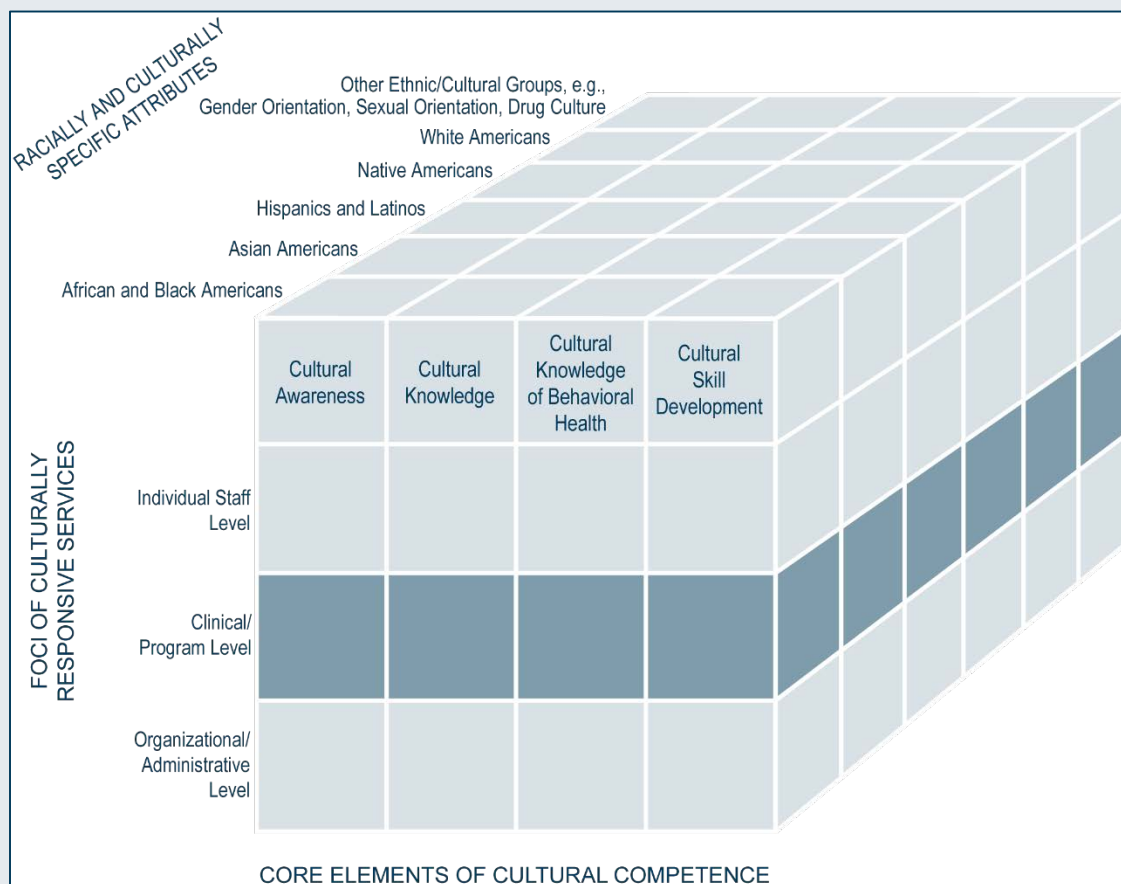
- Step 1: Engage Clients
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- Step 7: Determine Readiness and Motivation for Change
- Step 8: Provide Culturally Responsive Case Management
- Step 9: Incorporate Cultural Factors Into Treatment Planning

Zhang Min, a 25-year-old first-generation Chinese woman, was referred to a counselor by her primary care physician because she reported having episodes of depression. The counselor who conducted the intake interview had received training in cultural competence and was mindful of cultural factors in evaluating Zhang Min. The referral noted that Zhang Min was born in Hong Kong, so the therapist expected her to be hesitant to discuss her problems, given the prejudices attached to mental illness and substance abuse in Chinese culture. During the evaluation, however, the therapist was surprised to find that Zhang Min was quite forthcoming. She mentioned missing important deadlines at work and calling in sick at least once a week, and she noted that her coworkers had expressed concern after finding a bottle of wine in her desk. She admitted that she had been drinking heavily, which she linked to work stress and recent discord with her Irish American spouse.

Further inquiry revealed that Zhang Min's parents, both Chinese, went to school in England and sent her to a British school in Hong Kong. She grew up close to the British expatriate community, and her mother was a nurse with the British Army. Zhang Min came to the United States at the age of 8 and grew up in an Irish American neighborhood. She stated that she knew more about Irish culture than about Chinese culture. She felt, with the exception of her physical features, that she was more Irish than Chinese—a view accepted by many of her Irish American friends. Most men she had dated were Irish Americans, and she socialized in groups in which alcohol consumption was not only accepted but expected.

Zhang Min first started to drink in high school with her friends. The counselor realized that what she had learned about Asian

Multidimensional Model for Developing Cultural Competence: Clinical/Program Level



Americans was not necessarily applicable to Zhang Min and that knowledge of Zhang Min's entire history was necessary to appreciate the influence of culture in her life. The counselor thus developed treatment strategies more suitable to Zhang Min's background.

Zhang Min's case demonstrates why thorough evaluation, including assessment of the client's sociocultural background, is essential for treatment planning. To provide culturally responsive evaluation and treatment planning, counselors and programs must understand and incorporate relevant cultural factors into the process while avoiding a stereotypical or "one-size-fits-all" approach to treatment. Cultural responsiveness

in planning and evaluation entails being open minded, asking the right questions, selecting appropriate screening and assessment instruments, and choosing effective treatment providers and modalities for each client. Moreover, it involves identifying culturally relevant concerns and issues that should be addressed to improve the client's recovery process.

This chapter offers clinical staff guidance in providing and facilitating culturally responsive interviews, assessments, evaluations, and treatment planning. Using Sue's (2001) multidimensional model for developing cultural competence, this chapter focuses on clinical and programmatic decisions and skills that are

important in evaluation and treatment planning processes. The chapter is organized around nine steps to be incorporated by clinicians, supported in clinical supervision, and endorsed by administrators.

Step 1: Engage Clients

Once clients are in contact with a treatment program, they stand on the far side of a yet-to-be-established therapeutic relationship. It is up to counselors and other staff members to bridge the gap. Handshakes, facial expressions, greetings, and small talk are simple gestures that establish a first impression and begin building the therapeutic relationship. Involving one's whole being in a greeting—thought, body, attitude, and spirit—is most engaging.

Fifty percent of racially and ethnically diverse clients end treatment or counseling after one visit with a mental health practitioner (Sue and Sue 2013e). At the outset of treatment, clients can feel scared, vulnerable, and uncertain about whether treatment will really help. The initial meeting is often the first encounter clients have with the treatment system, so it is vital that they leave feeling hopeful and understood. Paniagua (1998) describes how, if a counselor lacks sensitivity and jumps to premature conclusions, the first visit can become the last:

Pretend that you are a Puerto Rican taxi driver in New York City, and at 3:00 p.m. on a hot summer day you realize that you have your first appointment with the therapist...later, you learned that the therapist made a note that you were probably depressed or psychotic because you dressed carelessly and had dirty nails and hands...would you return for a second appointment? (p. 120)

To engage the client, the counselor should try to establish rapport before launching into a series of questions. Paniagua (1998) suggests that counselors should draw attention to the presenting problem “without giving the impression that too much information is needed

Improving Cross-Cultural Communication

Health disparities have multiple causes. One specific influence is cross-cultural communication between the counselor and the client. Weiss (2007) recommends these six steps to improve communication with clients:

1. Slow down.
2. Use plain, nonpsychiatric language.
3. Show or draw pictures.
4. Limit the amount of information provided at one time.
5. Use the “teach-back” method. Ask the client, in a nonthreatening way, to explain or show what he or she has been told.
6. Create a shame-free environment that encourages questions and participation.

to understand the problem” (p. 18). It is also important that the client feel engaged with any interpreter used in the intake process. A common framework used in many healthcare training programs to highlight culturally responsive interview behaviors is the LEARN model (Berlin and Fowkes 1983). The how-to box on the next page presents this model.

Step 2: Familiarize Clients and Their Families With Treatment and Evaluation Processes

Behavioral health treatment facilities maintain their own culture (i.e., the treatment milieu). Counselors, clinical supervisors, and agency administrators can easily become accustomed to this culture and assume that clients are used to it as well. However, clients are typically new to treatment language or jargon, program expectations and schedules, and the intake and treatment process. Unfortunately, clients from diverse racial and ethnic groups can feel more estranged and disconnected from treatment services when staff members fail to educate them and their families about treatment expectations or when the clients are not walked

How To Use the LEARN Mnemonic for Intake Interviews

Listen to each client from his or her cultural perspective. Avoid interrupting or posing questions before the client finishes talking; instead, find creative ways to redirect dialog (or explain session limitations if time is short). Take time to learn the client's perception of his or her problems, concerns about presenting problems and treatment, and preferences for treatment and healing practices.

Explain the overall purpose of the interview and intake process. Walk through the general agenda for the initial session and discuss the reasons for asking about personal information. Remember that the client's needs come before the set agenda for the interview; don't cover every intake question at the expense of taking time (usually brief) to address questions and concerns expressed by the client.

Acknowledge client concerns and discuss the probable differences between you and your clients. Take time to understand each client's explanatory model of illness and health. Recognize, when appropriate, the client's healing beliefs and practices and explore ways to incorporate these into the treatment plan.

Recommend a course of action through collaboration with the client. The client must know the importance of his or her participation in the treatment planning process. With client assistance, client beliefs and traditions can serve as a framework for healing in treatment. However, not all clients have the same expectations of treatment involvement; some see the counselor as the expert, desire a directive approach, and have little desire to participate in developing the treatment plan themselves.

Negotiate a treatment plan that weaves the client's cultural norms and lifeways into treatment goals, objectives, and steps. Once the treatment plan and modality are established and implemented, encourage regular dialog to gain feedback and assess treatment satisfaction. Respecting the client's culture and encouraging communication throughout the process increases client willing to engage in treatment and to adhere to the treatment plan and continuing care recommendations.

Sources: Berlin and Fowkes 1983; Dreachslin et al. 2013; Ring 2008.

through the treatment process, starting with the goals of the initial intake and interview. By taking the time to acclimate clients and their families to the treatment process, counselors and other behavioral health staff members tackle one obstacle that could further impede treatment engagement and retention among racially and ethnically diverse clients.

Step 3: Endorse Collaboration in Interviews, Assessments, and Treatment Planning

Most clients are unfamiliar with the evaluation and treatment planning process and how they can participate in it. Some clients may view the initial interview and evaluation as

intrusive if too much information is requested or if the content is a source of family dishonor or shame. Other clients may resist or distrust the process based on a long history of racism and oppression. Still others feel inhibited from actively participating because they view the counselor as the authority or sole expert.

The counselor can help decrease the influence of these issues in the interview process through a collaborative approach that allows time to discuss the expectations of both counselor and client; to explain interview, intake, and treatment planning processes; and to establish ways for the client to seek clarification of his or her assessment results (Mohatt et al. 2008a). The counselor can encourage collaboration by emphasizing the importance of clients' input and interpretations. Client feedback is integral in interpreting results and

can identify cultural issues that may affect intake and evaluation (Acevedo-Polakovich et al. 2007). Collaboration should extend to client preferences and desires regarding inclusion of family and community members in evaluation and treatment planning.

Step 4: Integrate Culturally Relevant Information and Themes

By exploring culturally relevant themes, counselors can more fully understand their clients and identify their cultural strengths and challenges. For example, a Korean woman's family may serve as a source of support and provide a sense of identity. At the same time, however, her family could be ashamed of her co-occurring generalized anxiety and substance use disorders and respond to her treatment as a source of further shame because it encourages her to disclose personal matters to people outside the family. The following section provides a brief overview of suggested strength-based topics to incorporate into the intake and evaluation process.

Immigration History

Immigration history can shed light on client support systems and identify possible isolation or alienation. Some immigrants who live in ethnic enclaves have many sources of social support and resources. By contrast, others may be isolated, living apart from family, friends, and the support systems extant in their countries of origin. Culturally competent evaluation should always include questions about the client's country of origin, immigration status, length of time in the United States, and connections to his or her country of origin. Ask American-born clients about their parents' country of origin, the language(s) spoken at home, and affiliation with their parents' culture(s). Questions like these give the counselor

Advice to Counselors: Conducting Strength-Based Interviews

By nature, initial interviews and evaluations can overemphasize presenting problems and concerns while underplaying client strengths and supports. This list, although not exhaustive, reminds clinicians to acknowledge client strengths and supports from the outset.

Strengths and supports:

- Pride and participation in one's culture
- Social skills, traditions, knowledge, and practical skills specific to the client's culture
- Bilingual or multilingual skills
- Traditional, religious, or spiritual practices, beliefs, and faith
- Generational wisdom
- Extended families and nonblood kinships
- Ability to maintain cultural heritage and practices
- Perseverance in coping with racism and oppression
- Culturally specific ways of coping
- Community involvement and support

Source: Hays 2008.

important clues about the client's degree of acculturation in early life and at present, cultural identity, ties to culture of origin, potential cultural conflicts, and resources. Specific questions should elicit information about:

- Length of time in the United States, noting when immigration occurred or the number of generations who have resided in the United States.
- Frequency of returns and psychological and personal ties to the country of origin.
- Primary language and level of English proficiency in speaking and writing.
- Psychological reactions to immigration and adjustments made in the process.
- Changes in social status and other areas as a result of coming to this country.
- Major differences in attitudes toward alcohol and drug use from the time of immigration to now.

Cultural Identity and Acculturation

As shown in Zhang Min's case at the beginning of this chapter, cultural identity is a unique feature of each client. Counselors should guard against making assumptions about client identity based on general ethnic and racial identification by evaluating the degree to which an individual identifies with his or her culture(s) of origin. As Castro and colleagues (1999b) explain, "for each group, the level of within-group variability can be assessed using a core dimension that ranges from high cultural involvement and acceptance of the traditional culture's values to low or no cultural involvement" (p. 515). For African Americans, for example, this dimension is called "Afrocentricity." Scales for Afrocentricity have been developed in an attempt to provide an indicator of an individual's level of involvement within the traditional or core African-oriented culture (Baldwin and Bell 1985; Cokley and Williams 2005; Klonoff and Landrine 2000). Many other instruments based on models of identity evaluate acculturation and identity. A detailed discussion of the theory behind such models is beyond the scope of this Treatment Improvement Protocol (TIP); however, counselors should have a general understanding of what is being measured when administering such instruments. The "Asking About Culture and Acculturation" advice box at right addresses exploration of culture and acculturation with clients. For more information on instruments that measure acculturation and/or identity, see Appendix B.

Other areas to explore include the cross-cutting factors outlined in Chapter 1, such as socioeconomic status (SES), occupation, education, gender, and other variables that can distinguish an individual from others who share his or her cultural identity. For example, a biracial client could identify with African

Advice to Counselors: Asking About Culture and Acculturation

A thoughtful exploration of cultural and ethnic identity issues will provide clues for determining cultural, racial, and ethnic identity. There are numerous clues that you may derive from your clients' answers, and they cannot all be covered in this TIP; this is only one set of sample questions (Fontes 2008). Ask these questions tactfully so they do not sound like an interrogation. Try to integrate them naturally into a conversation rather than asking one after another. Not all questions are relevant in all settings. Counselors can adapt wording to suit clients' cultural contexts and styles of communication, because the questions listed here and throughout this chapter are only examples:

- Where were you born?
- Whom do you consider family?
- What was the first language you learned?
- Which other language(s) do you speak?
- What language or languages are spoken in your home?
- What is your religion? How observant are you in practicing that religion?
- What activities do you enjoy when you are not working?
- How do you identify yourself culturally?
- What aspects of being _____ are most important to you? (Use the same term for the identified culture as the client.)
- How would you describe your home and neighborhood?
- Whom do you usually turn to for help when facing a problem?
- What are your goals for this interview?

American culture, White American culture, or both. When a client has two or more racial/ethnic identities, counselors should assess how the client self-identifies and how he or she negotiates the different worlds.

Membership in a Subculture

Clients often identify initially with broader racial, ethnic, and cultural groups. However, each person has a unique history that warrants an understanding of how culture is practiced and has evolved for the person and his or her

family; accordingly, counselors should avoid generalizations or assumptions. Clients are often part of a culture within a culture. There is not just one Latino, African American, or Native American culture; many variables influence culture and cultural identity (see the “What Are the Cross-Cutting Factors in Race, Ethnicity, and Culture” section in Chapter 1). For example, an African American client from East Carroll Parish, LA, might describe his or her culture quite differently than an African American from downtown Hartford, CT.

Beliefs About Health, Healing, Help-Seeking, and Substance Use

Just as culture shapes an individual’s sense of identity, it also shapes attitudes surrounding health practices and substance use. Cultural acceptance of a behavior, for instance, can mask a problem or deter a person from seeking treatment. Counselors should be aware of how the client’s culture conceptualizes issues related to health, healing and treatment practices, and the use of substances. For example, in cases where alcohol use is discouraged or frowned upon in the community, the client can experience tremendous shame about drinking. Chapter 5 reviews health-related beliefs and practices that can affect help-seeking behavior across diverse populations.

Trauma and Loss

Some immigrant subcultures have experienced violent upheavals and have a higher incidence of trauma than others. The theme of trauma and loss should therefore be incorporated into general intake questions. Specific issues under this general theme might include:

- Migration, relocation, and emigration history—which considers separation from homeland, family, and friends—and the stressors and loss of social support that can accompany these transitions.

Advice to Counselors: Eliciting Client Views on Presenting Problems

Some clients do not see their presenting physical, psychological, and/or behavioral difficulties as problems. Instead, they may view their presenting difficulties as the result of stress or another issue, thus defining or labeling the presenting problem as something other than a physical or mental disorder. In such cases, word the following questions using the clients’ terminology rather than using the word “problem.” These questions help explore how clients view their behavioral health concerns:

- I know that clients and counselors sometimes have different ideas about illness and diseases, so can you tell me more about your idea of your problem?
- Do you consider your use of alcohol and/or drugs a problem?
- How do you label your problem? Do you think it is a serious problem?
- What do you think caused your problem?
- Why do you think it started when it did?
- What is going on in your body as a result of this problem?
- How has this problem affected your life?
- What frightens or concerns you most about this problem and its treatment?
- How is your problem viewed in your family? Is it acceptable?
- How is your problem viewed in your community? Is it acceptable? Is it considered a disease?
- Do you know others who have had this problem? How did they treat the problem?
- How does your problem affect your stature in the community?
- What kinds of treatment do you think will help or heal you?
- How have you treated your drug and/or alcohol problem or emotional distress?
- What has been your experience with treatment programs?

Sources: Lynch and Hanson 2011; Tang and Bigby 1996; Taylor 2002.

- Clients’ personal or familial experiences with American Indian boarding schools.
- Experiences with genocide, persecution, torture, war, and starvation.

How To Use a Multicultural Intake Checklist

Some clients do not see their presenting physical, psychological, and/or behavioral difficulties as problems. Instead, they may view their presenting difficulties as the result of stress or another issue, thus defining or labeling the presenting problem as something other than a physical or mental disorder. In such cases, word questions about the following topics using the client's terminology, rather than using the word "problem." Asking questions about the following topics can help you explore how a client may view his or her behavioral health concerns:

- | | |
|--|--|
| <input type="checkbox"/> Immigration history | <input type="checkbox"/> Sexual and gender orientation |
| <input type="checkbox"/> Relocations (current migration patterns) | <input type="checkbox"/> Health concerns |
| <input type="checkbox"/> Losses associated with immigration and relocation history | <input type="checkbox"/> Traditional healing practices |
| <input type="checkbox"/> English language fluency | <input type="checkbox"/> Help-seeking patterns |
| <input type="checkbox"/> Bilingual or multilingual fluency | <input type="checkbox"/> Beliefs about wellness |
| <input type="checkbox"/> Individualistic/collectivistic orientation | <input type="checkbox"/> Beliefs about mental illness and mental health treatment |
| <input type="checkbox"/> Racial, ethnic, and cultural identities | <input type="checkbox"/> Beliefs about substance use, abuse, and dependence |
| <input type="checkbox"/> Tribal affiliation, if appropriate | <input type="checkbox"/> Beliefs about substance abuse treatment |
| <input type="checkbox"/> Geographic location | <input type="checkbox"/> Family views on substance use and substance abuse treatment |
| <input type="checkbox"/> Family and extended family concerns (including nonblood kinships) | <input type="checkbox"/> Treatment concerns related to cultural differences |
| <input type="checkbox"/> Acculturation level (e.g., traditional, bicultural) | <input type="checkbox"/> Cultural approaches to healing or treatment of substance use and mental disorders |
| <input type="checkbox"/> Acculturation stress | <input type="checkbox"/> Education history and concerns |
| <input type="checkbox"/> History of discrimination/racism | <input type="checkbox"/> Work history and concerns |
| <input type="checkbox"/> Trauma history | <input type="checkbox"/> SES and financial concerns |
| <input type="checkbox"/> Historical trauma | <input type="checkbox"/> Cultural group affiliation |
| <input type="checkbox"/> Intergenerational family history and concerns | <input type="checkbox"/> Current network of support |
| <input type="checkbox"/> Gender roles and expectations | <input type="checkbox"/> Community concerns |
| <input type="checkbox"/> Birth order roles and expectations | <input type="checkbox"/> Review of confidentiality parameters and concerns |
| <input type="checkbox"/> Relationship and dating concerns | <input type="checkbox"/> Cultural concepts of distress (DSM-5*) |
| | <input type="checkbox"/> DSM-5 culturally related V-codes |

**Diagnostic and Statistical Manual of Mental Disorders*, Fifth Edition (American Psychiatric Association [APA] 2013).

Sources: Comas-Diaz 2012; Constantine and Sue 2005; Sussman 2004.

Step 5: Gather Culturally Relevant Collateral Information

A client who needs behavioral health treatment services may be unwilling or unable to provide a full personal history from his or her

own perspective and may not recall certain events or be aware of how his or her behavior affects his or her well-being and that of others. Collateral information—supplemental information obtained with the client's permission from sources other than the client—can be derived from family members, medical and court records, probation and parole officers,

community members, and others. Collateral information should include culturally relevant information obtained from the family, such as the organizational memberships, beliefs, and practices that shape the client's cultural identity and understanding of the world.

As families can be a vital source of information, counselors are likely to attain more support by engaging families earlier in the treatment process. Although counselor interactions with family members are often limited to a few formal sessions, the families of racially and ethnically diverse clients tend to play a more significant and influential role in clients' participation in treatment. Consequently, special sensitivity to the cultural background of family members providing collateral information is essential. Families, like clients, cannot be easily defined in terms of a generic cultural identity (Congress 2004; Taylor et al. 2012). Even families from the same racial background or ethnic heritage can be quite dissimilar, thus requiring a multidimensional approach in understanding the role of culture in the lives of clients and their families. Using the culturagram tool on the next page in preparation for counseling, treatment planning, or clinical supervision, clinicians can learn about the unique attributes and histories that influence clients' lives in a cultural context.

Step 6: Select Culturally Appropriate Screening and Assessment Tools

Discussions of the complexities of psychological testing, the interpretation of assessment measures, and the appropriateness of screening procedures are outside the scope of this TIP. However, counselors and other clinical service providers should be able to use assessment and screening information in culturally competent ways. This section discusses several

instruments and their appropriateness for specific cultural groups. Counselors should continue to explore the availability of mental health and substance abuse screening and assessment tools that have been translated into or adapted for other languages.

Culturally Appropriate Screening Devices

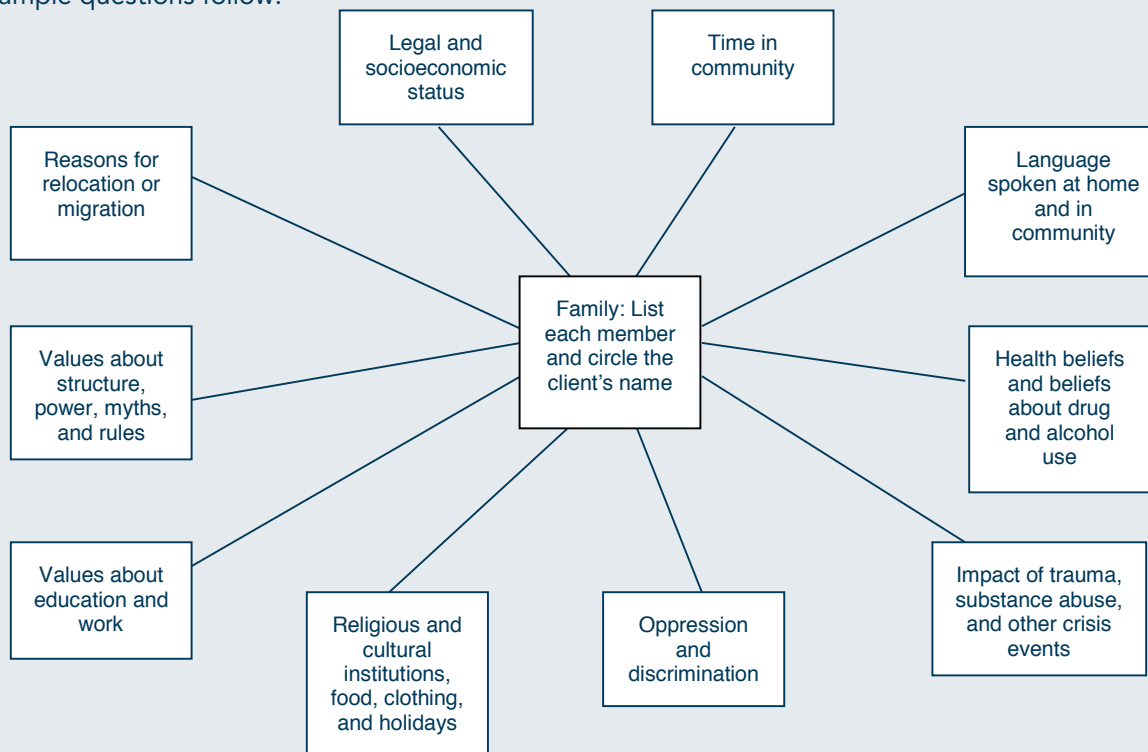
The consensus panel does not recommend any specific instruments for screening or assessing mental or substance use disorders. Rather, when selecting instruments, practitioners should consider their cultural applicability to the client being served (AACE 2012; Jome and Moody 2002). For example, a screening instrument that asks the respondent about his or her guilt about drinking could be ineffective for members of cultural, ethnic, or religious groups that prohibit any consumption of alcohol. Al-Ansari and Negrete's (1990) research supports this point. They found that the Short Michigan Alcoholism Screening Test was highly sensitive with people who use alcohol in a traditional Arab Muslim society; however, one question—"Do you ever feel guilty about your drinking?"—failed to distinguish between people with alcohol dependency disorders in treatment and people who drank in the community. Questions designed to measure conflict that results from the use of alcohol can skew test results for participants from cultures that expect complete abstinence from alcohol and/or drugs. Appendix D summarizes instruments tested on specific populations (e.g., availability of normative data for the population being served).

Culturally Valid Clinical Scales

As the literature consistently demonstrates, co-occurring mental disorders are common in people who have substance use disorders. Although an assessment of psychological problems helps match clients to appropriate

How To Use a Culturagram for Mapping the Role of Culture

The culturagram is an assessment tool that helps clinicians understand culturally diverse clients and their families (Congress 1994, 2004; Congress and Kung 2005). It examines 10 areas of inquiry, which should include not only questions specific to clients' life experiences, but also questions specific to their family histories. This diagram can guide an interview, counseling, or clinical supervision session to elicit culturally relevant multigenerational information unique to the client and the client's family. Give a copy of the diagram to the client or family for use as an interactive tool in the session. Throughout the interview, the client, family members, and/or the counselor can write brief responses in each box to highlight the unique attributes of the client's history in the family context. This diagram has been adapted for clients with co-occurring mental and substance use disorders; sample questions follow.



Values about family structure, power, myths, and rules:

- Are there specific gender roles and expectations in your family?
- Who holds the power within the family?
- Are family needs more important than, or equally as important as, individual needs?
- Whom do you consider family?

Reasons for relocation or migration:

- Are you and your family able to return home?
- What were your reasons for coming to the United States?
- How do you now view the initial reasons for relocation?
- What feelings do you have about relocation or migration?
- Do you move back and forth from one location to another?
- How often do you and your family return to your homeland?
- Are you living apart from your family?

Legal status and SES:

- Has your SES improved or worsened since coming to this country?
- Has there been a change in socioeconomic status across generations?

(Continued on the next page.)

How To Use a Culturagram for Mapping the Role of Culture (continued)

- What is the family history of documentation? (Note: Clients often need to develop trust before discussing legal status; they may come from a place where confidentiality is unfamiliar.)

Time in the community:

- How long have you and your family members been in the country? Community?
- Are you and your family actively involved in a culturally based community?

Languages spoken in and outside the home:

- What languages are spoken at home and in the community?
- What is your and your family's level of proficiency in each language?
- How dependent are parents and grandparents on their children for negotiating activities surrounding the use of English? Have children become the family interpreters?

Health beliefs and beliefs about help-seeking:

- What are the family beliefs about drug and alcohol use? Mental illness? Treatment?
- Do you and your family uphold traditional healing practices?
- How do help-seeking behaviors differ across generations and genders in your family?
- How do you and your family define illness and wellness?
- Are there any objections to the use of Western medicine?

Impact of trauma and other crisis events:

- How has trauma affected your family across generations?
- How have traumas or other crises affected you and/or your family?
- Has there been a specific family crisis?
- Did the family experience traumatic events prior to migration—war, other forms of violence, displacement including refugee camps, or similar experiences?

Oppression and discrimination:

- Is there a history of oppression and discrimination in your homeland?
- How have you and your family experienced discrimination since immigration?

Religious and cultural institutions, food, clothing, and holidays:

- Are there specific religious holidays that your family observes?
- What holidays do you celebrate?
- Are there specific foods that are important to you?
- Does clothing play a significant cultural or religious role for you?
- Do you belong to a cultural or social club or organization?

Values about education and work:

- How much importance do you place on work, family, and education?
- What are the educational expectations for children within the family?
- Has your work status changed (e.g., level of responsibility, prestige, and power) since migration?
- Do you or does anyone in your family work several jobs?

Sources: Comas-Diaz 2012; Congress 1994, 2004; Singer 2007.

treatment, clinicians are cautioned to proceed carefully. People who are abusing substances or experiencing withdrawal from substances can exhibit behaviors and thinking patterns consistent with mental illness. After a period of abstinence, symptoms that mimic mental illness can disappear. Moreover, clinical instruments are imperfect measurements of

equally imperfect psychological constructs that were created to organize and understand clinical patterns and thus better treat them; they do not provide absolute answers. As research and science evolve, so does our understanding of mental illness (Benuto 2012). Assessment tools are generally developed for particular populations and can be inapplicable

to diverse populations (Blume et al. 2005; Suzuki and Ponterotto 2008). Appendix D summarizes research on the clinical utility of instruments for screening and assessing co-occurring disorders in various cultural groups.

Diagnosis

Counselors should consider clients' cultural backgrounds when evaluating and assessing mental and substance use disorders (Bhugra and Gupta 2010). Concerns surrounding diagnoses of mental and substance use disorders (and the cross-cultural applicability of those diagnoses) include the appropriateness of specific test items or questions, diagnostic criteria, and psychologically oriented concepts (Alarcon 2009; Room 2006). Research into specific techniques that address cultural differences in evaluative and diagnostic processes so far remains limited and underrepresentative of diverse populations (Guindon and Sobhany 2001; Martinez 2009).

Does the DSM-5 accurately diagnose mental and substance use disorders among immigrants and other ethnic groups? Caetano and

Shafer (1996) found that diagnostic criteria seemed to identify alcohol dependency consistently across race and ethnicity, but their sample was limited to African Americans, Latinos, and Whites. Other research has shown mixed results.

In 1972, the World Health Organization (WHO) and the National Institutes of Health (NIH) embarked on a joint study to test the cross-cultural applicability of classification systems for various diagnoses, including substance use disorders. WHO and NIH identified factors that appeared to be universal aspects of mental and substance use disorders and then developed instruments to measure them. These instruments, the Composite International Diagnostic Interview (CIDI) and the Schedules for Clinical Assessment in Neuropsychiatry (SCAN), include some DSM and International Statistical Classification of Diseases and Related Health Problems criteria. Studies report that both the CIDI and SCAN were generally accurate, but the investigators urge caution in translation and interview procedures (Room et al. 2003).

Advice to Counselors and Clinical Supervisors: Culturally Responsive Screening and Assessment

- Assess the client's primary language and language proficiency prior to the administration of any evaluation or use of testing instruments.
- Determine whether the assessment materials were translated using specific terms, including idioms that correspond to the client's literacy level, culture, and language. Do not assume that translation into a stated language exactly matches the specific language of the client. Specifically, the client may not understand the translated language if it does not match his or her ways of thinking or speaking
- Educate the client on the purpose of the assessment and its application to the development of the treatment plan. Remember that testing can generate many emotional reactions.
- Know how the test was developed. Is normative data available for the population being served? Test results can be inflated, underestimated, or inaccurate due to differences within the client's population.
- Consider the role of acculturation in testing, including the influence of the client's worldview in responses. Unfamiliarity with mainstream United States culture can affect interpretation of questions, the client-evaluator relationship, and behavior, including participation level during evaluation and verbal and behavioral responses.

Sources: Association for Assessment in Counseling and Education (AACE) 2012; Saldaña 2001.

Overall, psychological concepts that are appropriate for and easily translated by some groups are inappropriate for others. In some Asian cultures, for example, feeling refers more to a physical than an emotive state; questions designed to infer emotional states are not easily translated. In most cases, these issues can be remedied by using culture-specific resources, measurements, and references while also adopting a cultural formulation in the interviewing process (see Appendix E for the APA's cultural formulation outline). The DSM-5 lists several cultural concepts of distress (see Appendix E), yet there is little empirical literature providing data or treatment guidance on using the APA's cultural formulation or addressing cultural concepts of distress (Martinez 2009; Mezzich et al. 2009).

Step 7: Determine Readiness and Motivation for Change

Clients enter treatment programs at different levels of readiness for change. Even clients who present voluntarily could have been pushed into it by external pressures to accept treatment before reaching the action stage. These different readiness levels require different approaches. The strategies involved in motivational interviewing can help counselors prepare culturally diverse clients to change their behavior and keep them engaged in treatment. To understand motivational interviewing, it is first necessary to examine the process of change that is involved in recovery. See TIP 35, *Enhancing Motivation for Change in Substance Abuse Treatment* (Center for Substance Abuse Treatment [CSAT] 1999b), for more information on this technique.

Stages of Change

Prochaska and DiClemente's (1984) classic transtheoretical model of change is applicable

to culturally diverse populations. This model divides the change process into several stages:

- *Precontemplation.* The individual does not see a need to change. For example, a person at this stage who abuses substances does not see any need to alter use, denies that there is a problem, or blames the problem on other people or circumstances.
- *Contemplation.* The person becomes aware of a problem but is ambivalent about the course of action. For instance, a person struggling with depression recognizes that the depression has affected his or her life and thinks about getting help but remains ambivalent on how he/she may do this.
- *Preparation.* The individual has determined that the consequences of his or her behavior are too great and that change is necessary. Preparation includes small steps toward making specific changes, such as when a person who is overweight begins reading about wellness and weight management. The client still engages in poor health behaviors but may be altering some behaviors or planning to follow a diet.
- *Action.* The individual has a specific plan for change and begins to pursue it. In relation to substance abuse, the client may make an appointment for a drug and alcohol assessment prior to becoming abstinent from alcohol and drugs.
- *Maintenance.* The person continues to engage in behaviors that support his or her decision. For example, an individual with bipolar I disorder follows a daily relapse prevention plan that helps him or her assess warning signs of a manic episode and reminds him or her of the importance of engaging in help-seeking behaviors to minimize the severity of an episode.

Progress through the stages is nonlinear, with movement back and forth among the stages at different rates. It is important to recognize that change is not a one-time process, but

rather, a series of trials and errors that eventually translates to successful change. For example, people who are dependent on substances often attempt to abstain several times before they are able to acquire long-term abstinence.

Motivational Interviewing

Motivational interventions assess a person's stage of change and use techniques likely to move the person forward in the sequence. Miller and Rollnick (2002) developed a therapeutic style called motivational interviewing, which is characterized by the strategic therapeutic activities of expressing empathy, developing discrepancy, avoiding argument, rolling with resistance, and supporting self-efficacy. The counselor's major tool is reflective listening and soliciting change talk (CSAT 1999c).

This nonconfrontational, client-centered approach to treatment differs significantly from traditional treatments in several ways, creating a more welcoming relationship. TIP 35 (CSAT 1999c) assesses Project MATCH and other clinical trials, concluding that the evidence strongly supports the use of motivational interviewing with a wide variety of cultural and ethnic groups (Miller and Rollnick 2013; Miller et al. 2008). TIP 35 is a good motivational interviewing resource. For specific application of motivational interviewing with Native Americans, see Venner and colleagues (2006). For improvement of treatment compliance among Latinos with depression through motivational interviewing, see Interian and colleagues (2010).

Step 8: Provide Culturally Responsive Case Management

Clients from various racial, ethnic, and cultural populations seeking behavioral health services may face additional obstacles that can

interfere with or prevent access to treatment and ancillary services, compromise appropriate referrals, impede compliance with treatment recommendations, and produce poorer treatment outcomes. Obstacles may include immigration status, lower SES, language barriers, cultural differences, and lack of or poor coverage with health insurance.

Case management provides a single professional contact through which clients gain access to a range of services. The goal is to help assess the need for and coordinate social, health, and other essential services for each client. Case management can be an immense help during treatment and recovery for a person with limited English literacy and knowledge of the treatment system. Case management focuses on the needs of individual clients and their families and anticipates how those needs will be affected as treatment proceeds. The case manager advocates for the client (CSAT 1998a; Summers 2012), easing the way to effective treatment by assisting the client with critical aspects of life (e.g., food, childcare, employment, housing, legal problems). Like counselors, case managers should possess self-knowledge and basic knowledge of other cultures, traits conducive to working well with diverse groups, and the ability to apply cultural competence in practical ways.

Cultural competence begins with self-knowledge; counselors and case managers should be aware of and responsive to how their culture shapes attitudes and beliefs.

This understanding will broaden as they gain knowledge and direct experience with the cultural groups of their client population, enabling them to better frame client issues and interact with clients in culturally specific and appropriate ways. TIP 27, *Comprehensive Case Management for Substance Abuse Treatment* (CSAT 1998a), offers more information on effective case management.

Exhibit 3-1 discusses the cultural matching of counselors with clients. When counselors cannot provide culturally or linguistically competent services, they must know when and how to bring in an interpreter or to seek other assistance (CSAT 1998a). Case management includes finding an interpreter who communicates well in the client's language and dialect and who is familiar with the vocabulary required to communicate effectively about sensitive subject matter. The case manager works within the system to ensure that the interpreter, when needed, can be compensated. Case managers should also have a list of appropriate referrals to meet assorted needs. For example, an immigrant who does not speak English may need legal services in his or her language; an undocumented worker may need to know where to go for medical assistance. Culturally competent case managers build and maintain rich referral resources for their clients.

The Case Management Society of America's *Standards of Practice for Case Management* (2010) state that case management is central in meeting client needs throughout the course of treatment. The standards stress understanding relevant cultural information and communicating effectively by respecting and being responsive to clients and their cultural contexts. For standards that are also applicable to case management, refer to the National Association of Social Workers' *Standards on Cultural Competence in Social Work Practice* (2001).

Step 9: Incorporate Cultural Factors Into Treatment Planning

The cultural adaptation of treatment practices is a burgeoning area of interest, yet research is limited regarding the process and outcome of culturally responsive treatment planning in behavioral health treatment services for

Exhibit 3-1: Client–Counselor Matching

The literature is inconclusive about the value of client–counselor matching based on race, ethnicity, or culture (Imel et al. 2011; Larrison et al. 2011; Suarez-Morales et al. 2010). Sue et al. (1991) found that for people whose primary language was not English, counselor–client matching for ethnicity and language predicted longer time in treatment (more sessions) with better outcomes for all ethnic groups studied: Asian Americans, African Americans, Mexican Americans, and White Americans.

Ethnic matches may work better for Latinos in treatment; gender congruence seems more important than race or ethnicity in client–counselor matching, particularly for female clients (Sue and Sue 2013a). For Asian Americans and Pacific Islanders, the many different ethnic subgroups make a cultural match more difficult. In multicultural communities, racial and ethnic matching may help develop a working alliance between the therapist and the consumer (Chao et al. 2012). Other relevant variables of both the client and therapist are age, marital status, training, language, and parental status. The extent to which a cultural match is necessary in therapy depends on client preferences, characteristics, presenting problems, and treatment needs. For example, gender matching could be more important than race/ethnicity matching to female sexual abuse survivors, who may have difficulty discussing their trauma with male counselors.

Most clients want to know that their counselors understands their worldviews, even if they do not share them. Counselors' understanding of their clients' cultures improves treatment outcomes (Suarez-Morales et al. 2010). Fiorentine and Hillhouse (1999) found that empathy, regardless of race or ethnicity of counselor and client, was the most important predictor of favorable treatment outcomes. Sue et al. (1991) found that clients using outpatient mental health services more readily attended treatment and stayed longer if services were culturally responsive. In the treatment planning process, matching clients with providers according to cultural (and subcultural, when warranted) backgrounds can help provide treatment that is responsive to the personal, cultural, and clinical needs of clients (Fontes 2008).

diverse populations. How do counselors and organizations respond culturally to the diverse needs of clients in the treatment planning process? How effective are culturally adaptive treatment goals? (For a review, see Bernal and Domenech Rodriguez 2012.) Typically, programs that provide culturally responsive services approach treatment goals holistically, including objectives to improve physical health and spiritual strength (Howard 2003). Newer approaches stress implementation of strength-based strategies that fortify cultural heritage, identity, and resiliency.

Treatment planning is a dynamic process that evolves along with an understanding of the clients' histories and treatment needs. Foremost, counselors should be mindful of each client's linguistic requirements and the availability of interpreters (for more detail on interpreters, see Chapter 4). Counselors should be flexible in designing treatment plans to meet client needs and, when appropriate, should draw upon the institutions and resources of clients' cultural communities. Culturally responsive treatment planning is achieved through active listening and should consider client values, beliefs, and expectations. Client health beliefs and treatment preferences (e.g., purification ceremonies for Native American clients) should be incorporated in addressing specific presenting problems. Some people seek help for psychological concerns and substance abuse from alternative sources (e.g., clergy, elders, social supports). Others prefer treatment programs that use principles and approaches specific to their cultures. Counselors can suggest appropriate traditional treatment resources to supplement clinical treatment activities.

In sum, clinicians need to incorporate culture-based goals and objectives into treatment plans and establish and support open client–counselor dialog to get feedback on the proposed plan's relevance. Doing so can improve

Group Clinical Supervision Case Study

Beverly is a 34-year-old White American who feels responsible for the tension and dissension in her family. Beverly works in the lab of an obstetrics and gynecology practice. Since early childhood, her younger brother has had problems that have been diagnosed differently by various medical and mental health professionals. He takes several medications, including one for attention deficit disorder. Beverly's father has been out of work for several months. He is seeing a psychiatrist for depression and is on an antidepressant medication. Beverly's mother feels burdened by family problems and ineffective in dealing with them. Beverly has always helped her parents with their problems, but she now feels bad that she cannot improve their situation. She believes that if she were to work harder and be more astute, she could lessen her family's distress. She has had trouble sleeping. In the past, she secretly drank in the evenings to relieve her tension and anxiety.

Most counselors agree that Beverly is too submissive and think assertiveness training will help her put her needs first and move out of the family home. However, a female Asian American counselor sees Beverly's priorities differently, saying that "a morally responsible daughter is duty-bound to care for her parents." She thinks that the family needs Beverly's help, so it would be selfish to leave them.

Discuss:

- How does the counselor's worldview affect prioritizing the client's presenting problems?
- How does the counselor's individualistic or collectivistic culture affect treatment planning?
- How might a counselor approach the initial interview and evaluation to minimize the influence of his or her worldview in the evaluation and treatment planning process?

Sources: The Office of Nursing Practice and Professional Services, Centre for Addiction and Mental Health & Faculty of Social Work, University of Toronto 2008; Zhang 1994.

client engagement in treatment services, compliance with treatment planning and recommendations, and treatment outcomes.

4 Pursuing Organizational Cultural Competence

IN THIS CHAPTER

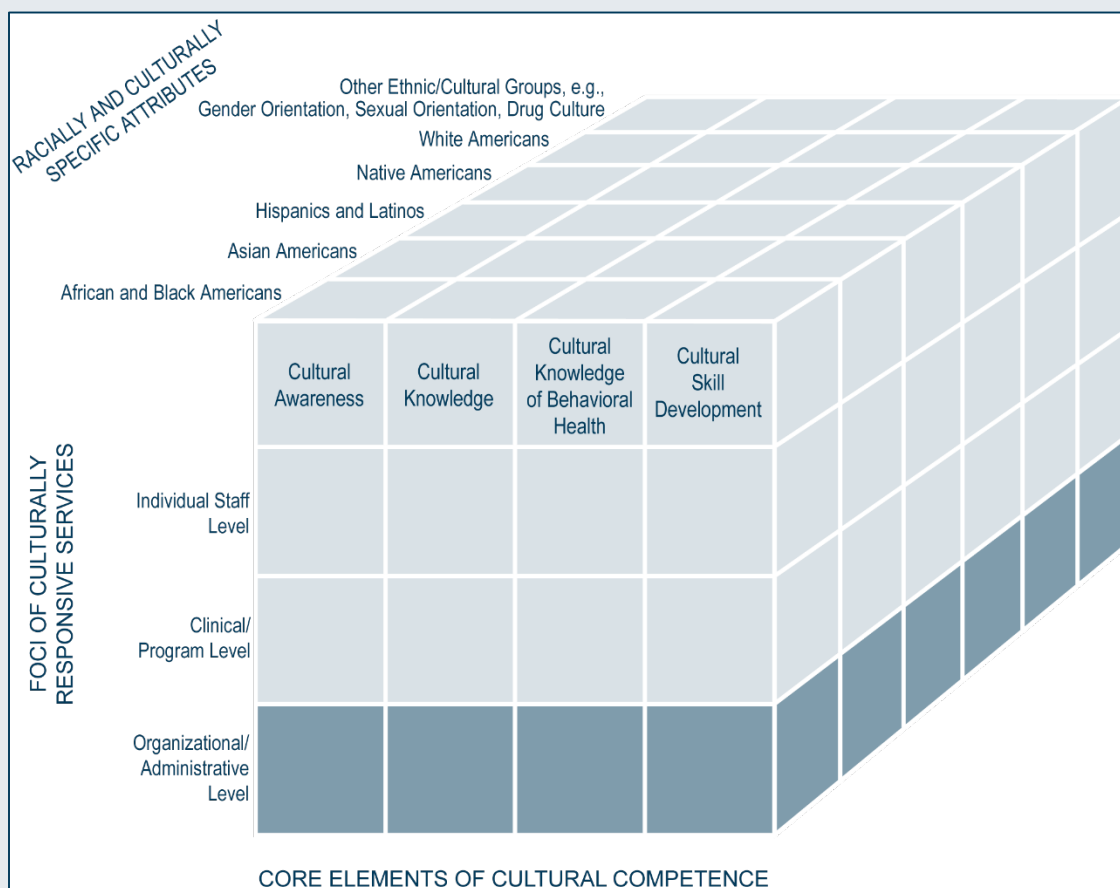
- Cultural Competence at the Organizational Level
- Organizational Values
- Governance
- Planning
- Evaluation and Monitoring
- Language Services
- Workforce and Staff Development
- Organizational Infrastructure

Cavin, a 42-year-old African American man, arrived at a well-known private substance abuse treatment center confused and unable to provide his medical history at intake. Referred to the center through his employee assistance program, he was accompanied by his spouse and 14-year-old son. Cavin's wife provided his medical history and recounted her husband's 2-year decline from a promising career as a journalist, researcher, and social commentator to a bitter, often paranoid man who abused cocaine and alcohol. Cavin, she explained, had become increasingly unpredictable.

Upon admission, Cavin was initially cooperative and grateful to his spouse for her efforts, but as withdrawal continued, he became increasingly agitated, insisting that he could detoxify on his own. He resisted any intervention by staff members whom he perceived to be critical or patronizing. On his fourth day in treatment, Cavin began to note the treatment center's "White" environment. There were almost no African American employees—none at the clinical level. He noted how decor reflected only White American culture. Driven in part by his substance use disorder, he was looking for reasons to leave. Later that evening, he checked out.

Cavin was unable to relate to his treatment. He found no cultural cues with which to identify or connect. Therefore, he started searching for reasons to leave—behavior typical in persons who abuse substances. People often leave treatment with the conscious hope of managing their substance abuse themselves and the unconscious drive to relive positive experiences associated with substance use; meanwhile, they all too easily forget the pain imposed by the use of alcohol and other substances. Cavin may have remained in treatment if services had been more culturally responsive. This is an example of how behavioral health programs benefit

Multidimensional Model for Developing Cultural Competence: Organizational/Administrative Level



from commitment to culturally responsive services, staffing, and treatment—if they make no such commitment, their services may be underused, unwelcome, and ineffective.

Cultural Competence at the Organizational Level

At the organizational level, cultural competence or responsiveness refers to a set of congruent behaviors, attitudes, and policies that enable a system, agency, or group of professionals to work effectively in multicultural environments (Cross et al. 1989). Organizational cultural responsiveness is a dynamic,

ongoing process; it is not something that is achieved once and is then complete. Organizational structures and components change. The demographics and needs of communities change. Employees and their job descriptions change. Consequently, the commitment to increase cultural competence must also involve a commitment to *maintain* it through periodic reassessments and adjustments. Based on the Cross et al. (1989) definition of the culturally competent organization, Goode (2001) identifies three principal components (Exhibit 4-1) that coincide with Sue's (2001) multidimensional model for developing cultural competence in behavioral health services.

Exhibit 4-1: Requirements for Organizational Cultural Competence

- The organization needs a defined set of values and principles, along with demonstrated behaviors, attitudes, policies, and structures that enable effective work across cultures.
- The organization must value diversity, conduct self-assessment, manage the dynamics of difference, acquire and institutionalize cultural knowledge, and adapt to diversity and the cultural contexts of the communities it serves.
- The organization must incorporate the above in all aspects of policymaking, administration, and service delivery and systematically involve consumers and families.

Source: Goode 2001.

This chapter provides a broad overview of how behavioral health organizations can create an institutional framework for culturally responsive program delivery, staff development, policies and procedures, and administrative practices. Built on the U.S. Department of Health and Human Services' (HHS's) Office of Minority Health (OMH) Enhanced National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (OMH 2013; for review, see Appendix C), this chapter is organized around the Health Resources and Services Administration's (HRSA's) domains of organizational cultural competence: organizational values, governance, planning, evaluation and monitoring, communication (language services), workforce and staff development, and organizational infrastructure (Linkins et al. 2002). (Another domain, services and interventions, is covered in Chapter 3.)

Within each domain, specific organizational tasks are suggested to aid program and administrative staff in developing a culturally responsive clinical, work, and organizational environment (Exhibit 4-2); these domains and

Exhibit 4-2: Creating Culturally Responsive Treatment Environments

Organizational values tasks:

- Commit to cultural competence.
- Review and update vision, mission, and value statements.
- Address cultural competence in strategic planning processes.

Governance tasks:

- Assign a senior manager to oversee the organizational development of culturally responsive practices and services.
- Develop culturally competent governing and advisory boards.
- Create a cultural competence committee.

Planning tasks:

- Engage clients, staff, and community in the planning, development, and implementation of culturally responsive services.
- Develop a cultural competence plan.
- Review and develop policies and procedures to ensure culturally responsive organizational practices.

Evaluation and monitoring tasks:

- Create demographic profiles of the community, clientele, staff, and board.
- Conduct an organizational self-assessment of cultural competence.

Language services tasks:

- Plan for language services proactively.
- Establish practice and training guidelines for the provision of language services.

Workforce and staff development tasks:

- Develop staff recruitment, retention, and promotion strategies that reflect the population(s) served.
- Create training plans and curricula that address cultural competence.
- Give culturally congruent clinical supervision.
- Evaluate staff performance on culturally congruent and complementary attitudes, knowledge, and skills.

Organizational infrastructure:

- Invest in long-range fiscal planning to promote cultural competence.
- Create an environment that reflects the populations served.
- Develop outreach strategies to improve access to care.

Source: Linkins et al. 2002.

tasks are adapted to behavioral health services. Task overlap across domains may require work on several tasks at once. HRSA's organizational cultural competence assessment profile is available online (<http://www.hrsa.gov/cultural-competence/healthdlvr.pdf>; Linkins et al. 2002).

Organizational Values

Journey Mental Health Center (JMHC), a large outpatient mental health and substance abuse treatment clinic in Wisconsin, is an organization that is committed to providing accessible, community-focused, culturally responsive behavioral health services. JMHC offers the following commentary on the importance of clear, culturally responsive organizational values (JMHC 2013, paragraphs 1-3):

...cultural competence is fundamental to providing quality services that promote individual and family strengths, dignity, and self-reliance. Cultural competence broadens and enriches the delivery of mental health and alcohol and other drug abuse (AODA) services by providing a more holistic, relevant view of the world and the helping process. Cultural competence does not stand apart from, but is intrinsic to good clinical practice. Its threads are woven into the tapestry of effective assessment, treatment planning, intervention, advocacy, and support. In addition, cultural competence is intrinsic to effective staff relationships and business practices.

Cultural competence promotes relationships based upon understanding and knowledge of how one's own cultural beliefs and values influence the organization of information, perceptions, feelings, experiences, and coping strategies. It involves being able to identify, learn from, and incorporate these into the helping process. When cultural competence is an integral part of personal competence, there is the maximum opportunity to increase the amount and quality of information and the speed with which that information can be shared and processed and to form healthy alliances.

Cultural competence demands an ongoing commitment to openness and learning, taking time and taking risks, sitting with uncertainty and discomfort, and not having quick solutions or easy answers. It involves building trust, mentoring, and developing and nurturing a frame of reference that considers alliances across culture as enriching rather than threatening shared goals.

Task: Commit to Cultural Competence

Counselors are typically a part of a larger organization or system, but the focus on and responsibility for developing culturally responsive services has historically fallen on individual practitioners rather than on organizations. Most literature on cultural competence addresses the cultural awareness, knowledge, and skills of the practitioner, but until recently, it has failed to apply these same concepts to agencies. Cultural competence among counselors is only as effective as their agencies' commitment to and support of cultural competence and ability to value diversity through culturally congruent administrative practices, including—but not limited to—policies and procedures, programming, staffing, and community involvement.

Counselors are unlikely to affect organizational change to the same degree as the agency's overall administration can. Hence, culturally responsive treatment cannot be sustained without an agency's commitment and support. In fact, the organization itself can prevent clients from receiving culturally responsive services or treatment opportunities. Organizations that are unaware of cultural issues can fail to recognize that diverse groups may have difficulty accessing and engaging in treatment. Also, counselors who attempt to use culturally responsive practices—such as the involvement of family members (as defined by the client) and traditional healers—can encounter insurmountable hurdles if their agencies' policies

Organizations that fail to endorse and make a commitment to cultural competence will more than likely displace the responsibility of cultural competence onto counselors or clients. If the responsibility is on the clients, it is likely that the clients will have to “fit” or change to match the treatment or program rather than treatment services being adapted to fit the needs of clients.

and resources do not support these practices. The system can actually impede efforts made by counselors invested and trained in cultural competence. Thus, the development of cultural competence begins at the top level of the organization, with an initial focus on systemic changes.

Cultural competence does not occur by accident. To maximize its effectiveness in working with diverse groups, the organization must first view diversity as an asset. As importantly, the organization must ensure that its process of developing cultural competence has the genuine, full, and lasting support of the organization’s leadership. The chief executive officer (CEO), senior management, and board of directors play critical roles. A strong mandate from the board or CEO, coupled with a commitment to provide resources, can be a good motivator for staff and committees to undertake major organizational change. Support of cultural competence must be made clear throughout the organization and community in meaningful ways, in words and actions.

Leadership can make a difference in the implementation of culturally responsive practices by creating an organizational climate that encourages and supports such practices. This includes a willingness to discuss the importance of cultural competence, try new practices or approaches, tolerate the uncertainty that accompanies transitional periods during which practices and procedures are

evolving, respond to unforeseen barriers, and revise innovations that are not working as intended. It is important that leadership be genuinely committed to the effort and that their support be tangibly apparent in the allocation of relevant resources. A strong commitment to improving organizational cultural competence should include the obligation to monitor procedures after they have been implemented, maintain and reevaluate new practices, and provide resources and opportunities for ongoing training and culturally competent supervision.

Task: Review and Update Vision, Mission, and Value Statements

The organization’s mission, vision, and value statements are vitally important in creating a conceptual framework that promotes culturally responsive behavioral health services. Agencies should examine how these statements are developed. Are stakeholders involved in the development process? In what ways does the organization ensure that its values and mission reflect the community and populations that it serves? Does the organization see this task as a singular event, or has it planned for periodic review of its values and mission to ensure continued organizational responsiveness as needs, populations, or environments change?

Initially, the planning committee should determine how the culture of the organization as well as the surrounding community can support achievement of the mission and vision statements. Culturally responsive organizational statements cannot provide a tangible framework unless supported by community, referral, and client demographics; a needs assessment; and an implementation plan. Mission and vision statements need to be operationalized through identified goals as well as measurable indicators to track progress. The Hands Across Cultures Corporation of

northern New Mexico, which serves Native peoples within pueblos (American Indians), the City of Española, Pojoaque Valley, and surrounding communities (predominantly Latino), addresses the importance of the cultural context of its work in its mission and philosophy statements (Exhibit 4-3).

Task: Address Cultural Competence in Strategic Planning Processes

The strategic planning process provides an opportunity to reevaluate an agency's values, mission, and vision regarding cultural competence. A comprehensive process involves evaluating the organization's internal and external environments prior to holding planning meetings; this evaluation involves conducting staff, client, and community assessments. From assessing current needs to evaluating global factors that influence the direction and delivery of services (e.g., funding sources, treatment mandates, changes in health insurance),

organizations can begin to gain insight into the demands and challenges of providing culturally responsive services. Moreover, strategic planning is an opportunity to explore and develop short- and long-term goals that focus on incorporating culturally responsive delivery systems while addressing issues of sustainability (i.e., how to provide resources and support the implementation of culturally responsive policies and procedures over time). A formal strategic planning meeting should be held to determine specific goals, objectives, and tasks that will ensure quality improvement in culturally responsive services. The development of timelines and methods to evaluate progress, obstacles, and directions for each goal are equally important. For organizations that do not have a specific cultural competence plan prior to the strategic planning meeting, this process can provide the forum for developing the steps needed to create a formal plan.

Governance

Task: Assign a Senior Manager To Oversee the Development of Culturally Responsive Practices and Services

From the outset, a senior staff member with the authority to implement change should be assigned to oversee the developmental process of planning, evaluating, and implementing culturally responsive administrative and clinical services. Key responsibilities include the ongoing development and facilitation of cultural competence committees and advisory boards, management of evaluative processes, facilitation of the development of a cultural competence plan and its implementation, and oversight of policies and procedures to ensure cultural competence within the organization and among staff. Cultural competence cannot come to fruition with only one voice being heard, but assigning a key person to oversee

Exhibit 4-3: Hands Across Cultures Mission Statement

Mission

To improve the health, education and well being of the people of Northern New Mexico through family-centered approaches deeply rooted in the multicultural traditions of their communities.

Philosophy

To believe in culture as the foundation of human growth; spirituality as the strength of the people; each person's need to love and be loved; family preservation; individual responsibility; and the pursuit of human potential.

With a firm commitment to these beliefs, Hands Across Cultures' Board of Directors, staff, and collaborators hold that:

**Culture Is the Cure
La Cultura Cura**

Source: Hands Across Cultures 2014.

the process will more likely keep top-priority goals and objectives in view.

Task: Develop Culturally Competent Governing and Advisory Boards

Beyond having the foresight to plan for and develop culturally responsive services, it is vital that executive staff members on governing and advisory boards and committees are educated about and invested in the organization's mission and plan. For example, the board's human resources committee may be more invested in developing and reinforcing culturally responsive recruitment and hiring policies and practices if they are involved in the strategic planning process and educated about the organization's mission, values, and vision. At the same time, the organization should seek outside direction. Given that sharing information about the agency's activities with others outside the organization can create some hesitancy or be a potential barrier, the executive staff can frame the planning process as an opportunity for positive development and community involvement as a powerful resource. The organization should establish a community advisory board that includes stakeholders, specialists, and/or experts in multicultural behavioral health services along with key administrators and staff. This advisory board should consist of local community members from whom the organization can solicit valuable advice, input, and potential support for the development of culturally responsive treatment (Minnesota Department of Human Services 2004).

Representation should include clients, alumni, family members, and community-based organizations and institutions (e.g., community centers, faith communities, social service organizations). Developing an inclusive advisory board of community members can enhance and extend use of and referral from

other community agencies. Moreover, this board can help identify community leaders and culturally appropriate resources for the client population to supplement treatment activities, such as traditional healing practices (Castro et al. 1999a). The advice box on the next page reviews strategies for engaging communities in the development of culturally responsive services.

Task: Establish a Cultural Competence Committee

By creating a committee within the organization to guide the process of becoming culturally competent and responsive, the organization ensures that a core group will provide oversight and direction. This committee should be inclusive not only in terms of the racial and ethnic composition of the population served, but also in terms of drawing from all levels of the organization (Whaley and Longoria 2008). Representatives of the advisory board should also be included. Program administrators should provide direction to the cultural competence committee. The person assigned to take the lead on cultural competence should chair the committee, and the CEO should be noticeably involved.

The cultural competence committee will oversee the organization's self-assessment process while also creating the demographic profile of the organization's community, developing a cultural competence plan, and formulating and monitoring procedures that evaluate the implementation and effectiveness of the organization's plan in developing culturally responsive services and practices. The committee should ensure that the organization's plans are continually updated. To succeed, this team must be empowered to influence, formulate, implement, and enforce initiatives on all levels and throughout every department of the organization (Constantine and Sue 2005; Fung et al. 2012), including, for example,

Advice to Administrators: Strategies To Engage Communities in Developing Culturally Responsive Treatment Services

- Ask board members to help recruit key members of the local community.
- Create a community advisory group to complement the governing boards in assessing and recommending culturally responsive policies, procedures, and practices.
- Develop local community focus groups to discuss key treatment needs, health beliefs, and attitudes and behaviors related to substance use, mental illness, and help-seeking that could be unknown to others outside of the community and in the organization.
- Develop a policy that supports the use of culturally congruent communication modalities and technologies for sharing information with communities.
- Provide inservice training, continuing education, and other professional development activities (e.g., networking events) that focus on strengthening skills for collaboration with culturally and linguistically diverse communities.
- Develop policies and procedures to support community involvement in the treatment setting (e.g., incorporating peer support programs, having a presence at community housing events, developing partnerships with traditional healers).
- Develop local outreach and educational programs in multiple languages (e.g., provide family education on substance use patterns and community issues in Spanish at a community center).
- Participate in community events to raise awareness of services, to develop trust and build relationships, and to gain further knowledge of local cultural groups and community practices.
- Periodically analyze community demographic trends and populations served by the treatment organization; ensure representation of these diverse populations on the advisory board.
- Become knowledgeable about and use available local goods and services.

Sources: Goode 2001; National Center for Cultural Competence 2013; Washington State Department of Social and Health Services 2011.

presenting data and subsequent recommendations to the administration and boards based on employee feedback about their experiences with newly adopted, culturally responsive procedures in the organization. Exhibit 4-4 highlights key issues in behavioral health treatment that must be addressed in providing culturally responsive services.

Planning

Task: Engage Clients, Staff, and the Community in the Planning, Development, and Implementation of Culturally Responsive Services

Organizations can sometimes have the best intentions of creating culturally responsive services but miss the mark by operating in a vacuum. Initially, the vacuum approach can

appear less time consuming, complex, and expensive, but it can also represent paternalism whereby organizations or administrators assume that they inherently know what is best for the program, clients, staff, and community. Instead, organizations and the services that

Exhibit 4-4: Critical Treatment Issues To Consider in Providing Culturally Responsive Services

- Access: Degree to which services for clients are quickly and readily available.
- Engagement: Having appropriate skills and an environment that have a positive personal impact on the quality of clients' commitment to treatment.
- Retention: The result of quality services that help maintain clients in treatment with continued commitment.

Source: The Connecticut Department of Children and Families, Office of Multicultural Affairs 2002.

they provide need to be congruent with the specific populations being served; clients and the community should have an opportunity to provide input on how services are delivered and the types of services that are needed. Otherwise, services may be poorly matched to clients, underused by the community, and detrimental to agency financial resources. For example, an agency could decide that family therapy is a culturally appropriate service and proceed to create a multifamily program (treating several families together in a group format) without considering that, for some cultural groups, family shame associated with seeking help can deter the use of such services.

Staff members are likely to have specific knowledge of client needs and to be able to identify potential obstacles or challenges in how an organization attempts to implement culturally responsive policies and procedures. A parallel process that can influence the potential success of staff involvement and commitment to the development of cultural competence is the organizational culture. Suppose, for example, that the staff perceives the organization's new commitment to cultural competence as another expectation of more work without training, adequate clinical supervision, or ongoing support. Maybe staff members have historically experienced frequent announcements, mandates, or excitement generated by the administration that fade quickly. Perhaps the organization arranges committees and meetings, purporting that they want staff input despite the fact that decisions have already been made.

The organizational climate sets the stage for staff responsiveness and motivation in developing cultural competence and in implementing culturally responsive services. Without an organizational history and culture of supporting change across time, staff members will likely resent an increase in expectations with-

out some means of compensating for additional work, perceive themselves as powerless over the proposed changes, or minimize the need to make any immediate changes. For example, staff members may view changes as temporary or a phase and believe that the organization will focus on other issues or new directions once the pressure or attention on this specific issue subsides.

Task: Develop a Cultural Competence Plan

To ensure the delivery of culturally responsive services, it is important to develop a cultural competence plan (see the “Criteria for Developing an Organizational Cultural Competence Plan” advice box on the next page). Using demographic data and an organizational self-assessment (including community and advisory board input), the organization's cultural competence committee can begin writing an organizational plan for improving cultural competence. The committee will need to assign staff members to research and write each component of the plan, which should outline specific objectives, means of achieving these objectives, and recommend timelines and processes for evaluating progress. The plan should contain at least the following components:

- A narrative introduction that covers community demographics and history, organizational self-assessment and other evaluation tools, the rationale for providing culturally responsive services, and the organization's strengths and needs for improvement in providing services that are responsive to client cultural groups; a brief overview of current priorities, goals, and tasks to help the organization develop and improve culturally responsive clinical services and administrative practices is also advisable.

Advice to Administrators: Criteria for Developing an Organizational Cultural Competence Plan

Using the core elements of access, engagement, and retention as criteria in developing a cultural competence plan, the following recommendations are offered:

- Develop a thorough knowledge and understanding of the social, cultural, and historical experiences of the community of people your agency is serving.
- Identify and clearly articulate an understanding of the ethnic, cultural, linguistic, and social groups in the area your agency serves.
- Document, track, and evaluate/assess the reasons why clients are not accepted for services.
- Know the demographics of clients within the program and their rates of program completion.
- Keep profiles of clients who do not complete services.
- Design steps for your agency to take to remove identified barriers that keep clients from using your agency's services.
- Establish steps your agency will implement or sustain to create a consumer-friendly environment that reflects and respects the diversity of the clients that use your services.
- Establish internal criteria the agency will use to measure the impact of the services and programs that it offers.

Source: The Connecticut Department of Children and Families, Office of Multicultural Affairs 2002.

- Strategies for recruiting, hiring, retaining, and promoting qualified diverse staff.
 - Resources and policies to support language services and culturally responsive services.
 - Methods to enhance professional development (e.g., staff education and training, peer consultation, clinical supervision) in culturally responsive treatment services.
 - Mechanisms for community involvement, beginning with the development of a community advisory board and cultural competence committee and including community participation in relevant treatment activities or in support of treatment services (e.g., spiritual direction).
 - Approaches to amending facility design and operations to present a culturally congruent atmosphere.
 - Identification of and recommendations for culturally and linguistically appropriate program materials.
 - Programmatic strategies to incorporate culturally congruent clinical and ancillary treatment services.
 - Fiscal planning for funding and human resources needed for priority activities (e.g., training, language services, program development, organizational infrastructure).
 - Guidelines for implementation that describe roles, responsibilities, timeframes, and specific activities for each step.
- The committee must determine how to oversee the plan (e.g., by tracking accomplishments, obstacles, and remediation strategies). Who will develop and revise guidelines for treatment planning, introduce new guidelines to the staff and provide counselor training, and coordinate revisions with the information technology specialist or department?

Task: Develop and Review Policies and Procedures To Ensure Culturally Responsive Organizational Practices

In essence, policies and procedures are the backbone of an organization's implementation of culturally responsive services. By creating, reviewing, and adapting clinical and administrative policies and procedures in response to the ever-changing needs of client populations, the agency is able to provide counselors and

other workers with support and the means to respond in a consistent, yet flexible, manner. Programs are likely to have the foresight to develop relevant policies and procedures through the planning and evaluative processes outlined in this chapter, but it is unlikely that they will anticipate every situation. Thus, ongoing flexibility is paramount.

When putting together an organizational cultural competence plan, providers should be careful to follow the requirements set by state licensing boards, accreditation agencies, and professional organizations that oversee certification and licensing of treatment professionals. Much of the push for cultural competence throughout the healthcare field is in response to the mandates of accrediting agencies, funders, and managed care organizations. These entities have standards and guidelines that state minimum expectations for client rights, program structure, and staffing, along with treatment content and conditions. Behavioral health organizations, including substance abuse treatment programs, must meet these standards to be accredited by national organizations and compensated by funders.

Although many accrediting bodies require a cultural competence plan that is assessed as part of the accreditation process, their requirements can be minimal. Consequently, organizations should go beyond such requirements in their own thinking and planning to ensure that they are responding adequately to the needs of the communities they serve. Above all, are the policies, procedures, and systems of care suited to the served populations? Do policies reflect the organization's commitment to cultural competence in administrative practices? For example, are strategies for professional development, personnel recruitment, and retention of culturally competent staff members reflective of the populations and cultures that they serve?

If an organization fails to develop culturally responsive policies or procedures yet claims to endorse or support culturally responsive services, counselors and staff members will likely carry the entire burden of implementing these services and will face numerous obstacles that could prevent the delivery of responsive services. Take, for example, a counselor from a county-funded program who was directed by her supervisor to complement her counseling approach with the client's traditional healing beliefs and practices. The agency did not provide staff support, have policies or procedures consistent with this request, or exhibit a willingness to adapt current procedures to meet the client's needs. The counselor had difficulty following this direction because of barriers in finding an appropriate traditional practitioner in the local area, coordinating services, establishing and securing confidentiality for the client and with the practitioner (including educating the practitioner about confidentiality), arranging transportation for the client, obtaining a stipend for services, and discerning how and when to incorporate the traditional practice into the treatment milieu.

Counselors who feel that they have been left to go it alone can view implementation of culturally responsive practices as an insurmountable challenge when the agency provides limited support or fails to endorse adaptive policies that are congruent with the needs of the client population. Counselors may have high motivation to incorporate culturally responsive care but find themselves without appropriate agency resources, permission, or infrastructure to implement it. By developing and endorsing culturally responsive policies and procedures, an organization can provide carefully thought-out strategies and processes to help staff members provide real-time responsive services. Well-defined policies and procedures reinforce commitment to and expectations of cultural competence.

Evaluation and Monitoring

To develop a viable cultural competence plan, information must be gathered from all levels of the organization, from clients and community, and from other stakeholders. Beginning with acquiring initial demographic data from the populations that are or could be served by the agency and extending to soliciting feedback from various stakeholders, gathering information prior to plan development helps the organization provide direction and determine priorities. Gathering information also allows ongoing monitoring and feedback regarding the plan's effectiveness and areas in need of improvement. Areas of evaluation and monitoring can include a demographic profile of the client, community, staff, and board constellations; community needs assessment; client, family, and referral feedback; administrative, clinical, medical, and nonclinical staff assessments; and more (American Evaluation Association 2011; LaVeist et al. 2008).

Task: Create a Demographic Profile of the Community, Clientele, Staff, and Board

Intake, admission, and discharge data provide a good starting point for determining the demographics of current populations being served. Programs would likely benefit from developing a demographic summary for each population served, consisting of age, gender, race, ethnic and cultural heritage, religion, socioeconomic status, spoken and written language preferences and capabilities, employment rates, treatment level, and health status (HHS 2003b). With adequate resources, the organization can generate reports dating back 5 years to determine program trends.

Agencies should also gather demographic information on groups in the agency's local community (Hernandez et al. 2009). This information can be easily obtained through

census data and national centers (e.g., Bureau of Labor Statistics) or through local sources, including the library, city hall, or the county commissioner's office (Whealin and Ruzek 2008). Community demographics can provide a quick benchmark on how well an agency serves the local community and how the community is represented at all levels of the organization. A demographic profile should also summarize information about clinical, medical, and nonclinical staff members as well as board members. Other information can also be helpful for specific agencies, as can hiring a consultant to gather demographic information and conduct the organization's self-assessment of cultural competence to limit bias; however, lack of funding can prohibit this possibility.

Task: Conduct Organizational Self-Assessment of Cultural Competence

An organization must have an awareness of how it functions within the context of a multicultural environment, evaluating operational aspects of the agency as well as staff ability and competence in providing culturally congruent services to racially and ethnically diverse populations. Therefore, an agency should assess how well it currently provides culturally responsive treatment. An honest and thorough organizational self-assessment can serve as a blueprint for the cultural competence plan and as a benchmark to evaluate progress across time (National Center for Cultural Competence 2013). To review a sample assessment guide, refer to Appendix C.

The importance of organizational self-assessment cannot be overstated. Thorough, reliable, valid evaluations can gauge the effectiveness of an agency's services, structure, and practices (e.g., clinical services, governing practices, policy development, staff composition, and professional development) with culturally and racially diverse clients, staff, and

communities. More and more, public and private funding sources—as well as accrediting bodies—use an organization’s self-assessment as a means of measuring compliance, effectiveness, or quality improvement practices.

A self-assessment can seem intensive in terms of both labor and capital, but in the long run, it can guide an organization’s quality improvement process more efficiently by helping it provide the most relevant services at the right time. Gathering feedback from many internal and external sources gives agencies considerable information needed to effectively evolve as a culturally responsive organization, including data on current performance, areas needing improvement, and development needs. In the initial self-assessment, an organization should obtain demographic information and seek feedback from key stakeholders—including community members, clients, families, and referral sources (e.g., probation and parole offices, family and child services, private practitioners)—and from all levels of the organization, including administrative, managerial, clinical, medical, and support staff. The following steps are recommended to help an agency gain the information necessary to guide and support the development of its cultural competence plan.

Step 1: With the advisory board and cultural competence committee, identify key stakeholders who can provide valuable feedback about current strengths and areas in need of

improvement regarding the function of the organization and the needs of its community.

Step 2: Adopt a self-assessment guideline for organizational cultural competence (see Appendix C).

Step 3: Determine the feasibility of using consultants and/or external evaluators to select, analyze, and manage assessment.

For many organizations, hiring outside consultants is financially prohibitive. Nonetheless, the cultural competence committee could recommend hiring outside evaluators and consultants to help them plan, conduct, and assess the results of the organizational self-evaluation. The committee should ensure that consultants understand the population being served by the treatment facility. This means understanding the population’s cultural groups across dimensions: language and communication, cultural beliefs and values, history, socioeconomic status, education, gender roles, substance use patterns, spirituality, and other distinctive aspects. Candidates should be able to articulate a clear understanding of cultural competence (American Evaluation Association 2011). If consultants will train staff, they should have specific knowledge and proficiency in training development and delivery.

If financially feasible, it can be useful for the agency to consider using more than one consultant and to invite each prospective consultant to present their qualifications to the board of directors and/or to a cultural competence

The Consumer Assessment of Healthcare Providers and Systems Cultural Competence Item Set

This assessment tool evaluates provider cultural competence through client surveys. It helps identify strengths and weaknesses of individual behavioral health service providers and organizations, aids in provider comparisons, and assesses the extent to which client responses differ based on race, ethnicity, or primary language. The surveys are available online through the Agency for Healthcare Research and Quality (https://cahps.ahrq.gov/clinician_group/), as is an overview and instructions (<https://cahps.ahrq.gov/surveys-guidance/hp/instructions/index.html>).

committee so that the best match can be achieved between the agency's needs and the consultant based on his or her expertise, cost, and consulting style. If a consultant is hired, the organization should establish guidelines for working closely with that person, including reporting requirements to the cultural competence committee. The organization must retain ownership of the process and provide clear oversight and guidance.

Step 4: Select assessment tools suitable for each stakeholder group (e.g., clinical staff, agency referrals, clients). Several self-assessment tools are available, including checklists and surveys, for use in evaluation or as development guides. To date, most instruments available have limited empirical support (Delphin-Rittmon et al. 2012b; Shorkey et al. 2009).

More often than not, surveys and feedback questionnaires will need to be individually developed and tailored to the organization and stakeholder group depending upon setting; available resources; racial, ethnic, and cultural

backgrounds; language preferences; and community accessibility (e.g., rural versus urban). Appendix C provides standards and lists the items that should be included in evaluating an agency and its services. Additional resources for provider and organizational assessment of cultural competence are available through the National Center for Cultural Competence (<http://nccc.georgetown.edu/>) and the Hogg Foundation for Mental Health (<http://www.hogg.utexas.edu/index.php>).

Step 5: Determine distribution, administration, and data collection procedures (e.g., confidentiality, participant selection methods, distribution time frames). Whatever methods are used to gather data for the self-assessment process, it is critical to explain the context of the assessment to all participants. They need to know why the assessment is being conducted and how the information they give will be used. Confidentiality can be a major concern for some respondents, especially staff members and clients, and every effort should be made to address this concern. Ideally, the evaluation

Advice to Administrators: Gathering Feedback From Clients, Community Members, and Referrals

Agencies should incorporate a client satisfaction survey into the assessment process. This survey should include questions to help determine whether clients believe that the organization relates well to persons of their ethnicity or race and gives them an opportunity to pinpoint problem areas. To review a sample assessment tool for clients, refer to the Iowa Cultural Understanding Assessment–Client Form (White et al. 2009), available in Appendix C. The tool is also available in Spanish.

If desired, external consultants can conduct interviews with a representative sample of clients, family members, and local community members. The key question should be “What can the treatment provider do to be more responsive to community needs?” The survey process can be as simple as a questionnaire, or it can involve interviews or focus groups with key people in touch with community issues. It can also be helpful to obtain a small but representative sample of community members at large to determine their level of awareness of the services available and their perceptions of the treatment agency based on what they have heard. Information from people not in treatment can be revealing and could suggest areas in which publicity is needed to counter misinformation. Likewise, facilitators can develop, from the information gathered, a map that highlights where people go to receive various services (Center for Substance Abuse Prevention 1995). The agency could also ask their sources of referrals, such as faith-based organizations, community agencies, or primary care physicians, whether they are referring clients to the agency, and if not, why. It is important to know who is not walking through the door.

instrument(s) should be administered by an objective third party, such as a consultant or a member of the cultural competence committee. Staff members should be asked about their attitudes toward cultural issues with the understanding that their attitudes are not necessarily indicative of the degree to which the staff mirrors the cultural groups served. In soliciting community feedback, the more credibility the organization has in the community, the higher the return rate will likely be. The lower the credibility, the more the organization needs to reassure respondents that it intends to listen to, and act on, what it hears. If many survey forms are to be distributed, the organization could consider hiring students or community members on a temporary basis to make follow-up or reminder calls.

Step 6: Compile and analyze the data. The process of reviewing and assessing data should be overseen by the cultural competence committee. Basic data analysis procedures should be used to ensure the accuracy of results and credibility of reported information. For most well-designed instruments, there are relatively simple and appropriate ways to present data. All available data should be assembled in a report, along with interpretive comments and recommended action steps. The report should note areas of strength and needed improvement and should offer possible explanations for any shortcomings. For example, if the community is 20 percent African American, but only 2 percent of the agency's clientele are African American, what are some possible explanations for this group's apparent underuse of services? It is also particularly important to share results with those who participated in the assessment process. Findings should be made available to staff, clients, community members, boards, and managers. This increases overall sense of ownership in the assessment and cultural competence development process and in implementing the

changes that will be made based on the findings of and the priorities established through this assessment.

Step 7: Establish priorities for the organization and incorporate these priorities into the cultural competence plan. After obtaining the results of the self-assessment process, the organization—including boards, cultural competence committee, community stakeholders, and staff members—needs to establish realistic priorities based on the current needs of clients and the community. Significant consideration should be given to the level of influence any given priority could have in effecting organizational change that will improve culturally responsive services. Some priorities will require more planning to implement and can involve more financial and staff resources, whereas other priorities will be easier to implement from the outset (e.g., hiring culturally competent counselors who are bilingual versus translating intake and program forms). Therefore, long- and short-range priorities should be established at the same time to maintain the momentum of change in the organization.

Step 8: Develop a system to provide ongoing monitoring and performance improvement strategies. Similar to the clinical assessment process with clients, the organizational self-assessment is only valuable if it provides guidance, determines direction and priorities, and facilitates action. Assessment is not a one-time activity. It is important to continue monitoring to identify barriers that may impede the full implementation of the cultural competence plan, to evaluate progress and performance, and to identify new service needs. Establishing a system to monitor an organization's cultural responsiveness equips it with the information necessary to formulate strategies to meet new demands and to continuously improve quality of services.

Language Services

Task: Plan for Language Services Proactively

An organization must anticipate the need for language services and the resources required to support these services, including funding, staff composition, program materials, and translation services. Assessing the language needs of the population to be served is essential. Upon determination, the foremost task is letting clients with limited English proficiency know that language services are available as a basic right for a client. Treatment providers need to plan for the provision of linguistically appropriate services, beginning with actively recruiting bicultural and bilingual clinical staff, establishing translation services and contracts, and developing treatment materials prior to client contact. Although it is not realistic to anticipate the language needs of all potential clients, it is important to develop a list of available resources and program procedures that staff members can follow when a client's language needs fall outside the organization's usual client demographics (The Joint Commission 2009).

How To Inform Clients About Language Assistance Services

- Use language identification or "I speak..." cards.
- Post signs in regularly encountered languages at all points of entry.
- Establish uniform procedures for timely, effective telephone communication between staff members and persons with limited English proficiency.
- Include statements about the services available and the right to free language assistance services in appropriate non-English languages in brochures, booklets, outreach materials, and other materials that are routinely distributed to the public.

Source: OMH 2000.

Planning for language services is crucial, and the need for these services must be assessed by staff members who have initial contact with clients, their family members, and/or other individuals in their support systems (American Psychological Association [APA] 1990, 2002). If frontline administrative and clinical staff members are bilingual, the initial screening and assessment process can begin uninterrupted. If this is not the case, receptionists or frontline clinical staff members should at least be familiar with some rudimentary phrases in the preferred languages of their client base. The conversation can be scripted so that they can convey their limited ability to speak the client's language, obtain contact information and inquire about language service needs, and inform the client that someone who can speak the language more fluently will be made available to facilitate the initial screening process. Most importantly, procedures should be in place to provide pretreatment contact and follow-up in the client's language to bridge the gap between initial contact and subsequent arrangement of language services.

Written and illustrated materials or a video about the program in the languages spoken by the client population should be available to answer frequently asked questions. All materials given to clients, family members, and community members should be available in their primary languages. It is preferable to develop the materials initially in those languages rather than simply translating materials from one language to another. Along with language, one should also consider the level of literacy of the group in question. Some clients may be functionally illiterate even in their native languages. Materials should graphically reflect the population served through pictures or photographs, using ethnic themes and traditional elements familiar to the target audience. Also, materials should be tested with the populations with whom they

will be used, perhaps through focus groups, to ensure that they communicate effectively.

Task: Establish Practice and Training Guidelines for the Provision of Language Services

Key issues to consider in implementing and overseeing language services within an organization include staff monitoring of language proficiencies, selection of translators and interpreters, confidentiality issues, and training needs. First, agencies need to assess language proficiencies among staff members and encourage them to learn a language relevant to the population served. At a minimum, staff members should acquire in the given language some basic terminology and phrases that are commonly used in the treatment setting.

In recruiting and hiring translators and interpreters, administrative staff members should consider experience, motivation, skill level, mastery of English, and fluency in the language in need of interpretation (OMH 2000; American Translators Association 2011). Be aware, however, that there can be considerable variation in dialects and levels of proficiency within the language, and these must be determined in the selection process. To supplement hiring practices, administrative policies should provide a means for determining the credentials of any language services organizations (Appendix F lists American Translators Association credentialing information).

Other important hiring issues revolve around potential ethical dilemmas. In particular, care should be taken in using interpreters from the local community, which can create potential challenges with confidentiality and dual relationships (e.g., the interpreter may also be client's cousin or neighbor). Policies should place the burden on language service providers

to identify and disclose dual relationships to supervisors immediately and on supervisors to assess and determine the appropriateness of using certain translator. Once a selection has been made, a confidentiality agreement should be signed. Organizations need to provide information routinely to clients about their confidentiality rights in using language services. Implementing a procedure for handling client grievances is also recommended.

In planning for the use of language services, organizations should initially provide training for staff on how to incorporate these services and should familiarize translators and interpreters with the clinical setting, terminology, behavioral expectations, and content related to behavioral health (see the “Training Content for Language Service Personnel” advice box on the next page). The language of mental health and substance abuse services requires an additional degree of specialization. Experienced translators and interpreters who are unfamiliar with concepts of addiction, illness, and recovery could convey information adequately from a linguistic perspective but not accurately convey the intent or meaning of clinically oriented information or dialog. Various training approaches can be used, including role-plays mirroring intakes, evaluations, and counseling sessions; indirect exposure to client sessions through audio or video recordings of sessions or viewing from an observation room; direct observation by sitting in on a session, if appropriate; and consultation with other experienced language service providers and clinical staff. Using other experienced translators and interpreters for training and/or for consultations, as well as sharing experiences in a peer support format, can be very beneficial for new language service providers.

Organizations must also create opportunities for translators and interpreters to inquire about and clarify clinical content and meaning. Language service providers often attempt to convey terminology or concepts that do not

exactly match the words or meaning of the client's language or culture by becoming more descriptive, taking longer to deliver the message in an effort to match the intent of a specific word or concept in English.

Advice to Clinical Supervisors and Administrators: Training Content for Language Service Personnel

Translators and interpreters need additional training to work in a clinical setting. Initial training should include:

- General mental health and substance abuse information.
- Introduction to behavioral health services.
- Familiarity with interviewing and assessment questions, instruments, and formats.
- Legal and ethical issues, including confidentiality and professional boundaries.
- Relevant programmatic policies and procedures.
- Review of program materials, forms, questionnaires, and other written clinical materials that clients receive during the course of treatment.
- Knowledge of technical vocabulary relevant to the behavioral health field.
- Emphasis on the importance of accurate interpretation and translation without additions or omissions.
- Behavioral and professional guidelines on how to manage potential client reactions in and outside the session (e.g., outward displays of anger or hostility; grief reactions; disclosing information to the translator with a request to keep it a secret from clinical staff; discomfort with translator's biological, social, and/or demographic characteristics, such as gender orientation, age, or socioeconomic status).
- Importance of cultural sensitivity in dialog between translator and client, including how questions are asked.
- General guidelines on how to handle personal issues that can be elicited by participation in the intake, assessment, and treatment processes, including identification with similar clinical issues (e.g., substance use patterns, family dynamics, traumatic events, emotional distress).

Workforce and Staff Development

Task: Develop Staff Recruitment, Retention, and Promotion Strategies That Reflect the Populations Served

To determine whether it adequately reflects the population it serves, an organization has to assess its personnel, including counselors, administrators, and board of directors. According to a 10-year study that collected data on treatment admissions, racial and ethnic composition of treatment populations has not significantly changed. Racially diverse groups (excluding non-Latino Whites) represent approximately 40 percent of treatment admissions (Substance Abuse and Mental Health Services Administration [SAMHSA] 2011c), yet 80 percent of counselors are non-Latino Whites (Duffy et al. 2004). In striving to improve cultural responsiveness, staff composition should be a major strategic planning consideration. As much as possible, the staff should mirror the client population.

Nevertheless, providers should avoid hiring “ethnic representatives,” which means hiring a single person from an ethnic or cultural group and expecting him or her to serve as the cultural resource on that group for the entire staff. This can be burdensome, if not offensive, to that person. Belonging to a group does not ensure cultural responsiveness toward, knowledge of, or skill in working with members of that group, nor does it guarantee that the person culturally identifies with that cultural group or its heritage. Hiring ethnic

“Improving the workforce to provide competent services to diverse populations goes far beyond merely increasing the number of individuals from each of the respective groups. While this is clearly an important strategy, there is a need not only to increase the numbers but also to improve the quality of training for all clinicians, regardless of their racial, ethnic, cultural, or linguistic background. This also includes the necessity to recruit, train, and support interpreters.”

(Hoge et al. 2007, p. 192).

representatives undermines the expansion of diversity at all organizational levels and the importance of developing opportunities for all staff members to gain awareness and improve their ability to effectively work with clients.

Some organizations struggle to find multicultural staff members that represent the diversity of their communities and clienteles. If recruitment is perceived as an immediate short-term goal, ongoing difficulties are likely in hiring, promoting, and retaining a diverse staff. Instead, recruitment strategies need to embrace a more comprehensive and long-term approach that includes internships, marketing to those interested in the field at an early age, mentoring programs for clinical and administrative roles, support networks, educational assistance, and training opportunities.

Task: Create Training Plans and Curricula That Address Cultural Competence

The primary purpose of training is to increase cultural competence in the delivery of services, beginning with outreach and extending to continuing care services that support behavioral health. Training should increase staff self-awareness and cultural knowledge, review culturally responsive policies and procedures, and improve culturally responsive clinical skills

(Anderson et al. 2003; Brach and Fraser 2000; Lie et al. 2011). The organization should be prepared to offer relevant professional development experiences consistent with counselors’ personal goals and assigned responsibilities as well as the organization’s goals for culturally responsive services. Board members, volunteers, and interpreters should all receive appropriate training.

A professional development training plan details the frequency, content, and schedule for staff training and continuing education. Because becoming culturally competent is a process, training and support for engaging in culturally responsive services can be more appropriate when delivered across a period of time involving follow-up sessions rather than through a single session. Outcome research that evaluates the effectiveness of cultural competence training materials, format, and content in mental health services, including treatment for substance use disorders (Bhui et al. 2007; Lie et al. 2010), is limited. Nonetheless, numerous resources have suggested that effective cultural training does feature certain qualities (Exhibit 4-5).

Sometimes, staff members will express resistance to participation in training activities aimed at promoting cultural competence—they may feel forced to learn about cultural competence, or they may feel unable to take the time away from their clients to attend the

“The learning objectives of a professional development program should include awareness- and knowledge-based objectives and skills-based objectives that motivate students to explore personal perspectives and multiple worldviews, understand and embrace culturally competent health promotion strategies, and engage in self-directed competency development.”

(Perez and Luquis 2008, p. 178).

Exhibit 4-5: Qualities of Effective Cultural Competence Training

The qualifications of the trainer, the selection of training strategies, and the use of reputable training curricula are extremely important in developing culturally competent staff and responsive services. The following concepts should be considered in the development and implementation of cultural training:

- Cultural training should begin with educating new staff members about the organization's vision, values, and mission as related to culturally responsive services. Orientation should address the demographic composition of clientele, policies and procedures for cultural and linguistic services, counseling and performance expectations for assessment, treatment planning, and delivery of culturally responsive services.
- Before developing and initiating a training plan for culturally responsive services, ask staff members about their training needs specific to the cultural groups that they serve. Receptivity will likely increase if managers and administrators involve clinical staff in the planning process rather than assuming that they know exactly what staff members need regarding cultural training.
- Training should occur across time, and a training plan should detail how to provide training for new employees. Too often, trainings occur at one time, ignoring the complexity of cultural groups and suggesting that one training session is sufficient to achieve cultural competence. Cultural competence evolves from ongoing professional development.
- Training should incorporate diverse learning strategies, including experiential learning and cultural immersion when appropriate (e.g., participation in community activities, role-plays, case presentations). Training should be experientially based and process oriented, allowing self-reflection as part of the training and assigning self-reflection activities between training sessions (see the how-to box on self-reflection on the next page).
- Training should provide information that is practice- or research-based to ensure that participants see it as reputable and clinically sound.
- Training should create a welcoming, nonjudgmental, and professional atmosphere in which staff members, regardless of race, ethnicity, or cultural group, have the freedom and safety to explore their own beliefs and to learn about other cultural groups. Training efforts should not scapegoat mainstream cultural groups or make general statements about specific racial or ethnic groups without noting that there are many cultural subgroups within a given racial or ethnic group—often characterized by, but not limited to, geographic location, socioeconomic status, or educational levels. Participation guidelines should be clarified for each training.
- Training should be conducted by an interdisciplinary, multicultural training team that is experienced in training and well versed in cultural competence.
- Trainers should allow time for staff members to ask questions and process the presented materials and experiential exercises, and they should use staff questions and exercises to explore and correct misperceptions in a nonjudgmental manner.

Sources: Brach and Fraser 2000; Dixon and Iron 2006; Gilbert 2003; Pack-Brown and Williams 2003; Roysircar 2006; Russell 2009.

trainings. Others might object on the grounds that they treat everyone equally, thus ignoring their own cultural blindness.

The organization's leadership needs to address staff reluctance and concerns regarding training through initial education on the rationale for cultural competence. Assume that staff members are invested in creating the best opportunities for their clients to achieve suc-

cess, and use this premise to introduce the need for training centered on culturally responsive care. Some staff members may respond to incentives or predetermined objectives and criteria reflected in employee performance evaluations. Others may be more motivated by opportunities that arise from the organization's commitment to culturally responsive services or by other factors, such as specialized training and supervision, the

How To Engage in Self-Reflection: A Tool for Counselor Training and Supervision

Ask participants to preselect three clients whom they are currently counseling and will likely continue to counsel prior to the next training or supervision session. Selection should be based on clients' diversity in age, race, gender, ethnicity, socioeconomic status, education, and/or geographic location. After each participant has selected three clients (remind participants not to disclose actual client identity if this is an external training outside of the agency), ask them to keep a self-reflection journal wherein the number of entries coincide with each client session until the next training. Participants should write about their internal process, including reactions such as feelings, thoughts, or behaviors during the session that relate to the influence of culture. For example:

- Identify racial, ethnic, and cultural similarities and differences between you and your client.
- Explain how your cultural and clinical worldviews influence your dialog, treatment planning, and expectations of yourself and your client in the session.
- Describe assumptions that you have learned to make about your client's specific race, ethnicity, or culture(s).
- Even if you think these assumptions, beliefs, or biases do not play a role in your current counseling relationship and approach, discuss how they could influence your counseling. Provide a specific example.
- Describe the feelings that you have about your client. How do these feelings relate to your client's racial, ethnic, or cultural identity?
- Explain the differences and similarities in worldviews between you and your client.
- Discuss how your and your client's beliefs about health, healing, disease, and addiction differ.
- Describe how your client's experience with discrimination, oppression, and prejudice could influence his/her current level of distress, psychological functioning, and response to treatment.
- Explore how you attend to your client's worldview in each session.
- Describe a misunderstanding or erroneous counseling response during a counseling session that appears related to differences in cultural identification, values, or behavior.
- Identify cultural knowledge that you must obtain to gain a better understanding of your client.
- Discuss the most important lessons that you have learned from your client.

desire to be perceived by other staff members as team players, or their roles as agents of change with other staff members.

Opportunities for cultural competence training abound. National organizations, agencies dedicated to multicultural learning, academic institutions, government agencies, and information clearinghouses offer training or have information about training opportunities and

curricula on cultural competence on their Web sites. In addition to OMH guidelines on staff education and training (Exhibit 4-6), guidelines are available from psychological and counseling associations (APA 2002). To review sample training modules, see *Cultural Competence for Health Administration and Public Health* (Rose 2011).

Task: Provide Culturally Congruent Clinical Supervision

Little research is available that measures cultural competence among clinical supervisors or evaluates the effects of supervision on cultural competence among counselors (Colistra and Brown-Rice 2011; Constantine and Sue 2005). Not much is known about the effectiveness of clinical supervision in enhancing culturally competent behavior among counselors,

"It takes time and energy to work through significant changes, whether in the workplace or in our personal lives. Many times, resistance to change is a natural reaction of people trying to understand what is expected of them and how the change will impact their lives."

(Addiction Technology Transfer Center 2004, p. 28)

Exhibit 4-6: OMH Staff Education and Training Guidelines

Only general agreement exists as to what constitutes an acceptable cultural competence curriculum. OMH (2000) recommends tailoring curriculum topics to the roles and responsibilities of trainees and the specific needs of populations served over time but suggests that training should at least address:

- The effects of cultural differences between counselors and clients/consumers on clinical and other workforce encounters, such as the therapeutic alliance.
- The elements of effective communication among staff members and clients/consumers from diverse cultural groups who use different languages, including how to work with interpreters and telephone language services.
- Strategies for resolving racial, ethnic, or cultural conflicts between staff members and clients.
- The organization's policies and procedures for written language access, including how to gain access to interpreters and translated written materials.
- Parts of the Civil Rights Act of 1964 that address services for clients with limited English proficiency.
- The organization's complaint or grievance procedures.
- The effects of cultural differences on health promotion and disease prevention, diagnosis and treatment, and supportive care.
- The impact of poverty and socioeconomic status, race and racism, ethnicity, and sociocultural factors on access to care, service use, quality of care, and health outcomes.
- Differences in the clinical management of diseases and conditions indicated by differences in the race or ethnicity of clients.
- The effects of cultural differences among clients/consumers and staff members on health outcomes, client satisfaction, and treatment planning.

Source: OMH 2000. Adapted from material in the public domain.

although some research with a multicultural focus has measured counselor self-efficacy after receiving supervision and has examined the dynamics of supervisee-supervisor relationships. Even though educational institutions have developed curricula and standards to reinforce the need for a multicultural perspective in training, many clinical supervisors lack sufficient training in this area (e.g., avoid cultural topics in supervision, have difficulty giving culturally appropriate consultations or direction, fail to guide/reinforce timely implementation of policies or procedures that

support culturally responsive services with their supervisees). This can significantly impede organizations attempting to introduce or improve culturally responsive clinical services.

It is essential for organizations to provide counselors with clinical supervisors who are culturally aware, have engaged in multicultural training, and model culturally competent behaviors in clinical supervision sessions (e.g., allowing or engaging in discussions centered on race, ethnicity, and cultural groups in the session). Clinical supervision is the glue that

Advice to Clinical Supervisors: Culturally Competent Clinical Supervision

Supported by a review of research on multicultural clinical supervision, Miville et al. (2005) suggest that clinical supervisors gain awareness of and assess:

- Their own racial, ethnic, and cultural identities and attitudes and those of their supervisees.
- Their own knowledge base, strengths, and weaknesses and those of their supervisees.
- Racial, ethnic, and cultural issues that generate reactions in supervisors and in supervisees.
- Current engagement in professional development activities that support culturally responsive practices (see the professional development advice box on the next page).

How To Discuss Professional Development in Multicultural Counseling

This tool facilitates supervisee–supervisor discussions surrounding professional development activities that promote cultural competence. Supervisors can ask supervisees to review the list and check off activities that they have engaged in recently or in the past several months. Supervisors can then use the completed exercise as a starting point for gaining more specific information on activities endorsed by supervisees. Even if supervisees check off no items, reviewing the list reinforces activities that build cultural competence.

Materials needed: A printed copy of the checklist and a pen or pencil.

Instructions: Mark off the activities you have engaged in during the past month and/or 6 months.

Past month	Past 6 months	
_____	_____	I recognized a prejudice I have about certain people.
_____	_____	I talked to a colleague about a cultural issue.
_____	_____	I sought guidance about a cultural issue that arose in therapy.
_____	_____	I attended a multicultural training seminar.
_____	_____	I attended a cultural event.
_____	_____	I attended an event in which most other people weren't of my race.
_____	_____	I reflected on my racial identity and how it affects my work with clients.
_____	_____	I read a chapter or an article about multicultural issues.
_____	_____	I read a novel about a racial group other than my own.
_____	_____	I sought consultation or supervision about multicultural issues.
_____	_____	I talked to a friend/associate about how our racial differences affect our relationship.
_____	_____	I challenged a racist remark—my own or someone else's.

Source: Pack-Brown and Williams 2003, p. 136. Used with permission.

reinforces culturally competent behavior, and it is often the only avenue of ongoing clinical training and follow-up after specific workshops or trainings are offered by the organization.

Clinical supervisors should adopt a multicultural framework to guide the supervision process (e.g., Sue's [2001] multidimensional model for developing cultural competence). Endorsement of a model for developing and enhancing cultural competence helps both supervisors and supervisees understand how to address cultural issues in supervision and pursue personal and professional development that supports culturally responsive clinical services. (For a specific example, see Field and colleagues' [2010] Latina–Latino multicultural developmental supervisory model.) The model guides supervision and reinforces the premise

that cultural variables influence each aspect of supervision: the relationship between supervisors and supervisees, the supervisors' and supervisees' perceptions and assessments of clients' presenting issues, the interactions between supervisees and their clients, and the treatment recommendations and directions that evolve from supervision.

Task: Evaluate Staff Performance on Culturally Congruent and Complementary Attitudes, Knowledge, and Skills

Organizations committed to endorsing and implementing culturally responsive services need policies and procedures that reflect this commitment in job descriptions and staff evaluations across all levels of the organization. By incorporating specific goals,

Advice to Administrators and Clinical Supervisors: Culturally Responsive Performance Evaluation Criteria

Cultural competence is measured by the degree to which counselors, administrators, and other staff members engage in observable actions and attitudes that reflect cultural responsiveness. Following are examples of descriptive evaluation criteria that address a few aspects of culturally responsive behavior:

- Engages in ongoing self-analysis to identify and address personal and cultural biases.
- Actively seeks to view life through the eyes of others and, through doing so, develops a greater level of sensitivity for the values and life challenges of other groups.
- Participates in hands-on training opportunities and seeks practice and feedback that build toward mastery of responsive needs assessment techniques.
- Seeks opportunities to engage in cross-cultural activities and interactions.

expectations, and tasks into performance evaluations, staff members will receive an important and consistent message from the organization that culturally competent behavior and responsive services are valued and rewarded.

Organizational Infrastructure

Task: Plan Long-Range Fiscal Support of Cultural Competence

An organization's commitment to providing culturally responsive treatment services will only succeed if resources are consistently dedicated to supporting the plan. Realistically, treatment program funds may be insufficient to initially meet the goals outlined in the organization's self-assessment. More often than not, the committee, executive staff, and board will have to prioritize the specific changes that are financially feasible. However, this necessity does not preclude the organization from soliciting help from the community, finding creative and inexpensive ways to make organizational changes, and using strategic and financial planning to build resources designated for culturally responsive services.

Task: Create an Environment That Reflects the Populations Served

The self-assessment process should include an environmental review of the organization's physical facilities in which barriers to access are examined. The plan should address identified deficits. For example, signage should be written in all primary languages spoken by the clients served; it should be written at an appropriate level of literacy in those languages. When possible, signs should use pictures and graphics to replace written instructions. The design of the facility, including use of space and décor, should be inviting, comfortable, and culturally sensitive. The plan should establish how to make facilities more accessible and culturally appropriate. In addition, the organization should create an environment that reflects the culture(s) of its clients not only within the facility, but through business practices, such as using local and community vendors.

Task: Develop Outreach Strategies To Improve Access to Care

The best-laid plans for providing culturally competent treatment are futile if clients cannot access treatment. Providers should develop outreach plans for diverse ethnic and

Advice to Administrators: Improving Outreach and Access to Care

Whenever it is not feasible to provide behavioral health services in the neighborhoods or communities where they are needed, treatment providers should consider the following:

- **Referring clients to community resources:** Ensure that all counselors and referral sources know where to refer individuals for culturally appropriate community services. Individuals should not have to “bounce around” through the system seeking care that is already difficult to access. Have culturally and linguistically appropriate brochures available that describe community services, eligibility, and the referral process.
- **Collaborating with other community services:** Collaboration with other community-based organizations is essential to compensate for the limitations faced by any single agency. Behavioral health service providers can reach larger numbers of underserved populations by teaming with others who have complementary missions and, at times, greater funding, such as other behavioral health agencies and programs dealing with welfare-to-work services, homelessness, or HIV/AIDS. Additional collaboration to increase use includes sending culturally competent counselors to work at another agency or community group on at least a part-time basis, training community members or other agency personnel to provide brief interventions or referral services, and supporting the establishment of mutual-help groups with translated/adapted literature in neighborhood locations.
- **Co-locating community services (creating a one-stop facility):** Co-locating with other agencies is often highly desirable, as it can facilitate connections among various community services that clients need and provide an easy central location to access these services (e.g., a substance abuse intensive outpatient treatment program, a community health service agency, and a community outpatient mental health program offered at one location). For culturally diverse people, the process of accessing services across agencies can be complex because of the need to obtain linguistically and culturally appropriate services and to overcome other barriers, such as economic challenges, issues surrounding eligibility, or the cumbersome repetition of completing forms for each agency. An effective one-stop facility ensures close coordination between each agency that participates while also ensuring client confidentiality. Co-location with a community-based organization that already has solid, positive visibility in the community and a culturally competent workforce can help improve the outreach and treatment efforts of behavioral health organizations that have had difficulty connecting with the communities that they serve.
- **Eliciting support from the community and employing outreach workers:** It is often easier and more persuasive for people who abuse substances or need mental health services to receive information and be encouraged to seek treatment by persons who are ethnically similar to them and speak the same language as they do. This is especially important for new immigrants, who do not yet know their way around the new country and could be unsure of whom they can trust. When possible, outreach workers should be of similar cultural origin as the population being served and should be familiar with the community where they are working. This allows them to explain the advantages of treatment in culturally appropriate ways, speak the appropriate language or dialect, address the concerns of community members, and respect clients’ priorities and issues. Outreach efforts can forge connections with important members of the community who encourage people with mental and substance use disorders and their families to seek treatment. These efforts are particularly important with new immigrants who may face legal and language barriers or may have a limited understanding of contemporary medicine and treatment possibilities. For example, lay people trained as *promotores de salud* (promoters of health) have been successful in reaching Latino migrant workers (Azevedo and Bogue 2001).
- **Supplying support services:** Providers can use a variety of means to make treatment accessible to culturally diverse clients. One strategy is to provide transportation from clients’ neighborhoods to the provider site. In many areas, people must travel long distances to receive culturally appropriate services. This limits the number of people able to receive treatment, especially

(Continued on the next page.)

Advice to Administrators: Improving Outreach and Access to Care (continued)

individuals with incomes too low to support travel. In addition, lengthy travel requirements reduce the chances of a person in the early stages of change with low motivation reaching a counselor who can help increase motivation and move the person toward recovery. Other strategies are the inclusion of child care and language services within the program. In addition, home-based outpatient treatment and telemedicine strategies can work, particularly for rural populations.

- **Selecting culturally appropriate strategies to provide community education:** Certain forms of outreach are more likely to be successful in some populations than in others. For example, in Chinese and Korean communities, community fairs are often an excellent way to publicize treatment services. Notices in community newspapers, on radio and television channels, on billboards, and in stores in the languages spoken locally can reach other potential clients. The person chosen to deliver or represent the messages in such situations should be someone familiar with the community and likely to inspire trust. Some agencies serving American Indian people have experienced success in publishing a monthly newsletter that is sent to individual American Indians and agencies serving the Native American community.

racial communities, particularly those whose members may find it difficult to seek services on their own. For example, see *Community-Defined Solutions for Latino Mental Health Care Disparities* (Aguilar-Gaxiola et al. 2012). From the outset, effective outreach and improved access to care should include formal and informal contacts with community organizations, spiritual leaders, and media. Providers can learn from these contacts about the behavioral health concerns in the community, special considerations for working with members of the community, cultural impediments to treatment, and cultural resources to aid treatment and recovery.

Unfortunately, many providers lack sufficient funding to offer the level of outreach services needed by the communities they serve. Because they are overwhelmed already, the issue of outreach to underserved populations is often seen as a low priority, which can cause these providers to send people in need of treatment away, disappointed and disheartened. However, thoughtful and strategic use of community resources can result in more members of underserved populations receiving the treatment they need and deserve. At minimum, outreach enables providers to offer

accurate information and referral to appropriate mutual-help or community groups.

Regarding fiscal planning and funding opportunities, some HHS initiatives support outreach through integrated care. For example, the Health Resources and Services Administration (HRSA) Center for Integrated Health Solutions (CIHS) promotes the development of integrated primary and behavioral health services to better address the needs of individuals with mental health and substance use concerns. Resources are available to help physicians screen for behavioral health problems and refer individuals to appropriate treatment. SAMHSA's Center for Substance Abuse Treatment has a Targeted Capacity Expansion Program that offers grants in support of outreach to specific populations.

The challenges outlined in this chapter are burdensome but can be overcome. Many organizations have been able to develop cultural competence over time (for a historical perspective of one organization's journey, see Exhibit 4-7). A well-defined and organized plan, coupled with a consistent organizational commitment, will enable organizations to initiate and accomplish the tasks necessary to promote culturally responsive services.

Exhibit 4-7: Cultural Competence Initiative Across Time in One Organization

Late 1980s

- The executive director and board endorse the need to pursue cultural competence and outline agency goals.
- An agency cultural competence committee forms to help develop policies, procedures, and a cultural competence plan. Community and client representation is established.
- A senior staff member is hired to oversee the organization's efforts to diversify staff.

Early 1990s

- The executive director, board of directors, and advisory board endorse the need to pursue culturally competent practices throughout the organization.
- General goals are established and senior management and staff members begin educating the staff on cultural competence.

Mid 1990s

- Culturally competent clinical standards are developed and implemented.
- Initial vision, mission, and value statements are modified to include cultural competence.
- Training for management and clinical supervisors incorporates cultural competence in practice.
- The agency begins a community cultural assessment and introduces a client satisfaction survey to gain feedback on current implementation of culturally responsive practices and to guide future direction and focus.
- Ongoing clinical supervisor training on cultural competence is initiated.
- The cultural competence committee develops recommendations for job descriptions and performance appraisals to reflect cultural competence skills and responsibilities.

Late 1990s

- Individuals and families who receive services are now involved in focus groups, orientations, and trainings.
- Partnerships with other agencies to promote cultural competence throughout the community are more strongly encouraged.
- A curriculum to train all staff members in the foundations of cultural competence is developed and implemented.

2000s

- Across the organization, clinical and administrative programs engage in cultural competence review and goal-setting.
- The mission statement is redefined to formally acknowledge the organization's values of respect for cultural differences, recovery, and advocacy.

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Appendix B—Instruments To Measure Identity and Acculturation

Some researchers have tested the usefulness of acculturation and identity models with people who abuse substances. For example, Peña and colleagues' racial identity attitude scale was found, in a study of African American men in treatment for cocaine dependence, to help counselors better understand the roles that ethnic and cultural identity play in clients' substance abuse issues (Peña et al. 2000). In 1980, Cuellar and colleagues published their acculturation rating scale for Mexican Americans, which conceptualized acculturation as progressing across a 5-point continuum ranging from Mexican or low acculturated (level 1) to American or high acculturated (level 5). The mid-level designation of bicultural (level 3) was set as the midpoint between the two extremes, although various investigators have questioned this assumption (Oetting and Beauvais 1990; Sayegh and Lasry 1993). Since then, scholars have developed new ways to conceptualize identity and acculturation, ranging from simple scales to

complex multidimensional models (Skinner 2001). The table that begins on the next page summarizes the instruments available to measure acculturation and ethnic identity. (See also the Center of Excellence for Cultural Competence for additional resources at <http://nyculturalcompetence.org>).

Other scales have been developed to examine specific culture-related variables, including *machismo* (Cuellar et al. 1995; Fragoso and Kashubeck 2000), *simpatía* (Griffith et al. 1998), *familismo* (Sabogal et al. 1987), traditionalism–modernism (Ramirez 1999), and family traditionalism and rural preferences (Castro and Gutierrez 1997). Counselors can use acculturation scales to help match patients to providers, to make treatment plans, and to identify the role of identity in substance abuse. Although these instruments can be helpful, the counselor must not rely solely on them to determine the client's identity or level of acculturation.

Acculturation and Ethnic Identity Measures

Instrument	Description	Cultural Group
African American Acculturation Scale-Revised (Klonoff and Landrine 2000)	This scale measures eight dimensions of African American culture: (1) traditional beliefs and practices, (2) traditional family structure and practices, (3) traditional socialization, (4) preparation and consumption of traditional foods, (5) preference for African American things, (6) interracial attitudes, (7) superstitions, and (8) traditional health beliefs and practices.	African Americans
Black Racial Identity Attitude Scale—Form B (Helms 1990)	This scale measures beliefs or attitudes of Blacks toward both Blacks and Whites using 5-point scales. It is available in short and long forms.	African Americans
Cross Racial Identity Scale (Worrell et al. 2001)	This scale measures six identity clusters associated with four stages of racial identity development.	African Americans
Multidimensional Inventory of Black Identity (MIBI; Sellers et al. 1997)	The MIBI measures centrality of Black identity, ideology, and regard for a Black identity. It is available online at http://sitemaker.umich.edu/aaril/files/mibiscaleandscoring.pdf .	African Americans
Scale To Assess African American Acculturation (Snowden and Hines 1999)	This is a 10-item scale that assesses media preferences, racial bias in relationships, race-related attitudes, and comfort in interacting with other races.	African Americans
African Self-Consciousness Scale (Baldwin and Bell 1985)	This scale measures within-group variability in the level of acculturation/cultural identity continuum (Baldwin and Bell 1985) based on degree of Afrocentricity or Nigrescence (White and Parham 1996). It indicates a client's level of involvement in traditional African American culture or the core African-oriented culture.	African Americans/African Immigrants
Native American Acculturation Scale (Garrett and Pichette 2000)	The Native American Acculturation scale asks 20 questions to ascertain a client's level of involvement with Native American culture.	Native Americans
Rosebud Personal Opinion Survey (Hoffmann et al. 1985)	This assessment evaluates components of acculturation, including language use, values, social behaviors, social networks, religious affiliation and practice, home community, education, ancestry, and cultural identification.	Native Americans
Asian American Multidimensional Acculturation Scale (AAMAS; Gim Chung et al. 2004)	The AAMAS was developed to be easy to use with a variety of Asian American ethnic groups. It includes questions relating to cultural identity, language use, cultural knowledge, and food preferences.	Asian Americans

(Continued on the next page.)

Acculturation and Ethnic Identity Measures (continued)

Instrument	Description	Cultural Group
Cultural Adjustment Difficulties Checklist (CADC; Sodowsky and Lai 1997)	The CADC helps avoid potential problems relating to acculturation by asking about language use, social customs, family interactions, perceptions of prejudice, friendship networks, and cultural adjustment.	Asian Americans (East Asians)
East Asian Acculturation Measure (Barry 2001)	This instrument includes 29 items that assess assimilation, level of separation from other Asians, integration, and marginalization.	Asian Americans (East Asians)
General Ethnicity Questionnaire (GEQ; Tsai et al. 2000)	The GEQ is an instrument designed to be used with minor modifications for assessing cultural orientation with different cultural groups. There are original and abridged versions. The original includes 75 items asking about language use, social affiliations, cultural practices, and cultural identification.	Asian Americans (although designed to be multicultural in orientation)
Suinn-Lew Asian Self-Identity Acculturation Scale (Suinn et al. 1992)	This instrument was modeled after the Acculturation Rating Scale for Mexican Americans, and research indicates it has high reliability.	Asian Americans
Ethnocultural Identity Behavioral Index (Yamada et al. 1998)	This is a 19-item self-report assessment with high validity.	Asian Americans and Pacific Islanders
Internal-External Ethnic Identity Measure (Kwan 1997)	The instrument evaluates ethnic friendships and affiliation, ethnocommunal expression, ethnic food orientation, and family collectivism, in order to differentiate three Chinese American identity groups: (1) internal, (2) external, and (3) internal-external undifferentiated.	Chinese Americans
Marín and Marín Acculturation Scale (Marín et al. 1987)	This scale is a 12-item instrument that assesses three domains: (1) language use, (2) media preferences, and (3) ethnic diversity of social relations. It is available online at http://www.columbia.edu/cu/ssw/projects/pmap/docs/gupta_acculturation.pdf	Chinese Americans
Behavioral Acculturation Scale and Value Acculturation Scale (Szapocznik et al. 1978)	These two scales, used in conjunction with one another, ask individuals about behaviors and values in order to determine acculturation. If used singly, the behavioral scale is the superior measure for acculturation.	Cuban Americans
Na Mea Hawai'i (Hawaiian Ways), A Hawaiian Acculturation Scale (Rezentes 1993)	This is a 34-item scale. An adolescent version is available (Hishinuma et al. 2000).	Native Hawaiians

(Continued on the next page.)

Acculturation and Ethnic Identity Measures (continued)

Instrument	Description	Cultural Group
Abbreviated Multi-dimensional Acculturation Scale (AMAS-ZABB; Zea et al. 2003)	The AMAS-ZABB is a multidimensional, bilinear, 42-item scale that evaluates identity, language competence, and cultural competence.	Latinos
Acculturation Scale (Marin et al. 1987)	This 12-item acculturation scale, available in English and Spanish, evaluates language use, media preferences, and social activities. It is available online at http://casaa.unm.edu/inst/MARIN%20Short%20Scale.pdf	Latinos
Bicultural Involvement Questionnaire (BIQ; Szapocznik et al. 1980)	The BIQ assesses language use and involvement in both Latino and mainstream American activities. It relates two sets of scores to derive a measure of bicultural involvement, with individuals who are highly involved in both cultures scoring highest on the scale.	Latinos
The Bidimensional Acculturation Scale for Hispanics (Marin and Gamba 1996)	This 24-item scale asks questions about language use, language proficiency, and media preferences.	Latinos
Brief Acculturation Scale for Hispanics (Norris et al. 1996)	This scale has only four items, but scores on the scale have been correlated highly with generation, nativity, length of time in the United States, language preferences, and subjective perceptions of acculturation.	Latinos
Multidimensional Measure of Cultural Identity for Latinos (Felix-Ortiz et al. 1994)	This measure places adolescents in one of four categories based on language, behavior/familiarity, and values/attitudes: (1) bicultural, (2) Latino-identified, (3) American-identified, and (4) low-level bicultural.	Latinos
Acculturation Rating Scale for Mexican Americans-I (ARSMA-I; Cuellar et al. 1980)	The ARSMA-I differentiates between 5 levels of acculturation: (1) Very Mexican, (2) Mexican-Oriented Bicultural, (3) True Bicultural, (4) Anglo-Oriented Bicultural, and (5) Very Anglicized. Established validity.	Mexican Americans
Acculturation Rating Scale for Mexican Americans-II (Cuellar et al. 1995)	This scale is like the ARSMA-I, except that it includes separate subscales to measure multidimensional aspects of cultural orientation toward Mexican and Anglo cultures independently.	Mexican Americans
Cultural Life Style Inventory (Mendoza 1989)	This self-report instrument, available in Spanish and English, evaluates five dimensions of acculturation: intrafamily language use, extrafamily language use, social activities and affiliations, cultural knowledge and activities, and cultural identification and pride.	Mexican Americans

(Continued on the next page.)

Acculturation and Ethnic Identity Measures (continued)

Instrument	Description	Cultural Group
Cultural Life Style Inventory (Mendoza 1989)	This self-report instrument, available in Spanish and English, evaluates acculturation on five dimensions: intrafamily language use, extrafamily language use, social activities and affiliations, cultural knowledge and activities, and cultural identification and pride.	Mexican Americans
Mexican American Acculturation Scale (Montgomery 1992)	This 28-item scale evaluates cultural orientation and comfort with ethnic identity. Items ask about language use, media preferences, cultural activities/traditions, and self-perceived ethnic identity.	Mexican Americans
Padilla's Acculturation Scale (Padilla 1980)	Padilla's Acculturation Scale is a 155-item questionnaire that assesses cultural knowledge and ethnic loyalties.	Mexican Americans
Bidimensional Acculturation Scale for Hispanics (Marín and Gamba 1996)	This scale measures evaluates two major dimensions of acculturation (Hispanic and non-Hispanic) using 12 items measuring 3 language-related areas. It has been found to have high consistency and validity.	Mexican Americans and Central Americans
Stephenson Multigroup Acculturation Scale (Stephenson 2000)	This is a 32-item instrument that evaluates immersion in both culture of origin and the dominant culture of the society.	Multicultural
Vancouver Index of Acculturation (Ryder et al. 2000)	This instrument includes 20 questions that assess interest/participation in one's "heritage culture" and "typical American culture" (available online at http://www2.psych.ubc.ca/~dpaulhus/Paulhus_measures/VIA.American.doc).	Multicultural
Bicultural Acculturation Scale (Cortés and Rogler 1994)	Developed for use with first- and second-generation Puerto Rican adults, this scale measures involvement in American culture and Puerto Rican culture, but it has limited evidence of validity and reliability.	Puerto Rican Americans
Psychological Acculturation Scale (Tropp et al. 1999)	The items on this scale pertain to the client's sense of psychological attachment to and belonging within Anglo American and Hispanic/Latino cultures.	Puerto Ricans on the U.S. mainland
Acculturation Scale for Southeast Asians (Anderson et al. 1993)	This 13-item scale evaluates languages proficiency and preferences regarding social interactions, cultural activities, and food. It includes two subscales for proficiency in languages, as well as language, social, and food preferences.	Cambodian, Laotian, and Vietnamese Americans
White Racial Identity Attitude Scale (Helms and Carter 1990)	This 50-item instrument rates items on a 5-point scale to measure attitudes associated with Helms's stages of racial identity development for Caucasians.	White Americans

Appendix C—Tools for Assessing Cultural Competence

There are numerous assessment tools available for evaluating cultural competence in clinical, training, and organizational settings. These tools are not specific to behavioral health treatment. Though more work is needed in developing empirically supported instruments to measure cultural competence, there is a wealth of multicultural counseling and healthcare assessment tools that can provide guidance in identifying areas for improvement of cultural competence. This appendix examines three resource areas: counselor self-assessment tools, guidelines and assessment tools to implement and evaluate culturally responsive services within treatment programs and organizations, and forms addressing client satisfaction with and feedback about culturally responsive services. Though not an exhaustive review of available tools, this appendix does provide samples of tools that are within the public domain. For additional resources and cultural competence assessment tools, visit the National Center for Cultural Competence (<http://nccc.georgetown.edu>) or refer to the University of Michigan Health System's Program for Multicultural Health (<http://www.med.umich.edu/multicultural/>).

Counselor Self-Assessment Tools

Multicultural Counseling Self Efficacy Scale—Racial Diversity Form

This 60-item self-report instrument assesses perceived ability to perform various counselor behaviors in individual counseling with a racially diverse client population. For additional information on psychometric properties and scoring, refer to Sheu and Lent (2007).

Self-Assessment Checklist for Personnel Providing Services and Supports to Children and Youth With Special Health Needs and Their Families

This instrument was developed by Tawara D. Goode of the Georgetown University Center for Child and Human Development. This version is adapted with permission from *Promoting Cultural Competence and Cultural Diversity in Early Intervention and Early Childhood Settings* (June 1989). It is available from the Web site of the National Center for Cultural Competence (<http://nccc.georgetown.edu/documents/ChecklistEIEC.pdf>).

Select A, B, or C for each numbered item listed:

A = Things I do frequently B = Things I do occasionally C = Things I do rarely or never

Physical Environment, Materials and Resources

_____ 1. I display pictures, posters, and other materials that reflect the cultures and ethnic backgrounds of children and families served by my program or agency.

_____ 2. I [e]nsure that magazines, brochures, and other printed materials in reception areas are of interest to and reflect the different cultures of children and families served by my program or agency.

_____ 3. When using videos, films, or other media resources for health education, treatment, or other interventions, I ensure that they reflect the cultures of children and families served by my program or agency.

_____ 4. When using food during an assessment, I [e]nsure that meals provided include foods that are unique to the cultural and ethnic backgrounds of children and families served by my program or agency.

_____ 5. I [e]nsure that toys and other play accessories in reception areas and those used during assessment are representative of the various cultural and ethnic groups within the local community and the society in general.

Communication Styles

_____ 6. For children who speak languages or dialects other than English, I attempt to learn and use key words in their language so that I am better able to communicate with them during assessment, treatment, or other interventions.

_____ 7. I attempt to determine any familial colloquialisms used by children and families that may have an impact on assessment, treatment, or other interventions.

_____ 8. I use visual aids, gestures, and physical prompts in my interactions with children who have limited English proficiency.

_____ 9. I use bilingual staff members or trained/certified interpreters for assessment, treatment, and other interventions with children who have limited English proficiency.

_____ 10. I use bilingual staff members or trained/certified interpreters during assessments, treatment sessions, meetings, and for other events for families who would require this level of assistance.

11. When interacting with parents who have limited English proficiency I always keep in mind that:

_____ Limitation in English proficiency is in no way a reflection of their level of intellectual functioning.

_____ Their limited ability to speak the language of the dominant culture has no bearing on their ability to communicate effectively in their language of origin.

_____ They may or may not be literate in their language of origin or English.

_____ 12. When possible, I ensure that all notices and communiqués to parents are written in their language of origin.

_____ 13. I understand that it may be necessary to use alternatives to written communications for some families, as word of mouth may be a preferred method of receiving information.

Values and Attitudes

_____ 14. I avoid imposing values that may conflict or be inconsistent with those of cultures or ethnic groups other than my own.

_____ 15. In group therapy or treatment situations, I discourage children from using racial and ethnic slurs by helping them understand that certain words can hurt others.

_____ 16. I screen books, movies, and other media resources for negative cultural, ethnic, or racial stereotypes before sharing them with the children and their parents served by my program or agency.

_____ 17. I intervene in an appropriate manner when I observe other staff members or parents within my program or agency engaging in behaviors that show cultural insensitivity, bias, or prejudice.

_____ 18. I understand and accept that family is defined differently by different cultures (e.g., extended family members, fictive kin, godparents).

_____ 19. I recognize and accept that individuals from culturally diverse backgrounds may desire varying degrees of acculturation into the dominant culture.

_____ 20. I accept and respect that male–female roles in families may vary significantly among different cultures (e.g., who makes major decisions for the family, play, and social interactions expected of male and female children).

_____ 21. I understand that age and lifecycle factors must be considered in interactions with individuals and families (e.g., high value placed on the decisions of elders or the role of the eldest male in families).

_____ 22. Even though my professional or moral viewpoints may differ, I accept the family/parents as the ultimate decisionmakers for services and supports for their children.

_____ 23. I recognize that the meaning or value of medical treatment and health education may vary greatly among cultures.

_____ 24. I recognize and understand that beliefs and concepts of emotional well-being vary significantly from culture to culture.

_____ 25. I understand that beliefs about mental illness and emotional disability are culturally based. I accept that responses to these conditions and related treatment/interventions are heavily influenced by culture.

_____ 26. I accept that religion and other beliefs may influence how families respond to illnesses, disease, disability, and death.

_____ 27. I recognize and accept that folk and religious beliefs may influence a family's reaction and approach to a child born with a disability or later diagnosed with a physical/emotional disability or special health care needs.

_____ 28. I understand that traditional approaches to disciplining children are influenced by culture.

_____ 29. I understand that families from different cultures will have different expectations of their children for acquiring toileting, dressing, feeding, and other self-help skills.

_____ 30. I accept and respect that customs and beliefs about food, its value, preparation, and use are different from culture to culture.

_____ 31. Before visiting or providing services in the home setting, I seek information on acceptable behaviors, courtesies, customs, and expectations that are unique to families of specific cultures and ethnic groups served by my program or agency.

_____ 32. I seek information from family members or other key community informants that will assist in service adaptation to respond to the needs and preferences of culturally and ethnically diverse children and families served by my program or agency.

_____ 33. I advocate for the review of my program's or agency's mission statement, goals, policies, and procedures to ensure that they incorporate principles and practices that promote cultural diversity and cultural competence.

There is no answer key with correct responses. However, if you frequently responded "C," you may not necessarily demonstrate values and engage in practices that promote a culturally diverse and culturally competent service delivery system for children with disabilities or special health care needs and their families.

Ethnic-Sensitive Inventory (ESI; Ho 1991, reproduced with permission)

Here are some statements made by some practitioners with ethnic minority clients. How often do you feel this way when you work with ethnic minority clients? Every statement should be answered by circling one number ranging from 5 (always) to 4 (frequently), 3 (occasionally), 2 (seldom), and 1 (never).

In working with ethnic minority clients, I . . .

- A. Realize that my own ethnic and class background may influence my effectiveness.
- B. Make an effort to ensure privacy and/or anonymity.
- C. Am aware of the systematic sources (racism, poverty, and prejudice) of their problems.
- D. Am against speedy contracting unless initiated by them.
- E. Assist them to understand whether the problem is of an individual or a collective nature.
- F. Am able to engage them in identifying major progress that has taken place.
- G. Consider it an obligation to familiarize myself with their culture, history, and other ethnically related responses to problems.

- H. Am able to understand and “tune in” the meaning of their ethnic dispositions, behaviors, and experiences.
- I. Can identify the links between systematic problems and individual concerns.
- J. Am against highly focused efforts to suggest behavioral change or introspection.
- K. Am aware that some techniques are too threatening to them.
- L. Am able at the termination phase to help them consider alternative sources of support.
- M. Am sensitive to their fear of racist or prejudiced orientations.
- N. Am able to move slowly in the effort to actively “reach for feelings.”
- O. Consider the implications of what is being suggested in relation to each client’s ethnic reality (unique dispositions, behaviors, and experiences).
- P. Clearly delineate agency functions and respectfully inform clients of my professional expectations of them.
- Q. Am aware that lack of progress may be related to ethnicity.
- R. Am able to understand that the worker–client relationship may last a long time.
- S. Am able to explain clearly the nature of the interview.
- T. Am respectful of their definition of the problem to be solved.
- U. Am able to specify the problem in practical, concrete terms.
- V. Am sensitive to treatment goals consonant to their culture.
- W. Am able to mobilize social and extended family networks.
- X. Am sensitive to the client’s premature termination of service.

Scoring: The 24 items include four items for each of six treatment phases of client–counselor interaction. The sum of the numbers circled for each item relating to a treatment phase is the score for that phase. The scoring grid is given below.

Scoring Grid for ESI

Process Phase	Items			
Precontact	A _____	G _____	M _____	S _____
Problem Identification	B _____	H _____	N _____	T _____
Problem Specification	C _____	I _____	O _____	U _____
Mutual Goal Formulation	D _____	J _____	P _____	V _____
Problem Solving	E _____	K _____	Q _____	W _____
Termination	F _____	L _____	R _____	X _____

Source: Ho 1991. Reproduced with permission.

Evaluating Cultural Competence in Treatment Programs and Organizations

Agency Cultural Competence Checklist—Revised Form (Dana 1998, reproduced with permission)

Staff and policy attitudes

- ☐ Bilingual/bicultural
- ☐ Bilingual
- ☐ Bicultural
- ☐ Culture broker
- ☐ Flexible hours/appointments/home visits
- ☐ Treatment immediate/day/week
- ☐ Indigenous intake
- ☐ Match client–staff
- ☐ Agency environment reflects culture

Total possible = 9 Total obtained = _____

Services

- ☐ Culture-relevant assessment
- ☐ Cultural context for problems
- ☐ Cultural-specific intervention model
- ☐ Culture-specific services:
 - ☐ Prevention ☐ Crisis ☐ Brief ☐ Individual
 - ☐ Couple ☐ Family ☐ Child ☐ Outreach
 - ☐ Community ☐ Education ☐ Non-mental health
 - ☐ Resource linkage ☐ Natural helpers/systems

Total possible = 4 Total obtained = _____

Total possible services = 13 Total obtained = _____

Relationship to community

- ☐ Agency operated by minority community
- ☐ Agency in minority community
- ☐ Easy access
- ☐ Uses existing minority community facilities
- ☐ Agency ties to minority community
- ☐ Community advocate for services
- ☐ Community as adviser
- ☐ Community as evaluator

Total possible = 8 Total obtained = _____

Training

- _____ In-service training for minority staff
 _____ In-service training for nonminority staff

Total possible = 2 Total obtained = _____

Evaluation

- _____ Evaluation plan/tool
 _____ Clients as evaluators/planners

Total possible = 2 Total obtained = _____

Enhanced National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care

The standards presented in this section were developed by the Office of Minority Health (OMH 2013) in the Centers for Disease Control and Prevention (CDC) and are available online (<https://www.thinkculturalhealth.hhs.gov/pdfs/EnhancedNationalCLASStandards.pdf>). This section is reproduced from material in the public domain. Note that the Centers for Medicare and Medicaid Services (CMS) have also developed tools to assess linguistic competence and interpreter services as well as guidelines for planning culturally responsive services (see the CMS Web site at <http://www.cms.gov>). The National Standards for Culturally and Linguistically Appropriate Services (CLAS) are meant to advance health equity, improve quality, and help eliminate health disparities by establishing a blueprint for health and health care organizations to:

Principal standard

1. Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.

Governance, leadership, and workforce

2. Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources.
3. Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service area.
4. Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.

Communication and language assistance

5. Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.
6. Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.
7. Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.

8. Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.

Engagement, continuous improvement, and accountability

9. Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization's planning and operations.
10. Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities.
11. Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.
12. Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.
13. Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.
14. Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints.
15. Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public.

The Organizational Cultural Competence Assessment Profile

The Health Resources and Services Administration (HRSA) developed the Organizational Cultural Competence Assessment Profile from the cultural competence literature, guided by a team of experts. The profile was used during site visits to a variety of healthcare settings. It is an organizing framework and set of specific indicators to assist in examining, demonstrating, and documenting cultural responsiveness in organizations involved in the direct delivery of health care and services. The profile is not intended to be prescriptive; rather, it is designed to be adapted, modified, or applied in ways that best fit within an organization's context. The profile is presented as a matrix that classifies indicators by critical domains of organizational functioning and by whether the indicators relate to the structures, processes, outputs, or outcomes of the organization. The indicators suggest that assessment of cultural competence should encompass both qualitative and quantitative data and evaluate progress toward achieving results, not just the end results. Although the profile can be used in whole or in part, the full application enables an organization to assess its level of cultural competence comprehensively. Adapted here from material in the public domain are the matrices for process and capacity/structure measures. For more information, see <http://www.hrsa.gov/culturalcompetence/healthdlvr.pdf>.

Sample of Process Measures by Domain

Domain	Topic Areas	Measures/Indicators
Communication	Interpreter	Yearly updated directory of trained interpreters is available within 24 hours for routine situations and within 1 hour or less for urgent situations.
Communication	Interpreter	Percentage of clients with limited English proficiency who have access to bilingual staff or interpretation services.

(Continued on the next page.)

Sample of Process Measures by Domain (continued)

Domain	Topic Areas	Measures/Indicators
Communication	Linguistically competent organization	Number of trained translators and interpreters available Number of staff proficient in languages of the community
Communication	Language ability, written and oral, of the consumer	Consumer reading and writing levels of primary languages and dialects is recorded.
Policies and procedures	Choice of health plan network	Contract continuation and renewal with health plan is contingent upon successful achievement of performance targets that demonstrate effective service, equitable access, and comparability of benefits for populations of racial/ethnic groups.
Policies and procedures	Staff hiring, recruitment	Number of multilingual/multicultural staff Ratio by culture of staff to clients
Family and community participation	Community and consumer participation	Degree to which families participate in key decisionmaking activities: <ul style="list-style-type: none"> • Family participation on advisory committees or task forces • Hiring of family members to serve as consultants to providers/programs • Inclusion of family members in planning, implementation, and evaluation of activities
Communication	Translated materials	Allocated resources for interpretation and translation services for medical encounters and health education/promotion material.
Communication	Linguistic capacity of the provider	Ability to conduct audit of the provider network, which includes the following components: <ul style="list-style-type: none"> • Languages and dialects of community available at point of first contact. • Number of trained translators and interpreters available. • Number of clinicians and staff proficient in languages of the community.
Communication	Provide information, education	<ul style="list-style-type: none"> • Organization has the capacity to disseminate information on health care plan benefits in languages of community. • Organization has the capacity to disseminate information and explanation of rights to enrollees.
Policies and procedures	Grievance and conflict resolution	Organization has structures in place to address cross-cultural ethical and legal conflicts in health care delivery and complaints or grievances by patients and staff about unfair, culturally insensitive, or discriminatory treatment, or difficulty in accessing services or denial of services.
Policies and procedures	Grievance and conflict resolution	Organization has feedback mechanisms in place to track number of grievances and complaints and number of incidents.
Policies and procedures	Planning and governance	Composition of the governing board, advisory committee, other policymaking and influencing groups, and consumers served reflects service area demographics.

Sample of Capacity/Structure Measures by Domain

Domain	Topic Areas	Measures/Indicators
Facility characteristics, capacity, and infrastructure	Available and accessible services	<ul style="list-style-type: none"> • Transportation is available from residential areas to culturally competent providers. • Organization has the flexibility to conduct home visits and community outreach. • Culturally responsive services are available evenings and weekends.
Facility characteristics, capacity, and infrastructure	Information systems	Capacity for tracking of access and utilization rates for population of different racial/ethnic groups in comparison to the overall service population.
Monitoring, evaluation, and research	Organizational assessment	Ability to conduct ongoing organizational self-assessments of cultural and linguistic competence and integration of measures of access, satisfaction, quality, and outcomes into other organizational internal audits and performance improvement programs.

Multiculturally Competent Service System Assessment Guide

Reproduced with permission from The Connecticut Department of Children and Families, Office of Multicultural Affairs (2002).

Instructions: Rate your organization on each item in Sections I through VIII using the following scale:

1 2 3 4 5

Not at all To a moderate degree To a great degree

Suggested Rating Interpretations:

#1 and #2: "Priority Concerns"; #3: "Needs Improvement"; #4 and #5: "Adequate"

When you have rated all items and assessed each section, please follow the instructions in Section IX to make an assessment of your program or agency and then formulate a culturally competent plan that addresses the need you feel is a priority.

I. Agency demographic data (assessment)

A culturally competent agency uses basic demographic information to assess and determine the cultural and linguistic needs of the service area.

- _____ Have you identified the demographic composition of the program's service area (from recent census data, local planning documents, statement of need, etc.) which should include ethnicity, race, and primary language spoken as reported by the individuals?
- _____ Have you identified the demographic composition of the persons served?

- _____ Have you identified the staff composition (ethnicity, race, language capabilities) in relation to the demographic composition of your service area?
- _____ Have you compared the demographic composition of the staff with the client demographics?

II. Policies, procedures and governance

A culturally competent agency has a board of directors, advisory committee, or policy-making group that is proportionally representative of the staff, client/consumers, and community.

- _____ Has your organization appointed executives, managers, and administrators who take responsibility for, and have authority over, the development, implementation, and monitoring of the cultural competence plan?
- _____ Has your organization's director appointed a standing committee to advise management on matters pertaining to multicultural services?
- _____ Does your organization have a mission statement that commits to cultural competence and reflects compliance with all federal and state statutes, as well as any current *Connecticut Commission on Human Rights and Opportunities* nondiscriminatory policies and affirmative action policies?
- _____ Does your organization have culturally appropriate policies and procedures communicated orally and/or written in the principal language of the client/consumer to address confidentiality, individual patient rights and grievance procedures, medication fact sheets, legal assistance, etc. as needed and appropriately?

III. Services/programs

A culturally competent agency offers services that are culturally competent and in a language that ensures client/consumer comprehension.

A. Linguistic and communication support

- _____ Has the program arranged to provide materials and services in the language(s) of limited English-speaking clients/consumer (e.g., bilingual staff, in-house interpreters, or a contract with outside interpreter agency and/or telephone interpreters)?
- _____ Do medical records indicate the preferred languages of service recipients?
- _____ Is there a protocol to handle client/consumer/family complaints in languages other than English?
- _____ Are the forms that client/consumers sign written in their preferred language?
- _____ Are the persons answering the telephones, during and after-hours, able to communicate in the languages of the speakers?
- _____ Does the organization provide information about programs, policies, covered services, and procedures for accessing and utilizing services in the primary language(s) of client/consumers and families?
- _____ Does the organization have signs regarding language assistance posted at key locations?

- _____ Are there special protocols for addressing language issues at the emergency room, treatment rooms, intake, etc.?
- _____ Are cultural and linguistic supports available for clients/consumers throughout different service offerings along the service continuum?

B. Treatment/rehabilitation planning

- _____ Does the program consider the client/consumer's culture, ethnicity and language in treatment planning (assessment of needs, diagnosis, interventions, discharge planning, etc.)?
- _____ Does the program involve client/consumers and family members in all phases of treatment, assessment, and discharge planning?
- _____ Has the organization identified community resources (community councils, ethnic cultural social entities, spiritual leaders, faith communities, voluntary associations, etc.) that can exchange information and services with staff, client/consumers, and family members?
- _____ Have you identified natural community healers, spiritual healers, clergy, etc., when appropriate, in the development and/or implementation of the service plan?
- _____ Have you identified natural supports (relatives, traditional healers, spiritual resources, etc.) for purposes of reintegrating the individual into the community?
- _____ Have you used community resources and natural supports to reintegrate the individual into the community?

C. Cultural assessments

- _____ Is the client/consumer's culture/ethnicity taken into account when formulating a diagnosis or assessment?
- _____ Are culturally relevant assessment tools utilized to augment the assessment/diagnosis process?
- _____ Is the client/consumer's level of acculturation identified, described, and incorporated as part of cultural assessment?
- _____ Is the client/consumer's ethnicity/culture identified, described, and incorporated as part of cultural assessment?

D. Cultural accommodations

- _____ Are culturally appropriate, educative approaches, such as films, slide presentations, or video tapes, utilized for preparation and orientation of client/consumer family members to your program?
- _____ Does your program incorporate aspects of each client/consumer's ethnic/cultural heritage into the design of specialized interventions or services?
- _____ Does your program have ethnic/culture-specific group formats available for engagement, treatment, and/or rehabilitation?
- _____ Is there provider collaboration with natural community healers, spiritual healers, clergy, etc., where appropriate, in the development and/or implementation of the service plan?

E. Program accessibility

- _____ Do persons from different cultural and linguistic backgrounds have timely and convenient access to your services?
- _____ Are services located close to the neighborhoods where persons from different cultures and linguistic backgrounds reside?
- _____ Are your services readily accessible by public transportation?
- _____ Do your programs provide needed supports to families of clients/consumers (e.g., meeting rooms for extended families, child support, drop-in services)?
- _____ Do you have services available during evenings and weekends?

IV. Care management

- _____ Does the level and length of care meet the needs for clients/consumers from different cultural backgrounds?
- _____ Is the type of care for clients/consumers from different backgrounds consistently and effectively managed according to their identified cultural needs?
- _____ Is the management of the services for people from different groups compatible with their ethnic/cultural background?

V. Continuity of care

- _____ Do you have letters of agreement with culturally oriented community services and organizations?
- _____ Do you have integrated, planned, transitional arrangements between one service modality and another?
- _____ Do you have arrangements, financial or otherwise, for securing concrete services needed by clients/consumers (e.g., housing, income, employment, medical, dental, other emergency personal support needs)?

VI. Human resources development

A culturally competent agency implements staff training and development in cultural competence at all levels and across all disciplines, for leadership and governing entities as well as for management, supervisory, treatment, and support staff.

- _____ Are the principles of cultural competence (e.g., cultural awareness, language training, skills training in working with diverse populations) included in staff orientation and on-going training programs?
- _____ Is the program making use of other programs or organizations that specialize in serving persons with diverse cultural and linguistic backgrounds as a resource for staff education and training?
- _____ Is the program maximizing recruitment and retention efforts for staff who reflect the cultural and linguistic diversity of populations needing services?
- _____ Has the staff's training needs in cultural competence been assessed?

- _____ Has the staff attended training programs on cultural competence in the past two years?
Describe: _____

VII. Quality monitoring and improvement

A culturally competent agency has a quality monitoring and improvement program that ensures access to culturally competent care.

- _____ Does the quality improvement (QI) plan address the cultural/ethnic and language needs?
- _____ Are client/consumers and families asked whether ethnicity/culture and language are appropriately addressed in order to receive culturally competent services in the organization?
- _____ Does the organization maintain copies of minutes, recommendations, and accomplishments of its multicultural advisory committee?
- _____ Is there a process for continually monitoring, evaluating, and rewarding the cultural competence of staff?

VIII. Information/management system

- _____ Does the organization monitor, survey, or otherwise access, the QI utilization patterns, Against Medical Advice (AMA) rates, etc., based on the culture/ethnicity and language?
- _____ Are client/consumer satisfaction surveys available in different languages in proportion to the demographic data?
- _____ Are there data collection systems developed and maintained to track clients/consumers by demographics, utilization and outcomes across levels of care, transfers, referrals, re-admissions, etc.?

IX. Formulating a culturally competent plan based on the assessment of your program or agency

Focus on the following critical areas of concern as you develop goals for a culturally competent plan for your agency's service system.

Access: Degree to which services to persons are quickly and readily available.

Engagement: The skill and environment to promote a positive personal impact on the quality of the client's commitment to be in treatment.

Retention: The result of quality service that helps maintain a client in treatment with continued commitment.

Based on an assessment of your agency, determine whether, in your initial plan, you need to direct efforts of developing cultural competency toward one, or a combination, of the above critical areas. **Then, structure your agency's cultural competence plan using the following instructions:**

1. Based on the results of this assessment, summarize and describe your organization's perceived **strengths** in providing **services to persons from different cultural groups**. Please provide specific examples. Attach supporting documentation (e.g., Data, Policies, Procedures, etc.)

2. Based on your assessment, summarize and describe your organization's primary areas considered either **"Priority Concerns" (#1 and/or #2)**, or **"Needs Improvement" (#3)** in providing services to persons from different cultural groups.
3. Based on your organization's **strengths** and **needs**, **prioritize** both the organizational goals and objectives addressed in your **cultural competence plan**. Describe clearly what you will do to provide services to persons who are culturally and linguistically different.
4. Using the developed goals and objectives, please describe in detail the plans, activities, and/or strategies you will implement to assist your organization in meeting each of the goals and objectives indicated.

Patient Satisfaction and Feedback on Clinical and Program Culturally Responsive Services

Iowa Cultural Understanding Assessment–Client Form

Please indicate your level of agreement with the statements below by circling the number to the right of the statement that best fits your opinion. All responses are confidential. When you have completed the survey, please either use the pre-addressed, stamped envelope to return the survey by mail or place it in the drop box at the facility. **Thank you very much for your participation!**

Demographic Information

What is your sex? ☐ Male ☐ Female

What is your race? ☐ Alaskan Native ☐ American Indian ☐ Asian ☐ Black or African American
☐ Native Hawaiian or other Pacific Islander ☐ White

Are you Hispanic or Latino? ☐ Yes ☐ No

STATEMENT	RESPONSE				
	Strongly Disagree	Disagree	Neither Agree Nor Disagree	Agree	Strongly Agree
1. The staff here understands some of the ideas that I, my family, and others from my cultural, racial, or ethnic group may have.	1	2	3	4	5
2. Staff here understands the importance of my cultural beliefs in my treatment process.	1	2	3	4	5
3. The staff here listens to me and my family when we talk to them.	1	2	3	4	5
4. If I want, the staff will help me get services from clergy or spiritual leaders.	1	2	3	4	5
5. The services I get here really help me work toward things like getting a job, taking care of my family, going to school, and being active with my friends, family, and community.	1	2	3	4	5

(Continued on the next page.)

Iowa Cultural Understanding Assessment–Client Form (continued)

STATEMENT	RESPONSE				
	Strongly Disagree	Disagree	Neither Agree Nor Disagree	Agree	Strongly Agree
6. The staff here seems to understand the experiences and problems I have in my past life.	1	2	3	4	5
7. The waiting room and/or facility has pictures or reading material that show people from my racial or ethnic group.	1	2	3	4	5
8. The staff here knows how to use their knowledge of my culture to help me address my current day-to-day needs.	1	2	3	4	5
9. The staff here understands that I might want to talk to a person from my own racial or ethnic group about getting the help I want.	1	2	3	4	5
10. The staff here respects my religious or spiritual beliefs.	1	2	3	4	5
11. Staff from this program comes to my community to let people like me and others know about the services they offer and how to get them.	1	2	3	4	5
12. The staff here asks me, my family, or others close to me to fill out forms that tell them what we think of the place and services.	1	2	3	4	5
13. Staff here understands that people of my racial or ethnic group are <i>not</i> all alike.	1	2	3	4	5
14. It was easy to get information I needed about housing, food, clothing, child care, and other social services from this place.	1	2	3	4	5
15. The staff here talks to me about the treatment they will give me to help me.	1	2	3	4	5
16. The staff here treats me with respect.	1	2	3	4	5
17. The staff seems to understand that I might feel more comfortable working with someone who is the same sex as me.	1	2	3	4	5

(Continued on the next page.)

Iowa Cultural Understanding Assessment–Client Form (continued)

STATEMENT	RESPONSE				
	Strongly Disagree	Disagree	Neither Agree Nor Disagree	Agree	Strongly Agree
18. Most of the time, I feel I can trust the staff here who work with me.	1	2	3	4	5
19. The waiting room has brochures or handouts that I can easily understand that tell me about services I can get here.	1	2	3	4	5
20. If I want, my family or friends are included in discussions about the help I need.	1	2	3	4	5
21. The services I get here deal with the problems that affect my day-to-day life such as family, work, money, relationships, etc.	1	2	3	4	5
22. Some of the staff here understand the difference between their culture and mine.	1	2	3	4	5
23. Some of the counselors are from my racial or ethnic group.	1	2	3	4	5
24. Staff members are willing to be flexible and provide alternative approaches or services to meet my cultural/ethnic treatment needs.	1	2	3	4	5
25. If I need it, there are translators or interpreters easily available to assist me and/or my family.	1	2	3	4	5

Source: White et al. 2009. Reproduced with permission.

Appendix D—Screening and Assessment Instruments

Important Note: The following tables provide an overview of selected instruments that screen and assess for substance use disorders and mental disorders and symptoms. These tables only represent a sample of instruments. In reviewing the tables, do not assume that the instruments have normative data across race and ethnicities. The citations and information

listed in this appendix serve only as a starting point for investigating the appropriateness of available instruments within specific populations. Citations reflect information about the effectiveness of the testing measurements as well as research that suggests modifications or reports testing discrepancies among racial and ethnic populations.

Screening and Assessment Instruments for Substance Use Disorders

Instrument	Description	Clinical Utility
Alcohol, Smoking, and Substance Involvement Screening Test (ASSIST; Humeniuk et al. 2010)	The ASSIST (version 3.1) has eight items to screen for use of tobacco products, alcohol, and drugs	ASSIST was developed by the World Health Organization (WHO) as a culturally neutral tool for use in primary and general medical care settings. This paper-pencil instrument takes 5 to 10 minutes to complete and is designed to be administered by a health worker. ASSIST determines a risk score for each substance; the score starts a discussion with clients about their substance use. For information about the instrument and its availability in other languages, see http://www.who.int/substance_abuse/activities/assist/en/
Alcohol Use Disorders Identification Test (AUDIT; Babor et al. 1992; Saunders et al. 1993)	This 10-item screening questionnaire was developed to identify people whose alcohol consumption is hazardous or harmful to their health.	The AUDIT was developed by WHO for use in multinational settings—the original sample included subjects from Australia, Bulgaria, Kenya, Mexico, Norway, and the United States (Allen et al. 1997; Saunders et al. 1993). Populations researched: Latinos (Cherpitel 1999; Cherpitel and Bazargan 2003; Cherpitel and Borges 2000; Frank et al. 2008; Reinert and Allen 2007; Volk et al. 1997), northern (Asian) Indians (Pal et al. 2004); Vietnamese (Giang et al. 2005); Brazilians (Lima et al. 2005), and Nigerians (Adewuya 2005).

(Continued on the next page.)

Screening and Assessment Instruments for Substance Use Disorders (continued)

Instrument	Description	Clinical Utility
		Languages available in: Numerous languages, including Spanish (de Torres et al. 2009; Medina-Mora et al. 1998), French (Gache et al. 2005), Mandarin and Cantonese (Leung and Arthur 2000), Nigerian languages (Adewuya 2005), Russian, German, and Korean (Kim et al. 2008).
Addiction Severity Index (McLellan et al. 1980). Available online at http://www.tresearch.org/index.php/tools/download-asi-instruments-manuals/	Currently in its 5th edition, this instrument assesses the severity of substance use disorders. It has 200 items distributed over seven subscales.	Populations researched: African Americans (Drake et al. 1995; Leonhard et al. 2000; McLellan et al. 1985), and Northern Plains American Indians (Carise and McLellan 1999). Languages available in: Numerous languages, including Spanish (Sandí Esquivel and Avila Corrales 1990; for multimedia version see Butler et al. 2009), French (Daeppen et al. 1996; Krenz et al. 2004), Japanese (Haraguchi et al. 2009), and Chinese (Liang et al. 2008).
Alcohol Use Disorder and Associated Disabilities Interview Schedule (AUDADIS; Grant and Hasin 1990). Available online at http://pubs.niaaa.nih.gov/publications/audadis.pdf	This structured interview is administered by nonprofessional interviewers to diagnose substance use disorders and assess some co-occurring mental disorders. It evaluates acculturation and racial/ethnic orientation. Currently in its 4th edition (AUDADIS-IV).	The AUDADIS has been found reliable in large general-population studies (Grant et al. 1995; Ruan et al. 2008). Populations researched: African Americans, Latinos, Asians, and Native Americans (Canino et al. 1999; Chatterji et al. 1997; Grant et al. 1995; Ruan et al. 2008). Languages available in: Chinese and Spanish (Canino et al. 1999; Horton et al. 2000; Leung and Arthur 2000).
CAGE (Ewing 1984; Mayfield et al. 1974)	This is a set of four questions used to detect possible alcohol use disorder.	Populations researched: African Americans (Cherpitel 1997; Frank et al. 2008); Latino (Saitz et al. 1999). Languages available in: Numerous languages, including Spanish, Creole, Chinese, and Japanese.
Composite International Diagnostic Interview-Substance Abuse Module (CIDI-SAM; Cottler 2000)	This structured, detailed interview diagnoses substance abuse and dependence; it is an expanded version of the substance use section of the CIDI.	The instrument has been well evaluated with international populations from a variety of different nations and found to have good reliability for most substances of abuse (Ustün et al. 1997). Populations researched: African Americans (Horton et al. 2000) and Brazilians (Quintana et al. 2004; 2007). Languages available in: Numerous languages, including Portuguese, Spanish, Arabic, Japanese, Vietnamese, and Malay.

(Continued on the next page.)

Screening and Assessment Instruments for Substance Use Disorders (continued)

Instrument	Description	Clinical Utility
Drug Abuse Screening Test (DAST; Skinner 1982)	This self-report instrument (10- and 20-item versions) identifies people who are abusing psychoactive drugs and measures degree of related problems.	No significant differences in DAST reliability across race or cultural background were found (Yudko et al. 2007). Languages available in: Numerous, including Spanish for the 10-item DAST (DAST-10; Bedregal et al. 2006), Portuguese, Hebrew, Arabic, and Thai.
Rapid Alcohol Problems Screen (RAPS; Cherpitel 1995, 2000)	The RAPS is a five-question test (also available in a newer four-item version, the RAPS-4) that combines optimal questions from other instruments.	The RAPS has high sensitivity across both ethnicity and gender (Cherpitel 1997; 2002). It has also been found to work significantly better than the AUDIT for screening African American and Latino men and to be on par with the AUDIT for women (Cherpitel and Bazargan 2003). Populations researched: Mexican Americans (Borges and Cherpitel 2001); residents of various countries (Argentina, Belarus, Brazil, Canada, China, Czech Republic, India, Mexico, Mozambique, Poland, South Africa, and Sweden; Cherpitel et al. 2005). Languages available in: Numerous, including Spanish, Chinese, and Portuguese.
Short Michigan Alcohol Screening Test (S-MAST; Selzer et al. 1975)	The S-MAST screens for alcohol use disorder.	Populations researched: African Americans, Arab Muslims, American Indians, Asian Indians, and Thai (Al-Ansari and Negrete 1990; Pal et al. 2004; Nanakorn et al. 2000; Robin et al. 2004). Languages available in: Numerous, including Spanish, French, Thai, and Asian Indian languages.
TWEAK (Russell 1994)	TWEAK is a five-item screening instrument originally created to screen for risky drinking during pregnancy (but has been validated for a range of male and female populations).	Populations researched: Mexican Americans (Borges and Cherpitel 2001) and African Americans (Cherpitel 1997). Languages available in: Spanish (Cremonte and Cherpitel 2008).

Screening and Assessment Instruments for Mental Disorders and Symptoms

Instrument	Description	Clinical Utility With Specific Racial/Ethnic Groups
Beck Anxiety Inventory (BAI; Beck and Steer 1990)	The BAI is a 21-item scale that distinguishes anxiety from depression.	Populations researched: African Americans (Chapman et al. 2009). Languages available in: Numerous languages, including Spanish (Novy et al. 2001), Arabic, Chinese, Farsi, Korean, and Turkish.
Beck Depression Inventory (BDI) and Beck Depression Inventory, 2nd Edition (BDI-II; Beck et al. 1996)	The BDI is a 21-item instrument used to assess the intensity of depression.	Several versions of the BDI are available with cultural specificity. Populations researched: African Americans (Dutton et al. 2004; Grothe et al. 2005; Joe et al. 2008), Asian Americans (Carmody 2005; Crocker et al. 1994), Hmong (Mouanoutoua et al. 1991), Mexican Americans (Gatewood-Colwell et al. 1989), and Latinos (Contreras et al. 2004). Languages available in: Numerous, including Spanish (Azocar et al. 2001; Bonilla et al. 2004; Carmody 2005; Wiebe and Penley 2005), Chinese (Yeung et al. 2002; Zheng and Lin 1991), French, Arabic (Abdel-Khalek 1998; Alansari 2006), Hebrew, and Farsi (Ghassemzadeh et al. 2005).
Center for Epidemiological Studies-Depression Scale (CES-D; Radloff 1977)	The CES-D is a 20-item self-report scale designed to measure depressive symptoms.	May underestimate symptoms in African Americans (Bardwell and Dimsdale 2001; Cole et al. 2000). Populations researched: Latinos (Batistoni et al. 2007; Garcia and Marks 1989; Posner et al. 2001; Reuland et al. 2009; Roberts et al. 1990), Asian Indians (Diwan et al. 2004; Gupta et al. 2006), Native Americans (Chapleski et al. 1997), and African Americans (Canady et al. 2009; Makambi et al. 2009; Nguyen et al. 2004). Languages available in: Numerous languages, including Spanish (Reuland et al. 2009), Chinese (Lin 1989), Greek, Korean, and Portuguese.
Geriatric Depression Scale (Sheikh and Yesavage 1986)	Available in 30- and 15-item forms, this instrument screens for depression in older adults.	Populations researched: Latinos (Reuland et al. 2009) and Asians (Broekman et al. 2008; Nyunt et al. 2009). Languages available in: Available in 30 languages and validated with a number of different populations (available online at http://www.stanford.edu/~yesavage/GDS.html).
Millon Clinical Multiaxial Inventory-III (Millon et al. 2009)	Assesses 13 personality disorders (DSM-III-R Axis II disorders) and 9 clinical syndromes (DSM-III-R Axis I disorders); includes scales to assess substance related problems.	Populations researched: African Americans (Calsyn et al. 1991; Craig and Olson 1998) and Latinos (Fernández-Montalvo et al. 2006). Languages available in: Multiple languages, including Spanish, Korean, Cantonese, and Portuguese.

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Instruments To Screen and Assess Mental Disorders and Symptoms (continued)

Minnesota Multiphasic Personality Inventory, 2nd Edition (MMPI-2) (Butcher et al. 1989)	The MMPI-2 measures personality traits and symptom patterns.	Normed for Asian Americans, African Americans, Latinos, and American Indians (Hathaway et al. 1989). Populations researched: African Americans (Castro et al. 2008; McNulty et al. 2003; Monnot et al. 2009; Whatley et al. 2003) and Asian Americans (Tsai and Pike 2000; Tsushima and Tsushima 2009). Languages available in: Numerous, including French, Hmong, and Spanish (Velasquez et al. 2000).
Mini International Neuropsychiatric Interview (M.I.N.I.; Sheehan et al. 1998)	This is a short, structured, diagnostic interview that assesses the most common mental disorders (including substance use disorders).	Populations researched: African Americans (Black et al. 2004). The Major Depressive Episode and Posttraumatic Stress Disorder (PTSD) sections of the M.I.N.I. have been adapted for use in screening for PTSD in refugees, and found effective across cultures in a multinational sample (Eytan et al. 2007). Languages available in: Over 43 languages, including French, Italian (Rossi et al. 2004), Japanese (Otsubo et al. 2005), Spanish, Italian, and Arabic (Amorim et al. 1998; Lecrubier et al. 1997; Sheehan et al. 1997, 1998).
Schedules for Clinical Assessment in Neuropsychiatry, 2nd Version (SCAN-2; Wing et al. 1998)	The SCAN-2 is a set of instruments that measure psychopathology and behavior associated with major mental disorders.	Populations researched: The SCAN-2 was developed by WHO with an international sample that included participants from Turkey, Greece, India, the United States, Nigeria, Romania, Mexico, Spain, and South Korea and is intended to be cross-culturally appropriate (Room et al. 1996). Languages available in: Chinese (Cheng et al. 2001), Danish, Dutch, English, French, German, Greek, Italian, Kannada, Portuguese, Spanish, Thai, Turkish, and Yoruba.
Symptom Checklist-90-R (SCL-90R; Derogatis 1992)	This 90-item checklist evaluates psychiatric symptoms and their intensity in nine different categories and screens for a broad range of mental disorders.	The SCL-90R has been normed for adult inpatient and outpatient psychiatric patients and adult and adolescent nonpatients across a number of ethnic groups (Derogatis 1992). Populations researched: Latinos (Martinez et al. 2005) and African Americans (Ayalon and Young 2009). Languages available in: Spanish, French, Armenian, and Persian.

Appendix E—Cultural Formulation in Diagnosis and Cultural Concepts of Distress

Cultural Formulation in Diagnosis

Clinicians need to consider the effects of culture when diagnosing clients. The following cultural formulation adopted by the American Psychiatric Association (APA) in the *Diagnostic and Statistical Manual of Mental Disorders*, Fifth Edition (DSM-5; 2013, pp. 749–759) provides a systematic outline for incorporating culturally relevant information when conducting a multi-axial diagnostic assessment. Whether or not they are credentialed to diagnose disorders, counselors and other clinical staff can use the main content areas listed below to guide the interview, initial intake, and treatment planning processes. (For review, see Mezzich and Caracci 2008; for Native American application, specifically Lakota, refer to Brave Heart 2001.)

1. Cultural identity of the person. Note the person's ethnic or cultural reference groups. For immigrants and ethnic minorities, also note degree of involvement with culture of origin and host culture (where applicable). Also note language ability, use, and preference (including multilingualism).

2. Cultural explanations of the person's illness. Identify the following: the predomi-

nant idioms of distress through which symptoms or the need for social support are communicated (e.g., “nerves,” possessing spirits, somatic complaints, inexplicable misfortune), the meaning and perceived severity of the individual's symptoms in relation to norms of the cultural reference group, any local illness category used by the individual's family and community to identify a condition (see the “Cultural Concepts of Distress” section of this appendix), the perceived causes or explanatory models that the individual and the reference group use to explain the illness, and current preferences for and past experiences with professional and popular sources of care.

3. Cultural factors related to psychosocial environment and level of functioning. Note culturally relevant interpretations of social stressors, available social supports, and levels of functioning and disability, including stresses in the local social environment and the role of religion and kin networks in providing emotional, instrumental, and informational support.

4. Cultural elements of the relationship between client and clinician. Indicate differences in culture and social status between client and clinician, as well as any problems these differences may cause in diagnosis and

treatment (e.g., difficulty communicating in the client’s first language, eliciting symptoms or understanding their cultural significance, negotiating an appropriate relationship or level of intimacy, determining whether a behavior is normative or pathological).

5. Overall cultural assessment for diagnosis and care. Conclude cultural formulation by discussing how cultural considerations specifically influence comprehensive diagnosis and care.

Cultural Concepts of Distress

Just as standard screening instruments can sometimes be of limited use with culturally

diverse populations, so too are standard diagnoses. Expressions of psychological problems are, in part, culturally specific, and behavior that is aberrant in one culture can be standard in another. For example, seemingly paranoid thoughts are to be expected in clients who have migrated from countries with oppressive governments. Culture plays a large role in understanding phenomena that might be construed as mental illnesses in Western medicine. These cultural concepts of distress may or may not be linked to particular DSM-5 diagnostic criteria (APA 2013). The table that follows lists DSM-5 cultural concepts of distress; other concepts exist that are not recognized in DSM-5.

DSM-5 Cultural Concepts of Distress

Syndrome	Description	Populations
Ataque de nervios	Commonly reported symptoms include uncontrollable shouting, attacks of crying, trembling, heat in the chest rising into the head, and verbal or physical aggression. Dissociative experiences, seizurelike or fainting episodes, and suicidal gestures are prominent in some attacks but absent in others. A general feature of an ataque de nervios is a sense of being out of control. Ataques de nervios frequently occur as a direct result of a stressful event relating to the family (e.g., death of a close relative, separation or divorce from a spouse, conflict with spouse or children, or witnessing an accident involving a family member). People can experience amnesia for what occurred during the ataque de nervios, but they otherwise return rapidly to their usual level of functioning. Although descriptions of some ataques de nervios most closely fit with the DSM-IV description of panic attacks, the association of most ataques with a precipitating event and the frequent absence of the hallmark symptoms of acute fear or apprehension distinguish them from panic disorder. Ataques range from normal expressions of distress not associated with a mental disorder to symptom presentations associated with anxiety, mood dissociative, or somatoform disorders.	Caribbean, Latin American, Latin Mediterranean
Dhat (<i>jiryān</i> in India, <i>skra prameha</i> in Sri Lanka, <i>shen-k’uei</i> in China)	A folk diagnosis for severe anxiety and hypochondriacal concerns associated with the discharge of semen, whitish discoloration of the urine, weakness, and exhaustion.	Asian Indian

(Continued on the next page.)

DSM-5 Cultural Concepts of Distress (continued)

Nervios	Refers both to a general state of vulnerability to stress and to a syndrome evoked by difficult life circumstances. <i>Nervios</i> includes a wide range of symptoms of emotional distress, somatic disturbance, and inability to function. Common symptoms include headaches and “brain aches,” irritability, stomach disturbances, sleep difficulties, nervousness, tearfulness, inability to concentrate, trembling, tingling sensations, and <i>mareos</i> (dizziness with occasional vertigo-like exacerbations). <i>Nervios</i> tends to be an ongoing problem, although it is variable in the degree of disability manifested. <i>Nervios</i> is a broad syndrome that ranges from cases free of a mental disorder to presentations resembling adjustment, anxiety, depressive, dissociative, somatoform, or psychotic disorders. Differential diagnosis depends on the constellation of symptoms, the kind of social events associated with onset and progress, and the level of disability experienced.	Latin American
Shenjing shuairuo	A condition characterized by physical and mental fatigue, headaches, difficulty concentrating, dizziness, sleep disturbance, and memory loss. Other symptoms include gastrointestinal problems, sexual dysfunction, irritability, excitability, and autonomic nervous system disturbances.	Chinese
Susto (<i>espanto, pismo, tripa ida, perdida del alma, or chibih</i>)	An illness attributed to a frightening event that causes the soul to leave the body and results in unhappiness and sickness. Individuals with <i>susto</i> also experience significant strains in key social roles. Symptoms can appear days or years after the fright is experienced. In extreme cases, <i>susto</i> can result in death. Typical symptoms include appetite disturbances, inadequate or excessive sleep, troubled sleep or dreams, sadness, lack of motivation, and feelings of low self-worth or dirtiness. Somatic symptoms accompanying <i>susto</i> include muscle aches and pains, headache, stomachache, and diarrhea. Ritual healings focus on calling the soul back to the body and cleansing the person to restore bodily and spiritual balance. <i>Susto</i> can be related to major depressive disorder, posttraumatic stress disorder, and somatoform disorders. Similar etiological beliefs and symptom configurations are found in many parts of the world.	Latino American, Mexican, Central and South American
Taijin kyofusho	This syndrome refers to an individual’s intense fear that his or her body, its parts, or its functions displease, embarrass, or are offensive to other people in appearance, odor, facial expressions, or movement. This syndrome is included in the official Japanese diagnostic system for mental disorders.	Japanese

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Appendix F—Cultural Resources

General Resources

Addiction Technology Transfer Centers

<http://www.nattc.org>

The Addiction Technology Transfer Centers Network identifies and advances opportunities for improving substance abuse treatment. The Network comprises 14 regional centers as well as a national office serving the United States and its territories. Regional centers cater to unique needs in their areas while supporting national initiatives. Improving cultural competence is a major focus for the Network, which seeks to improve substance abuse treatment by identifying standards of culturally competent treatment and generating ways to foster their adoption in the field.

Agency for Healthcare Research and Quality—Minority Health

<http://www.ahrq.gov/research/findings/factsheets/minority/index.html>

This site provides research findings, papers, and press releases related to minority health.

American Translators Association

<http://www.atanet.org>

The American Translators Association (ATA) offers a certification program that evaluates the competence of translators according to

guidelines that reflect current professional practice. The ATA also has online directories available. The Directory of Translation and Interpreting Services is an online directory of individual translators and interpreters. The Directory of Language Services Companies is a directory of companies that offer translating or interpreting services.

Center for Research on Ethnicity, Culture, and Health

<http://www.crech.org>

Established in 1998 in the University of Michigan's School of Public Health, the Center provides a forum for basic and applied public health research on relationships among ethnicity, culture, socioeconomic status, and health. It develops new interdisciplinary frameworks for understanding these relationships while promoting effective collaboration among public health academicians, healthcare providers, and communities to reduce racial and ethnic disparities in health care.

Community Toolbox: Cultural Competence in a Multicultural World

<http://ctb.ku.edu/en/table-of-contents/culture/cultural-competence>

The cultural competence section of this Web site provides information (including examples and links) on a number of relevant topics, such

as how to build relationships with people from different cultures, reduce prejudice and racism, build organizations and communities that are responsive to people from diverse cultures, and heal the effects of internalized oppression.

The Cross Cultural Health Care Program

<http://www.xculture.org>

Since 1992, the Cross Cultural Health Care Program (CCHCP) has been addressing broad cultural issues that affect the health of individuals and families in ethnic minority communities in Seattle and nationwide. Through a combination of cultural competency trainings, interpreter trainings, research projects, community coalition building, and other services, CCHCP serves as a bridge between communities and healthcare institutions to ensure full access to quality health care that is culturally and linguistically appropriate.

Cultural Competence Standards in Managed Care Mental Health Services

Western Interstate Commission for Higher Education. *Cultural Competence Standards in Managed Mental Health Care for Four Underserved/Underrepresented Racial/Ethnic Groups*. Boulder, CO: Western Interstate Commission for Higher Education, 1998.

The Center for Mental Health Services (CMHS) presents cultural competence standards for managed care mental health services to improve the availability of high-quality services for four underserved and/or underrepresented racial and ethnic groups—African Americans, Latinos, Native Americans, and Asian/Pacific Islander Americans. With help from the Western Interstate Commission for Higher Education Mental Health Program, CMHS convened national panels representing each major racial/ethnic group. Mental health

professionals, families, and consumers on the panels prepared the document.

Diversity Rx

<http://www.diversityrx.org>

This Web site offers resources relating to cross-cultural communication issues in healthcare settings and information on inter-preter practice, legal issues relating to language barriers and access to linguistically appropriate services, and the ways language and culture can affect the use of healthcare services.

Health Resources and Services Administration Culture, Language and Health Literacy Page

<http://www.hrsa.gov/culturalcompetence/>

The Health Resources and Services Administration Culture, Language and Health Literacy Web site provides links to various online resources relating to cultural competence in general and to providing culturally competent health care to a number of specific cultural/ethnic groups.

Instruments for Measuring Acculturation, University of Calgary

http://www.ucalgary.ca/~taras/_private/Acculturation_Survey_Catalogue.pdf

This document gives information on acculturation and cultural identity measures, presenting many in full. It does not always include scoring information but typically provides questions from each instrument.

Minority Health Project

<http://www.minority.unc.edu/>

The Minority Health Project (MHP) of the University of North Carolina's Gillings School of Global Public Health seeks to improve the

quality of racial and ethnic population data, to expand the capacity for conducting statistical research and developing research proposals on minority health, and to foster a network of researchers in minority health. MHP collaborates with the Center for Health Statistics Research, the University of North Carolina, the National Center for Health Statistics, and the Association of Schools of Public Health to conduct educational programs and provide information on minority health research and data sources.

National Center for Cultural Competence

<http://nccc.georgetown.edu>

The National Center for Cultural Competence's (NCCC) mission is to increase the capacity of health and mental health programs to design, implement, and evaluate culturally and linguistically responsive service delivery systems. NCCC conducts training, technical assistance, and consultation; participates in networking, linkages, and information exchange; and engages in knowledge and product development and dissemination.

The National Center on Minority Health and Health Disparities

<http://www.ncmhd.nih.gov>

The Center's mission is to promote minority health and reduce health disparities. It is particularly useful as a resource for information about health disparities and the best methods to address them.

International MultiCultural Institute

<http://www.imciglobal.org/>

The International MultiCultural Institute (iMCI) works with individuals, organizations, and communities to create a society that is

strengthened and empowered by its diversity. iMCI's initiatives aim to increase communication, understanding, and respect among people of diverse backgrounds and address systemic cultural issues facing our society. The Institute accomplishes this through its conferences, individualized organizational training and consulting interventions, publications, and leading-edge projects.

Office of Civil Rights

<http://www.hhs.gov/ocr/civilrights/resources/specialtopics/lep/>

The Office of Civil Rights of the U.S. Department of Health and Human Services investigates complaints, enforces rights, develops policies, and promulgates regulations to ensure compliance with nondiscrimination and health information privacy laws. The agency offers technical assistance and public education to ensure understanding of and compliance with these laws, including the provision of resources and tools to improve services for individuals with limited English proficiency.

Office of Minority Health Resource Center

<http://minorityhealth.hhs.gov/>

The Office of Minority Health (OMH) was established by the U.S. Department of Health and Human Services in 1985 to advise the Secretary and the Office of Public Health and Science on public health policies and programs affecting Native Americans, African Americans, Asian Americans, Latinos, and Native Hawaiians and other Pacific Islanders. The mission of OMH is to improve and protect the health of racial and ethnic minority populations through the development of policies and programs that will eliminate health disparities.

The OMH Resource Center (OMHRC) is a national resource and referral service for

minority health issues. It collects and distributes information on various health topics, including substance abuse, cancer, heart disease, violence, diabetes, HIV/AIDS, and infant mortality. OMHRC also facilitates information exchange on minority health issues, and offers customized database searches, publications, mailing lists, referrals, and the like regarding Native American, African American, Asian American, Pacific Islander, and Latino populations.

Substance Abuse and Mental Health Services Administration

<http://store.samhsa.gov/>

The Substance Abuse and Mental Health Services Administration (SAMHSA) is the Nation's one-stop resource for information about substance abuse and mental illness prevention and behavioral health treatment. The SAMHSA Store Web site provides information on behavioral health topics such as cultural competence, healthcare-related laws, and mental health and substance abuse.

Surgeon General's Report on Mental Health: Culture, Race, and Ethnicity

U.S. Department of Health and Human Services. *Mental Health: Culture, Race, and Ethnicity. A Supplement to Mental Health: A Report of the Surgeon General*. HHS Pub. No. SMA 01-3613. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, 2001.

This report highlights the roles that culture and society play in mental health, mental illness, and the types of mental health services people seek. The report finds that, although effective, well-documented treatments for mental illnesses are available, minorities are

less likely to receive quality care than the general population. It articulates the foundation for understanding relationships among culture, society, mental health, mental illness, and services, and also describes how these issues affect different racial and ethnic groups.

Stanford University Curriculum in Ethnogeriatrics

<http://www.stanford.edu/group/ethnoger/>

This online curriculum explores healthcare issues for older adults from a variety of cultural groups (with modules on African Americans, Latinos, Native Americans, and several Asian American populations).

African and Black American Resources

Congressional Black Caucus Foundation Health

<http://www.cbcfinc.org/what-we-do/researchandpolicy.html>

Congressional Black Caucus Foundation Health's mission is to empower people of African descent to make better decisions about their health and that of their communities. The Web site provides information about public health issues, key legislation on public policy issues, health initiatives, and local events directly and indirectly relating to the health of people of African descent worldwide. It includes a section on substance abuse.

National Black Alcoholism and Addictions Council, Inc.

<http://www.nbacinc.org>

The National Black Alcoholism and Addictions Council, Inc. (NBAC) is a nonprofit, tax-exempt organization of Black individuals concerned about alcoholism and drug abuse.

NBAC educates the public about the prevention of alcohol and drug abuse and alcoholism and is committed to increasing services for persons who are dependent upon alcohol and their families, providing quality care and treatment, and developing research models designed for Blacks. NBAC helps Blacks concerned with or involved in the field of alcoholism and drug-related issues to exchange ideas, offer services, and facilitate substance abuse treatment programs for Black Americans.

National Medical Association

<http://www.nmanet.org>

A professional and scientific organization representing the interests of more than 25,000 physicians and their patients, the National Medical Association (NMA) is the collective voice of African American physicians and a leading force for parity and justice in medicine and health. Established in 1895, NMA aims to prevent diseases, disabilities, and adverse health conditions that disproportionately or differentially affect African American and underserved populations; improve quality and availability of health care for poor and underserved populations; and increase representation and contributions of African Americans in medicine. NMA provides educational programs and opportunities for scholarly exchange, conducts outreach to promote improved public health, and establishes national health policy agendas in support of African American physicians and their patients.

Asian American, Native Hawaiian, and Other Pacific Islander Resources

Asian and Pacific Islander American Health Forum

<http://www.apiahf.org>

The Asian and Pacific Islander American Health Forum (APIAHF) is a national advocacy organization that promotes policy, program, and research efforts to improve the health of Asian and Pacific Islander Americans. APIAHF established the Asian and Pacific Islander Health Information Network (APIHIN) in 1995. APIHIN was developed as an integrated telecommunications infrastructure that gives Asians and Pacific Islanders access to health information and resources through local community access points and key provider intermediaries. The organization supports two mailing lists: API-HealthInfo, which concentrates on Asian and Pacific Islander American health, and API-SAMH, which deals with issues related to behavioral health of special interest to the Asian and Pacific Islander community.

National Asian American Pacific Islander Mental Health Association

<http://www.naapimha.org>

The National Asian American Pacific Islander Mental Health Association (NAAPIMHA) evolved from an Asian American Pacific Islander Mental Health Summit sponsored by SAMHSA. NAAPIMHA focuses on five interrelated areas: enhancing collection of appropriate and accurate data; identifying current best practices and service models; capacity building, including provision of technical assistance and training of service providers, both professional and paraprofessional; conducting research and evaluation; and working to engage consumers and families.

National Asian Pacific American Families Against Substance Abuse

<http://www.napafasa.org>

The National Asian Pacific American Families Against Substance Abuse is a nonprofit

membership organization that addresses the alcohol, tobacco, and drug issues of Asian American and Pacific Islander populations; it involves providers, families, and youth in reaching Asian American and Pacific Islander communities to promote health and social justice and reduce substance abuse and related problems.

Psychosocial Measures for Asian American Populations: Tools for Direct Practice and Research

<http://www.columbia.edu/cu/ssw/projects/pmap>

This Web site presents information on psychosocial measures (including some related to substance abuse) found to be reliable and valid with Asian Americans (in general group or for a specific subgroup).

The Vietnamese Community Health Promotion Project

<http://www.suckhoelavang.org/main.html>

This project's mission is to improve the health of Vietnamese Americans. A part of the University of California–San Francisco School of Medicine, the Web site provides information in Vietnamese and English, along with links to Vietnamese Web sites related to health issues.

Hispanic and Latino Resources

Hispanic/Latino Portal to Drug Abuse Prevention

<http://www.latino.prev.info>

The Indiana University Prevention Resource Center created this trilingual Web site to serve the growing Latino population and those who work with Latinos. Many Latinos face a language barrier, as do many prevention profes-

sionals trying to address their needs. This Web site helps bridge the communication barrier by offering information about and links to resources for substance abuse prevention, general health information, building cultural pride, and research tools, such as databases and bibliographies.

National Alliance for Hispanic Health

<http://www.hispanichealth.org>

The National Alliance for Hispanic Health is the nation's oldest and largest network of Hispanic health and human service providers. Alliance members deliver quality services to more than 12 million persons annually. As the nation's action forum for Hispanic health and well-being, the programs of the Alliance inform and mobilize consumers, support providers in the delivery of quality care, promote appropriate use of technology, improve the science base for accurate decisionmaking, and promote philanthropy.

National Council of La Raza Institute for Hispanic Health

http://www.nclr.org/index.php/issues_and_programs/health_and_nutrition/hispanic_health

The Institute for Hispanic Health (IHH) works closely with National Council of La Raza affiliates, government partners, private funders, and Latino-serving organizations to deliver quality health interventions and improve access to and use of quality health promotion and disease prevention programs. IHH provides culturally responsive and linguistically appropriate technical assistance and science-based approaches that emphasize public health, rather than disease-specific, themes. Themes include behavior change communication, healthy lifestyle promotion, improving access to quality services, and

increasing the number and level of Latinos in health fields.

National Hispanic Medical Association

<http://www.nhmamd.org>

Established in 1994, the National Hispanic Medical Association (NHMA) is a nonprofit association representing 36,000 licensed Hispanic physicians in the United States. Its mission is to improve the health of Latinos and other underserved populations. NHMA provides policymakers and healthcare providers with expert information and support in strengthening health service delivery to Latino communities across the Nation. Its agenda includes expanding access to quality health care; increasing medical education, cultural competence, and research opportunities for Latinos; and developing policy and education to eliminate health disparities for Latinos.

Native American Resources

Centers for American Indian and Alaska Native Health

<http://www.ucdenver.edu/academics/colleges/PublicHealth/research/centers/CAIANH/Pages/caianh.aspx>

The Centers for American Indian and Alaska Native Health (CAIANH) at the University of Colorado, Denver promote the health and well-being of American Indians and Alaska Natives by pursuing research, training, continuing education, technical assistance, and information dissemination in a biopsychosocial framework that recognizes the unique cultural contexts of this special population. The site provides online access to the group's journal, *American Indian and Alaska Native Mental*

Health Research, as well as information about ongoing research projects.

Indian Health Service

<http://www.ihs.gov>

The Indian Health Service (IHS) is the principal federal healthcare provider and advocate for Native Americans; it ensures that comprehensive, culturally acceptable personal and public health services are available and accessible to Native peoples. Its Web site provides a tour of the IHS and its service areas, administrative reports, legislative news, IHS job opportunities, and healthcare resources targeted to this group.

National Indian Child Welfare Association

<http://www.nicwa.org>

The National Indian Child Welfare Association (NICWA), a comprehensive source of information on American Indian child welfare, works on behalf of Indian children and families to provide public policy, research, and advocacy; information and training on Indian child welfare; and community development services to Tribal governments and programs, State child welfare agencies, and other organizations, agencies, and professionals interested in Indian child welfare. NICWA addresses child abuse and neglect through training, research, public policy, and grassroots community development. NICWA also supports compliance with the Indian Child Welfare Act of 1978, which seeks to keep American Indian children with American Indian families.

One Sky Center

<http://www.oneskycenter.org>

One Sky Center aims to improve prevention and treatment of substance abuse for Native peoples by identifying, promoting, and disseminating effective, evidence-based, culturally

appropriate substance abuse prevention and treatment services and practices for application across diverse Tribal communities. It also provides training, technical assistance, and products to expand the capacity and quality of substance abuse prevention and treatment services for this population. SAMHSA created, designed, and funds One Sky Center to work with all federal and state agencies providing services to Native Americans.

SAMHSA's Tribal Training and Technical Assistance Center

<http://beta.samhsa.gov/tribal-ttac>

The Tribal Training and Technical Assistance (TTA) Center uses a culturally relevant, evidence-based, holistic approach to support Native communities in their self-determination efforts through infrastructure

development and capacity building, as well as program planning and implementation. The Center provides TTA on mental and substance use disorders, bullying and violence, suicide prevention, and the promotion of mental health. It offers TTA to federally recognized tribes, other American Indian and Alaska Native communities, SAMHSA Tribal grantees, and organizations serving Indian Country. The Web site provides resources across behavioral health topics relevant to Native peoples.

White Bison

<http://www.whitebison.org/>

This Web site offers resources related to the Wellbriety self-help movement for Native Americans, including a discussion board and access to the *Wellbriety* online magazine.

Appendix G—Glossary

Acculturation typically refers to the socialization process through which people from one culture adopt certain elements from the dominant culture in a society.

American Indian and Alaska Native people include those “having origins in any of the original peoples of North and South America (including Central America), and who maintain tribal affiliation or community attachment” (Grieco and Cassidy 2001, p. 2).

Asians are defined in the United States (U.S.) Census as “people having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent,” including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam (Grieco and Cassidy 2001, p. 2).

Biculturalism is “a well-developed capacity to function effectively within two distinct cultures based on the acquisition of the norms, values, and behavioral routines of the dominant culture” and one’s own culture (Castro and Garfinkle 2003, p. 1385).

Biracial individuals have two distinct racial heritages, either one from each parent or as a result of racial blending in an earlier generation (Root 1992).

Blacks/African Americans are, according to the U.S. Census Bureau (2000) definition,

people whose origins are “in any of the black racial groups of Africa” (p. A-3). The term includes descendants of African slaves brought to this country against their will and more recent immigrants from Africa, the Caribbean, and South or Central America (many individuals from these latter regions, if they come from Spanish-speaking cultural groups, identify or are identified primarily as Latino). The term Black is often used interchangeably with African American, although for some, the term African American is used specifically to describe those individuals whose families have been in this country since at least the 19th century and thus have developed distinctly African American cultural groups. Black can be a more inclusive term describing African Americans as well as for more recent immigrants with distinct cultural backgrounds.

Confianza means trust or confidence in the benevolence of the other person.

Conformity in Helms’s model of racial identity development refers to the tendency of members of a racial group to behave in congruence with the values, beliefs, and attitudes of their own culture to which they have been exclusively exposed.

Cultural competence is “a set of congruent behaviors, attitudes, and policies that . . . enable a system, agency, or group of professionals to work effectively in cross-cultural situations”

(Cross et al. 1989, p. 13). It refers to the ability to honor and respect the beliefs, languages, interpersonal styles, and behaviors of individuals and families receiving services, as well as staff members who are providing such services. “Cultural competence is a dynamic, ongoing developmental process that requires a long-term commitment and is achieved over time” (U.S. Department of Health and Human Services [HHS] 2003a, p. 12).

Cultural competence plans are strategic plans that outline a systematic organizational approach to providing culturally responsive services to individuals and to increasing cultural competence among staff at each level of the organization.

Cultural diffusion is the process of cultural intermingling.

Cultural humility “incorporates a lifelong commitment to self-evaluation and critique” (Tervalon and Murray-García 1998, p. 123) to redress the power imbalances in counselor–client relationships.

Cultural norms are the spoken or unspoken rules or standards for a cultural group that indicate whether a certain social event or behavior is considered appropriate or inappropriate.

Cultural proficiency involves a deep and rich knowledge of a culture—an insider’s view—that allows the counselor to accurately interpret the subtle meanings of cultural behavior (Kim et al. 1992).

Culture is the conceptual system that structures the way people view the world—it is the particular set of beliefs, norms, and values that influence ideas about the nature of relationships, the way people live their lives, and the way people organize their world.

Ethnicity refers to the social identity and mutual belongingness that defines a group of

people on the basis of common origins, shared beliefs, and shared standards of behavior (culture).

Ethnocentrism is “the tendency to view one’s own culture as best and to judge the behavior and beliefs of culturally different people by one’s own standards” (Kottak 1991, p. 47).

Health disparity is a particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion (HHS 2011a).

Hembrismo refers to female strength, endurance, courage, perseverance, and bravery (Falicov 1998).

Latinos are those who identify themselves in one of the specific Hispanic or Latino Census categories—Mexican, Puerto Rican, or Cuban—as well as those who indicate that they are “other Spanish, Hispanic, or Latino.” Origin can be viewed as the heritage, nationality, group, lineage, or country of birth of the person or the person’s parents or ancestors before their arrival in the United States.

Immersion–emersion is a stage in the identity development models of both Cross and Helms during which a transition takes place from satisfaction with the old self to commitment to personal change: from immersion in one’s old identity to emerging with a more mature view of one’s identity (Cross 1995b).

Indigenous peoples are those people native to a particular country or region. In the case of the United States and its territories, this

includes Native Hawaiians, Alaska Natives, Pacific Islanders, and American Indians.

Institutional racism generally “refers to the policies, practices, and norms that incidentally but inevitably perpetuate inequality,” resulting in “significant economic, legal, political and social restrictions” (Thompson and Neville 1999, p. 167).

Language is a culture’s communication system and the vehicle through which aspects of race, ethnicity, and culture are communicated.

Machismo is the traditional sense of responsibility Latino men feel for the welfare and protection of their families.

Marianismo is the traditional belief that Latinas should be self-sacrificing, endure suffering for the sake of their families, and defer to their husbands in all matters. The Virgin Mary is held up as the model to which all women should aspire.

Motivational interviewing is a counseling style characterized by the strategic therapeutic activities of expressing empathy, developing discrepancy, avoiding argument, rolling with resistance, and supporting self-efficacy. In motivational interviewing, the counselor’s major tool is reflective listening.

Multiracial individuals are any racially mixed people and include biracial people, as well as those with more than two distinct racial heritages (Root 1992).

Native Hawaiians and other Pacific Islanders include those with “origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands” (Grieco and Cassidy 2001, p. 2). Other Pacific Islanders include Tahitians; Northern Mariana Islanders; Palauans; Fijians; and cultural groups like Melanesians, Micronesians, or Polynesians.

Nguzo saba are the seven African American principles celebrated during Kwanzaa:

- *Umoja* is unity with family, community, nation, and race.
- *Kujichagulia* means self-determination to define collective selves, create for collective selves, and speak for collective selves.
- *Ujima* refers to collective responsibility to build and maintain community and solve problems together.
- *Ujamaa* refers to cooperative economics to build and maintain businesses and to profit from them together.
- *Nia* is a sense of purpose to collectively build and develop community to restore people to their traditional greatness.
- *Kuumba* is creativity to always do as much as possible to leave the community more beautiful and beneficial than it was.
- *Imani* refers to belief in the community’s parents, teachers, and leaders and in the righteousness and victory of the struggle.

Organizational cultural competence and responsiveness refers to a set of congruent behaviors, attitudes, and policies that enable a system, agency, or group of professionals to work effectively in cross-cultural situations (Cross et al. 1989). It is a dynamic, ongoing process.

Orgullo means pride and dignity.

Personalismo is the use of positive personal qualities to accomplish a task.

Race is a social construct that describes people with shared physical characteristics.

Racism is an attitude or belief that people with certain shared physical characteristics are better than others.

Reculturation occurs when individuals return to their countries of origin after a prolonged period in other countries and readapt to the dominant culture.

Respeto can be translated as respect but also includes elements of both emotional dependence and dutifulness (Barón 2000).

Selective perception is, in Helms's model of racial identity development, the tendency of people early in the process to observe their environment in ways that generally confirm their pre-existing beliefs.

Simpatía is an approach to social interaction that avoids conflict and confrontation. One who is *simpático* is agreeable and strives to maintain harmony within the group.

Syncretism is the result of combining differing systems, such as traditional and introduced cultural traits.

Transculturation is the acceptance of a part or a trait of one culture into another culture.

White privilege is a form of ethnocentrism and refers to a position of entitlement based on a presumed culturally superior status.

Whites/Caucasians are people "having origins in any of the original peoples of Europe, the Middle East, or North Africa." This category includes people who indicate their race as White or report entries "such as Irish, German, Italian, Lebanese, Near Easterner, Arab, or Polish" (Grieco and Cassidy 2001, p. 2).

Appendix H—Resource Panel

Note: Information given indicates each participant’s affiliation during the time the panel was convened and may no longer reflect the individual’s current affiliation.

Ana Anders, M.S.W., LICSW

Senior Advisor
Special Populations Office
National Institute on Drug Abuse
National Institutes of Health
Bethesda, MD

Candace Baker, Ph.D.

Clinical Affairs Manager
Lesbian, Gay, Bisexual, and Transgender
Special Interest Group
National Association of Alcoholism and Drug
Abuse Counselors
Alexandria, VA

Carole Chrvala, Ph.D.

Senior Program Officer
Board on Neuroscience & Behavioral Health
Institute of Medicine
Washington, DC

Christine Cichetti

Drug Policy Advisor
United States Department of Health and
Human Services
Washington, DC

Cathi Coridan, M.A.

Senior Director for Substance Abuse
Programs
National Mental Health Association
Alexandria, VA

Edwin M. Craft, Dr.P.H.

Program Analyst
Practice Improvement Branch
Division of Services Improvement
Center for Substance Abuse Treatment
Substance Abuse and Mental Health Services
Administration
Rockville, MD

Christina Currier

Public Health Analyst
Practice Improvement Branch
Division of Services Improvement
Center for Substance Abuse Treatment
Substance Abuse and Mental Health Services
Administration
Rockville, MD

Dorynne Czechowicz, M.D.

Medical Officer
Treatment Development Branch
Division of Treatment Research and Development
National Institute on Drug Abuse
National Institutes of Health
Bethesda, MD

Janie B. Dargan

Senior Policy Analyst
Office of National Drug Control Policy
Executive Office of the President
Washington, DC

James (Gil) Hill, Ph.D.

Director
Office of Rural Health and Substance Abuse
American Psychological Association
Washington, DC

Hendree E. Jones, M.A., Ph.D.

Assistant Professor
CAP Research Director
Department of Psychiatry and Behavioral
Sciences
Johns Hopkins University Center
Baltimore, MD

Guadalupe Pacheco, M.P.A.

Special Assistant to the Deputy Assistant
Secretary
Office of Minority Health
Department of Health and Human Services
Rockville, MD

Cecilia Rivera-Casale, Ph.D.

Senior Project Officer
Center for Mental Health Services
Substance Abuse and Mental Health Services
Administration
Rockville, MD

Deidra Roach, M.D.

Health Science Administrator
National Institute on Alcohol Abuse and
Alcoholism
Bethesda, MD

Kevin Shipman, M.H.S., LPC

Deputy Chief
Grants and Program Management Division
Special Population Services
Washington, DC

Richard T. Suchinsky, M.D.

Associate Chief for Addictive Disorders and
Psychiatric Rehabilitation
Mental Health and Behavioral Sciences
Services
Department of Veterans Affairs
Washington, DC

Jan Towers, Ph.D.

Director
Health Policy
American Academy of Nurse Practitioners
Washington, DC

Jose Luis Velasco

Project Director
National Hispanic Council on Aging
Washington, DC

Karl D. White, Ed.D.

Public Health Analyst
Practice Improvement Branch
Division of Services Improvement
Center for Substance Abuse Treatment
Substance Abuse and Mental Health Services
Administration
Rockville, MD

Jeanean Willis, D.P.M., CDR, USPHS

Public Health Analyst
Office of Minority Health
Health Resources and Services
Administration
Rockville, MD

Appendix I—Cultural Competence and Diversity Network Participants

Note: Information given indicates each participant’s affiliation during the time the network was convened and may no longer reflect the individual’s current affiliation.

Elmore T. Briggs, CCDC, NCAC II
President/CEO
SuMoe Partners
Germantown, MD
African American Workgroup Member

Deion Cash
Executive Director
Community Treatment and Correction
Center, Inc.
Canton, OH
African American Workgroup Member

Magdalen Chang, Ph.D.
Center Manager
Haight Ashbury Free Clinics, Inc.
San Francisco, CA
Asian/Pacific Islander Workgroup Member

Diana Yazzie Devine, M.B.A.
Executive Director
Native American Connections, Inc.
Phoenix, AZ
Native American Workgroup Member

Terry S. Gock, Ph.D.
Director
Pacific Clinics Asian Pacific Family Center
Rosemead, CA
*Asian/Pacific Islander Workgroup and Lesbian/
Gay/Bisexual/Transgender Workgroup Member*

Renata J. Henry, M.Ed.
Director
Delaware Health and Social Services
New Castle, DE
African American Workgroup Member

Adelaida F. Hernandez, M.A., LCDC
Youth OSR Services Program Director
S.C.A.N., Inc.
Laredo, TX
Hispanic/Latino Workgroup Member

Ford H. Kuramoto, D.S.W.
President
National Asian Pacific American Families
Against Substance Abuse
Los Angeles, CA
Asian/Pacific Islander Workgroup Member

Victor Leo, M.S.W., LCSW

Board Chair

Asian/Pacific American Consortium on Substance Abuse

Portland, OR

Aging Workgroup Member and Asian/Pacific Islander Workgroup Member

Harry Montoya, M.A.

President/CEO

Hands Across Cultures

Espanola, NM

Hispanic/Latino Workgroup Member

Michael E. Neely, Ph.D., MFCC

Administrator

Integrated Care System

Los Angeles, CA

African American Workgroup Member

Tam Khac Nguyen, M.D., CCJS, LMSW

President

Vietnamese Mutual Association, Inc.

Polk City, IA

Asian/Pacific Islander Workgroup Member

Rick Rodriguez

Manager/Counselor

Services United

Santa Paula, CA

Hispanic/Latino Workgroup Member

Mariela C. Shirley, Ph.D.

Assistant Professor

University of North Carolina at Wilmington

Wilmington, NC

Hispanic/Latino Workgroup Member

Appendix J—Field Reviewers

Note: Information given indicates each participant's affiliation during the time the review was conducted and may no longer reflect the individual's current affiliation.

Alan J. Allery, M.Ed., M.H.A.

Director
Student Health Services
University of North Dakota
Grand Forks, ND

Deborah Altschul, Ph.D.

Assistant Professor/Psychologist
Mental Health Services Research and
Evaluation Unit
Adult Mental Health Division
Hawaii Department of Health
University of Hawaii
Honolulu, HI

Diana S. Amodia, M.D.

Medical Director
Substance Abuse Treatment Services
Haight Ashbury Free Clinics, Inc.
San Francisco, CA

Ronald G. Black

Director, Residential Group
Drug Abuse Foundation
Del Ray Beach, FL

Patricia T. Bowman

Probation Counselor
Fairfax Alcohol Safety Action Program
Fairfax, VA

Rodolfo T. Briseno, M.D., M.P.H.

Facilitator
Worker's Assistance Program—Youth
Advocacy
Austin, TX

Stephanie Brooks, M.S.W.

Interim Director & Assistant Professor
Programs in Couple & Family Therapy
College of Nursing and Health Professions
Drexel University
Philadelphia, PA

Jutta H. Butler, B.S.N., M.S.

Public Health Advisor
Practice Improvement Branch
Division of Services Improvement
Center for Substance Abuse Treatment
Substance Abuse and Mental Health Services
Administration
Rockville, MD

Flanders Byford, M.S.W., LCSW

Licensed Clinical Social Worker
Oklahoma City County Health Department
Oklahoma City, OK

Maria J. Carrasco, M.P.A

Director
Multicultural Action Center
Arlington, VA

Gerhard E. Carrier, Ph.D.

Chair, Mental Health & Addiction Studies
Department of Mental Health
Alvin Community College
Alvin, TX

Carol J. Colleran, CAP, ICADC

National Director of Older Adult Services
Center of Recovery for Older Adults
Hazelden Foundation/Hanley-Hazelden
West Palm Beach, FL

Cynthia C. Crone, APN, MNSC

Executive Director
Center for Addictions Research, Education,
and Services
College of Medicine, Department of
Psychiatry and Behavior Health
University of Arkansas for Medical Sciences
Little Rock, AR

John P. de Miranda, Ed.M.

Executive Director
National Association on Alcohol, Drugs, and
Disability, Inc.
San Mateo, CA

Efrain R. Diaz, Ph.D., LCSW

Program Supervisor
Connecticut Department of Mental Health
and Addiction Services
Hartford, CT

Dedric L. Doolin, M.P.A.

Deputy Director
Area Substance Abuse Council, Inc.
Cedar Rapids, IA

Donna Doolin, LCSW

Director
Division of Health Care Policy, Addiction &
Prevention Services
Kansas Department of Social and
Rehabilitation Services
Topeka, KS

Lynn Dorman, Ph.D., J.D.

President
Creating Solutions
Portland, OR

Gayle R. Edmunds

Director
Indian Alcoholism Treatment Services
Wichita, KS

Michele J. Eliason, Ed.S., Ph.D.

Associate Professor
The University of Iowa
Iowa City, IA

Jill Shepard Erickson, M.S.W., ACSW

Public Health Advisor
Child and Family Branch
Center for Mental Health Services
Substance Abuse and Mental Health Services
Administration
Rockville, MD

Elena Flores, M.A., Ph.D.

Associate Professor
School of Education
Counseling and Psychology Department
University of California, San Francisco
San Francisco, CA

Jo Ann Ford, M.R.C.

Assistant Director
Substance Abuse Resources and Disability
Issues
School of Medicine
Wright State University
Dayton, OH

Maria del Mar Garcia, M.S.W., M.H.S.

Continuing Education Coordinator
Caribbean Basin and Hispanic Addiction
Centro de Estudios en Adicción
Universidad Central del Caribe
Bayamon, PR

**Virgil A. Gooding, Sr., M.A., M.S.W.,
LISC**

Clinical Director
Foundation II, Inc.
Cedar Rapids, IA

Maya D. Hennessey, CRADC

Women's Specialist
Supervisor, Quality Assurance, Technical
Assistance & Training
Office of Special Programs
Division of Substance Abuse
Illinois Department of Human Services and
Substance Abuse
Chicago, IL

Michael W. Herring, LCSW

Wayne Psychiatric Associates, P.A.
Goldsboro, NC

Deborah J. Hollis, M.A.

Administrator
Office of Drug Control Policy
Division of Substance Abuse and Gambling
Services
Michigan Department of Community Health
Lansing, MI

Ruth Hurtado, M.H.A.

Public Health Advisor
Center for Substance Abuse Treatment
Division of Pharmacologic Therapies
Substance Abuse and Mental Health Services
Administration
Rockville, MD

Ting-Fun May Lai, M.S.W., CASAC

Director
Chinatown Alcoholism Center
Hamilton-Madison House
New York, NY

Tom Laws

Talihina, OK

Susan F. LeLacheur, M.P.H., PA-C

Assistant Professor of Health Care Sciences
The George Washington University
Washington, DC

Jeanne Mahoney

Director
Provider's Partnership-Women's Health Issues
American College of Obstetricians and
Gynecologists
Washington, DC

Michael Mobley, Ph.D., M.Ed.

Assistant Professor in Counseling Psychology
Department of Educational, School and
Counseling Psychology
University of Missouri–Columbia
Columbia, MO

Valerie Naquin, M.A.

Vice President
Planning and Development
Cook Inlet
Anchorage, AK

Paul C. Purnell, M.S.

President
Social Solutions, LLC
Potomac, MD

Laura Quiros, M.S.W.

Program Associate
Program Planning & Development Department
Palladia, Inc.
New York, NY

Melissa V. Rael, USPHS

Senior Program Management Officer
Co-Occurring and Homeless Branch
Division of State and Community Assistance
Center for Substance Abuse Treatment
Substance Abuse and Mental Health Services
Administration
Rockville, MD

Susanne R. Rohrer, R.N.

Nurse Consultant
Practice Improvement Branch
Division of Services Improvement
Center for Substance Abuse Treatment
Substance Abuse and Mental Health Services
Administration
Rockville, MD

**Laurie J. Rokutani, Ed.S., NCC, CPP,
MAC**

Training Coordinator
Virginia Commonwealth University
Mid-America Addiction Technology Transfer
Center
Richmond, VA

LaVerne R. Saunders, B.S.N., R.N., M.S.

Training Specialist and Consultant
Dorrington & Saunders and Associates
Framingham, MA

**Gary Q. Tester, MAC, CCDC III-E, OCPS
II**

Director
Ohio Department of Alcohol and Drug
Addiction Services
Columbus, OH

Ralph Varela, M.S.W.

Chief Executive Officer
Pinal Hispanic Council
Eloy, AZ

Ming Wang, L.C.S.W.

Program Manager
Division of Substance Abuse and Mental
Health
Utah Department of Human Services
Salt Lake City, UT

Mike Watanabe, M.S.W.

President and CEO
Asian American Drug Abuse Program, Inc.
Los Angeles, CA

Debbie A. Webster

Community Program Coordinator
Best Practice Team
Division of Mental Health, Developmental
Disabilities, and Substance Abuse Services
North Carolina Department of Health and
Human Services
Raleigh, NC

Melvin H. Wilson, M.B.A., LCSW-C

High Intensity Drug Trafficking Area
Coordinator
Maryland Division of Parole and Probation
Baltimore, MD

Ann S. Yabusaki, M.Ed., M.A., Ph.D.

Director
Coalition for a Drug-Free Hawaii
Honolulu, HI

Appendix K—Acknowledgments

Numerous people contributed to the development of this Treatment Improvement Protocol (TIP), including the TIP Consensus Panel (page vii), the Knowledge Application Program (KAP) Expert Panel and Federal Government Participants (page ix), the Resource Panel (Appendix H), the Cultural Competence and Diversity Network Participants (Appendix I), and the Field Reviewers (Appendix J).

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CDM KAP personnel included Rose M. Urban, M.S.W., J.D., LCSW, CCAC, CSAC, KAP Executive Project Director; Jessica L. Culotta, M.A., KAP Managing Project Co-Director and former Managing Editor; Susan Kimner, Former Managing Project Co-Director; Raquel Witkin, M.S., former Deputy Project Manager; Claudia A. Blackburn, Psy.D., Expert Content Director; Shel Weinberg, Ph.D., Senior Research/Applied Psychologist; J. Max Gilbert, M.A., Ph.D., Senior Editor/Writer; Deborah Steinbach, M.A., and Janet G. Humphrey, M.A., former Senior Editors/Writers; Claudia Askew, Catalina Bartlett, M.A., Angela Cross, Timothy Ferguson, M.A., Randi Henderson, and Susan Hills, Ph.D., Writers; Angela Fiastro, Junior Editor; Sonja Easley, former Editorial Assistant; Virgie D. Paul, M.L.S., Librarian; and Maggie Nelson, former Project Coordinator.

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Treatment Improvement Protocols (TIPs) are the products of a systematic and innovative process that brings together clinicians, researchers, program managers, policymakers, and other federal and non-federal experts to reach consensus on state-of-the-art treatment practices. TIPs are developed under the Substance Abuse and Mental Health Services Administration's (SAMHSA's) Knowledge Application Program (KAP) to improve the treatment capabilities of the Nation's alcohol and drug abuse treatment service system.

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A Quick Guide clearly and concisely presents the primary information from a TIP in a pocket-sized booklet. Each Quick Guide is divided into sections to help readers quickly locate relevant material. Some contain glossaries of terms or lists of resources. Page numbers from the original TIP are referenced so providers can refer back to the source document for more information.

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