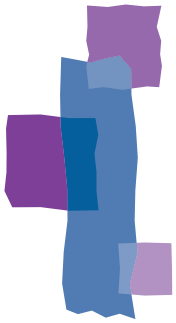


EVIDENCE-BASED PRACTICES KIT

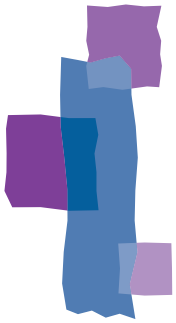
Knowledge Informing Transformation

# Getting Started with Evidence-Based and Promising Practices

## Supported Education

A Promising Practice

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
www.samhsa.gov



EVIDENCE-BASED PRACTICES KIT

Knowledge Informing Transformation

# Getting Started
## with Evidence-Based and Promising Practices

## Supported Education

A Promising Practice

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administration
Center for Mental Health Services

## Acknowledgments

This document was prepared for the Substance Abuse and Mental Health Services Administration (SAMHSA) by Karen V. Unger, Ph.D., Rehabilitation Through Education, Portland, Oregon, under contract number P233200500802P and Westat under contract number 270-03-6005 with SAMHSA, U.S. Department of Health and Human Services (HHS). Marian Scheinholtz served as the SAMHSA Government Project Officer.

## Disclaimer

The views, opinions, and content of this publication are those of the authors and contributors and do not necessarily reflect the views, opinions, or policies of the Center for Mental Health Services (CMHS), SAMHSA, or HHS.



## Electronic Access and Copies of Publication

This publication may be downloaded or ordered at http://store.samhsa.gov. Or, please call SAMHSA at **1-877-SAMHSA-7** (1-877-726-4727) (English and Español).

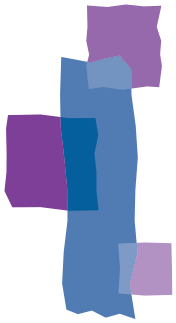
## Recommended Citation

Substance Abuse and Mental Health Services Administration. *Supported Education: Getting Started with Evidence-Based and Promising Practices.* HHS Pub. No. SMA-11-4654, Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services, 2011.

**Originating Office**

**Center for Mental Health Services**
**Substance Abuse and Mental Health Services Administration**
**1 Choke Cherry Road**
**Rockville, MD 20857**

HHS Publication No. SMA-11-4654
Printed 2011



EVIDENCE-BASED PRACTICES KIT

Knowledge Informing Transformation

## Getting Started with Evidence-Based and Promising Practices

*Getting Started with Evidence-Based and Promising Practices* gives you an overview of the activities that are generally involved in implementing evidence-based and promising practices and tells you how to make them culturally competent. This booklet is particularly relevant to the following:

- Mental health authorities; and
- Agency staff who develop and manage these programs.

# Supported Education

## A Promising Practice

For references, see the booklet *The Evidence*.

This KIT is part of a series created by the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services.

This booklet is part of the Supported Education KIT that includes a CD-ROM and seven booklets:

**How to Use the KITs**

**Getting Started with Evidence-Based and Promising Practices**

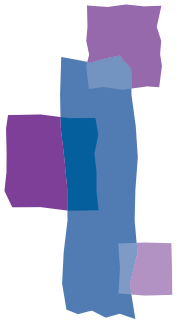
**Building Your Program**

**Training Frontline Staff**

**Evaluating Your Program**

**The Evidence**

**Using Multimedia to Introduce Your Promising Practice**



EVIDENCE-BASED PRACTICES KIT

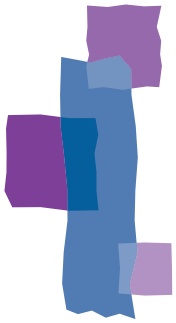
Knowledge Informing Transformation

## What's in *Getting Started with Evidence-Based and Promising Practices*



# Supported Education

A Promising Practice



EVIDENCE-BASED PRACTICES KIT

Knowledge Informing Transformation

# Getting Started with Evidence-Based and Promising Practices

## Consensus Building: Build Support for Change

Within a system, change affects stakeholders differently. Consequently, when making changes in the mental health system, mental health agencies should expect varied reactions from staff, community members, consumers, and families. Since misunderstandings can stymie your efforts to implement evidence-based and promising practices, it is important to build consensus in the community.

**Practitioner training alone is not effective.** The experience of mental health authorities and agencies that have successfully implemented evidence-based practices (EBPs) reinforces that fact. Instead, practitioner training must be complemented by a broad range of implementation activities, including the following:

- Building support for the practice;
- Integrating practice principles into agency policies and procedures;
- Training staff agency-wide; and
- Allowing for ongoing monitoring and evaluation of the program.

This overview introduces the *general range* of activities involved in successfully implementing evidence-based or promising practices. For guidelines and suggestions for practice-specific activities, see the remaining sections of each KIT.



## How to build support

Consensus-building activities are designed to build support. Here are some ways to develop them:

**Step 1** **Identify key stakeholders or people who will be affected by the practice.** Stakeholders may include agency personnel at all levels, mental health authority staff, and consumer and family representatives. Depending on the practice, you may also wish to build relationships with other community organizations, such as the Department of Education, state and local educational agencies, the Department of Vocational Rehabilitation, homeless shelters, food banks, police, hospitals, peer-support programs, and consumer and family groups.

**Step 2** **Invite one potential champion from each stakeholder group to participate in an advisory committee.** According to agencies that have successfully implemented EBPs, identifying ongoing champions and forming an advisory committee are critical activities. While at first you may feel that creating an advisory committee slows the process, any amount of time used to build stakeholder support is worth the effort.

Evidence-based and promising practices have little hope for success if the community doesn't recognize that they are needed, affordable, worth the effort, and congruent with community values and the agency's practice philosophy. Mental health authorities and agency administrators must convey to key stakeholders a clear vision and a commitment to implementing the practice. By forming an advisory committee of potential champions from each stakeholder group, you will be able to broadly disseminate information in the community. After training committee members in the basic practice principles, ask them to hold informational meetings or to regularly disseminate information to their stakeholder groups.

**Step 3** **Ask for advice.** Developing the advisory committee and educating its members early in the planning process will allow you to ask committee members for their advice during all phases of the implementation process. Community members may help assess how ready the community and the agency are to implement the practice and its activities. Once the practice is in place, committee members can keep staff informed of relevant community trends that may have an impact on providing services.

Advisory committees are crucial for sustaining the practice over time. When staff turn over, or other well-trained staff leave and must be replaced, or when funding streams or program requirements change, community and political alliances are essential. A well-established committee can champion the initiative through changes.

**Step 4** **Build an action plan.** Once key stakeholders understand the practice, have your advisory committee develop an action plan for implementation. Action plans outline activities and strategies involved in developing the program, including the following:

- Integrating the practice principles into mental health authority and agency policies and procedures;
- Outlining initial and ongoing training plans for internal and external stakeholders; and
- Designing procedures to regularly monitor and evaluate the evidence-based or promising practice.

Base the activities in your action plan on the needs of the population you serve, your community, and your organization.

**Step 5** **Involve the advisory committee in ongoing evaluation.** Committee members can help you decide which outcomes you should target. They can help you integrate continuous quality improvements.

## To start implementing your evidence-based or promising practice:

- Pinpoint key stakeholder groups that will be affected by implementing the practice.
- Identify potential champions from each group and invite them to participate in an advisory committee.
- Ask the committee to advise you during the process.
- Build an action plan.
- Outline responsibilities for committee members, such as the following:
  - ❑ Participating in basic training;
  - ❑ Providing basic information about the practice to their stakeholder groups;
  - ❑ Advising you during all phases of the implementation process; and
  - ❑ Participating in an ongoing evaluation.

## Integrate the Practice into Policies and Procedures

### Examine policies and procedures

Mental health authorities and agencies that have successfully implemented evidence-based and promising practices highlight the importance of integrating the practice into policies and procedures. For example, you will immediately face decisions about staffing the program. Mental health authorities can support the implementation process by integrating staffing criteria into regulations. Agency administrators should select program leaders and practitioners based on mental health authority regulations and qualifications that the practice requires. New position descriptions should be integrated into the agency's human resource policies. Specific suggestions in *Building Your Program* will help mental health authorities and agency staff determine the appropriate mix and number of staff, define staff roles, and develop a supervision structure.

Agency administrators and mental health authorities should also review administrative policies and procedures to ensure that they are compatible with practice principles. For example, you may need to modify admission and discharge assessments, treatment planning, and service-delivery procedures. Make sure policies and procedures include information about how to identify consumers who are most likely to benefit from a particular EBP or promising practice and how to integrate inclusion and exclusion criteria into referral mechanisms. Integrating practice principles into policies and procedures will build the foundation of the program and will ensure that the program is sustainable. Examine policies and procedures early in the process. While most changes will occur in the planning stages, regularly monitoring and evaluating the program (*see discussion below*) will allow you to periodically assess the need for more changes.

### Identify funding issues

Identifying and addressing financial barriers is critical since specific costs are associated with starting new programs and sustaining them. Identify short- and long-term funding mechanisms for services, including federal, state, local government, and private foundation funds. You can work with your advisory committee to project startup costs by identifying the following:

- Time for meeting with stakeholders that is not reimbursed;
- Time for staff while in training;
- Staff time for strategic planning;
- Travel to visit other model programs; and
- Costs for needed technology (cell phones and computers) or other one-time expenses incurred during the initial implementation effort.

You should also identify long-term funding mechanisms to support services and continuous quality improvement efforts, such as ongoing training, supervision, technical assistance, fidelity, and outcomes monitoring. In addition, you may need to revise rules for reimbursement that are driven by service definitions and criteria; this may require interagency meetings on the federal, state, and local levels.

### Get these valuable resources to help implement your EBP

Numerous materials are available through the U.S. Department of Health and Human Services (**http://www.hhs.gov**) about using Medicaid and Medicare to fund necessary services. If you are implementing EBPs, one useful resource is *Using Medicaid to Support Working Age Adults with Serious Mental Illnesses in the Community: A Handbook*, published by the Assistant Secretary of Planning and Evaluation, January 2005.

**http://aspe.hhs.gov/daltcp/reports/handbook.pdf**

This handbook gives you an excellent introduction to the Medicaid program, including essential features, eligibility, and coverage of mental health services, community services, and waivers. It also provides helpful information for states seeking Medicaid funding to implement the following:

- Family Psychoeducation;
- Assertive Community Treatment;
- Illness Management and Recovery;
- Integrated Treatment for Co-Occurring Disorders;
- Medication Evaluation, Treatment, and Management (MedTEAM);
- Supported Employment;
- Permanent Supportive Housing;
- Consumer-Directed Services; and
- Peer Support.

## Assess Training Needs

One of the next steps in implementing your evidence-based or promising practice is to develop a training plan. You may gauge the amount of training needed by assessing the readiness of your community. If a community doesn't know about the practice and doesn't recognize the existing need, you may have to conduct a wide range of educational activities. If a community already understands the practice and knows how it may address problems that community members want to solve, you may need fewer educational activities.

You can help train key stakeholder groups if you first train members of your advisory committee and then ask them to disseminate information about the purpose and benefits of the practice.

In addition to assessing training needs in the community, agency administrators should gauge how well staff across the agency understand the practice. Agency administrators who have successfully implemented EBPs highlight the importance of providing basic training on the EBP to all levels of staff throughout the agency. Educating and engaging staff will promote support for the practice. In the long run, if they are well trained, staff will have an easier time obtaining referrals, collaborating with staff from other service programs, and facilitating a continuum of care.

Ongoing inservice training is an efficient way to provide background information, the practice philosophy and values, and the basic rationale for service components in a comfortable environment. Consider including members of your advisory committee in decisions about the frequency and content of basic training.

## Offer more intensive training to program leaders and practitioners

While staff at all levels in the agency should receive basic training, the program leader and practitioners will require more intensive training. To help practitioners integrate practice principles into their daily practice, offer comprehensive skills training to those who provide services. Each KIT contains a variety of specific training tools to help you provide both basic and intensive training.

Although most skills that practitioners need may be introduced through these training tools, research and experience show that the most effective way to teach new skills is through on-the-job consultation. Consultants may provide comprehensive training and case consultation to practitioners.

Consultants may also help mental health authorities and agency administrators to do the following:

- Provide basic information to key stakeholders;
- Assess the community's readiness for change;
- Assist in integrating principles into policies and procedures; and
- Design ongoing training plans.

In many mental health agencies, turnover of staff is high. This means that the evidence-based or promising practice will not be sustained unless ongoing training is offered to all employees.

Many agencies have also found it useful for program leaders and practitioners to become familiar with the structure and processes of the practice by visiting agencies that have successfully implemented the practice.

Early in the process, mental health authorities and agency administrators must decide how to accomplish the following:

- Identify internal and external stakeholders who will receive basic training;
- Determine how often basic training will be offered;
- Identify who will provide the training;
- Identify staff and advisory group members who will receive comprehensive skills training;
- Determine the training format for ongoing training; and
- Determine whether staff may visit a model program.

Specific suggestions in *Building Your Program* will help mental health authorities and agency staff develop a training plan.

## Monitor and Evaluate Regularly

Key stakeholders who implement evidence-based and promising practices may find themselves asking two questions:

- **Has the practice been implemented as planned?**
- **Has the practice resulted in the expected outcomes?**

Asking these two questions and using the answers to improve your program is a critical component for ensuring success.

- To answer the first question, ***collect process measures*** (by using the practice-specific Fidelity Scale). Process measures capture how services are provided.
- To answer the second question, ***collect outcome measures.*** Outcome measures capture the results or achievements of your program.

As you prepare to implement an evidence-based or promising practice, we strongly recommend that you develop a quality assurance system using both process and outcome measures to monitor and improve the program's quality from the startup phase and continuing through the life of the program. *Evaluating Your Program* in the KIT contains a practice-specific Fidelity Scale and sample outcome measures. These measures may be integrated into existing quality assurance programs or help agencies develop new ones.

### Why you should collect process measures

Process measures, such as the practice-specific Fidelity Scale, help you assess whether the core elements of the practice were put into place in your agency. Research tells us that the higher an agency scores on a fidelity scale, the greater the likelihood that the agency will achieve favorable outcomes (Becker et al., 2001; Bond & Salyers, 2004). For this reason, it is important to monitor both fidelity and outcomes.

Process measures give agency staff an objective, structured way to determine if you are delivering services in the way that research has shown will result in desired outcomes. Collecting process measures is an excellent method to diagnose program weaknesses while helping to clarify program strengths. Process measures also give mental health authorities a comparative framework to evaluate the quality of evidence-based and promising practices across the state.They allow mental health authorities to identify statewide trends and exceptions to those trends.

### Why you should collect outcome measures

While process measures capture how services are provided, outcome measures capture the program's results. Every service intervention has both immediate and long-term consumer goals. In addition, consumers have goals for themselves, which they hope to attain by receiving mental health services. These goals translate into outcomes and the outcomes translate into specific measures.

Some outcomes directly result from an intervention, such as getting a job by participating in a Supported Employment program. Others are indirect, such as improving consumers' quality of life as a result of having a job. Some outcomes are concrete and observable, such as the number of days worked in a month. Others are subjective, such as being satisfied with services.

Therefore, you should collect outcome measures, such as homelessness, hospitalization, incarceration, and recovery, that show the effect that services have had on consumers, in addition to fidelity measures. Monitoring fidelity and outcomes on an ongoing basis is a good way to ensure that your program is effective.

**Developing a quality assurance system will help you:**

- Diagnose your program's strengths and weaknesses;
- Formulate action plans to improve the program;
- Help consumers achieve their goals for recovery; and
- Deliver mental health services both efficiently and effectively.

## How process and outcome data improve practice

Collecting and using process and outcome data can improve consumer participation and staff performance.

**Consider the following story:**

> Participants in a partial hospitalization program sponsored by a community mental health center consistently showed very little vocational interest or activity. Program staff began gathering data monthly about consumers' vocational status and reporting the data to their program consultant. Every 3 months, the consultant returned the data to them using a simple bar graph.
>
> The positive result of gathering and using information about consumers' vocational activity was evident almost immediately. Three months after starting this monitoring system, the percentage of the program's consumers who showed an interest or activity in vocational areas increased from 36 percent to 66 percent. Three months later, 72 percent of program participants were involved in some form of vocational activity.

This example shows that sharing process and outcomes data with consumers can stimulate participation in your program.

Similarly, disseminating assessment data can enhance staff performance and increase motivation, professional learning, and a sense of accomplishment. In their study of successful companies, Peters and Waterman (1982) observed:

> We are struck by the importance of available information as the basis for peer comparison. Surprisingly, this is the basic control mechanism in the excellent companies. It is not the military model at all. It is not a chain of command wherein nothing happens until the boss tells somebody to do something. General objectives and values are set forward and information is shared so widely that people know quickly whether or not the job is getting done—and who's doing it well or poorly (p. 266).

Information in *Evaluating Your Program* will teach quality assurance team members how to collect, analyze, and use process and outcomes data to improve their program.

## Maximize Effectiveness by Making Services Culturally Competent

*Cultural competence* is an approach to delivering services that assumes that services are more effective when they are provided within the most relevant and meaningful cultural, gender-sensitive, and age-appropriate context for the people being served.

You can improve the quality of your program by ensuring that it is culturally competent—that it adapts to meet the needs of consumers from diverse cultures. First, it's important to understand what culture and cultural competence are and how they affect care.

### What culture is and how it affects care

Broadly defined, *culture* is a common heritage or set of beliefs, norms, and values that a group of people shares. People who are placed—either by census categories or by identifying themselves—into the same racial or ethnic group are often assumed to share the same culture; however, not all members who are grouped together will share the same culture.

A great diversity exists within each broad category. Some individuals may identify with a given racial or ethnic culture to varying degrees, while others may identify with multiple cultures, including those associated with their religion, profession, sexual orientation, region, or disability status.

Culture is dynamic. It changes continually and is influenced both by people's beliefs and by the demands of their environment. Immigrants from different parts of the world arrive in the United States with their own culture but gradually begin to adapt and develop new, hybrid cultures that allow them to function in the dominant culture. This process is called *acculturation*. Even groups that have been in the U.S. for many generations may share beliefs and practices that maintain influences from multiple cultures. This complexity necessitates an individualized approach to understanding culture and cultural identity in the context of mental health services.

Culture influences many aspects of care, starting with whether people think care is even needed. Culture influences the concerns that people bring to the clinical setting, the language they use to express those concerns, and the coping styles they adopt.

Culture affects family structure, living arrangements, and the degree of support that people receive in time of difficulties. Culture also influences patterns of help-seeking, whether people start with a primary care doctor, a mental health program, or a minister, spiritual advisor, or community elder. Finally, culture affects whether people attach a stigma to mental health problems and how much trust they place in the hands of providers.

### Culture isn't just a consumer issue

It's easy to think that culture belongs only to consumers without realizing how it also applies to providers and administrators. Professional culture influences how providers and administrators organize and deliver care. Some cultural influences are more obvious than others—such as the manner in which practitioners ask questions or how they interact with consumers. Less obvious but equally important are issues such as the following:

- The operating hours of an agency;
- The importance that staff attaches to reaching out to family members and community leaders; and
- The respect that staff gives to the culture of consumers who enter their doors.

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

## The need for cultural competence

For decades, many mental health agencies neglected to recognize the growing diversity around them. Often, people from non-majority cultures found programs off-putting and hard to access. They avoided getting care, stopped looking for care, or—if they managed to find care—they dropped out.

Troubling disparities resulted. Many minority groups faced lower access to care, lower use of care, and poorer quality of care. Disparities were most apparent for racial and ethnic minority groups, such as the following:

- African Americans;
- American Indians and Alaska Natives;
- Asian Americans;
- Hispanic Americans; and
- Native Hawaiians and other Pacific Islanders.

But disparities also affect many other groups, such as the following:

- Women and men;
- Children and older adults;
- People from rural areas;
- People of different religions;
- People with different sexual orientations; and
- People with physical or developmental disabilities.

Altogether, those disparities meant that millions of people suffered needless disability from mental illnesses.

Starting in the late 1980s, the mental health profession responded to the issue of disparity with a new approach to care called cultural competence. Originally *cultural competence* was defined as a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals to enable people to work effectively in cross-cultural situations. *Cultural competence* is intended to do the following:

- Improve consumers' access to care;
- Build trust; and
- Promote consumers' engagement and retention in care.

## What is cultural competence?

In the Surgeon General's report on the topic *cultural competence,* it is defined in the most general terms as

> "... the delivery of services responsive to the cultural concerns of racial and ethnic minority groups, including their languages, histories, traditions, beliefs, and values" (U.S. Department of Health and Human Services, 2001).

In most cases, *cultural competence* refers to sets of guiding principles developed to increase the ability of mental health providers, agencies, or systems to meet the needs of diverse communities, including racial and ethnic minorities.

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

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

## How cultural competence relates to EBPs

According to the Surgeon General, evidence-based practices are intended for every consumer who enters care, regardless of his or her culture. But programs often need to adjust evidence-based or promising practices to make them accessible and effective for cultural groups that differ in language or behavior from the original study populations. The adjustments should help, rather than interfere with, a program's ability to implement these practices using the KITs.

In a nutshell, to deliver culturally competent programs, you must tailor to the unique communities you serve either the practice itself or the context in which the practice is delivered. In time, specific fidelity measures may be available to assess a program's cultural competence, but not yet. The evidence base of cultural competence is too small.

While the evidence is being collected, programs can and should tailor evidence-based and promising practices to each cultural group they serve, for instance, by translating their informational brochures into the languages often used in their communities. For more suggestions, see the next section, *How to put cultural competence into practice*.

Many providers ask,

> How can we know if EBPs apply to a particular ethnic, racial, or cultural group if the research supporting those practices was done on a very different population?

The answer is that we will not know for sure until we try; but the limited research that does exist suggests that EBPs, perhaps with minor modifications, work well across cultures. Furthermore, because EBPs represent the highest quality of care currently available, it is a matter of fairness and prudence to provide them to all people who may need them. Yet the question remains, *How can we do this effectively?*

## How to put cultural competence into practice

Since the goal is for all programs to be culturally competent, we offer a variety of straightforward steps to help agency administrators respond more effectively to the people they serve. These steps apply to all facets of a program; they are not restricted to the EBP program alone. Please note that the following guidelines are meant to be illustrative, not prescriptive:

- Understand the racial, ethnic, and cultural demographics of the population served.
- Become most familiar with one or two of the groups you most commonly encounter.
- Create a cultural competence advisory committee consisting of consumers, family, and community organizations.
- Translate your forms and brochures.
- Offer to match a consumer with a practitioner who has a similar background.
- Use bilingual staff, including those trained in American Sign Language, when needed. If this is not possible, then have ready access to qualified interpreters.
- Ask consumers about their cultural backgrounds and identities.
- Incorporate cultural awareness into consumers' assessment and treatment.
- Tap into natural networks of support, such as the extended family and community groups that represent the consumer's culture.
- Reach out to religious and spiritual organizations to encourage referrals or as another network of support.
- Offer training to staff in culturally responsive communication or interviewing skills.
- Understand that some behaviors that one culture may consider to be signs of psychopathology are acceptable in a different culture.
- Be aware that consumers from other cultures may hold different beliefs about causes and treatment of illness.

## How mental health authorities can help

We offer you a few examples of how public mental health authorities can help develop a more culturally competent mental health system:

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

For more suggestions about adapting evidence-based and promising practices to diverse groups, see the remaining booklets in the KIT.

## A look at cultural competence through six vignettes

### Vignette—Integrated Treatment for Co-Occurring Disorders

Kevin is a 40-year-old African American homeless man in Chicago who, for a decade, cycled between jail, street, and shelter. At the shelter, he refused help for what the staff believed was a longstanding combination of untreated schizophrenia and alcoholism.

He became so drunk one night that he walked in front of a car and was seriously injured. While in the hospital, he was treated for his injuries, as well as placed on anti-psychotic medications after psychiatrists diagnosed him with schizophrenia.

When he was discharged from the hospital, Kevin was referred to an integrated treatment program for co-occurring disorders. Realizing that Kevin needed aggressive treatment to avoid spiraling into homelessness again, the head of the treatment team recommended concurrently treating the alcoholism and schizophrenia. The integrated treatment specialist was an African American psychiatrist who appreciated the years of alienation, discrimination, and victimization that Kevin described as having contributed to his co-occurring disorders.

The integrated treatment specialist worked hard to develop a trusting relationship. He worked with the treatment team to ensure that, in addition to mental health and substance abuse treatment, Kevin received social skills training and a safe place to live. When Kevin was well enough, and while he continued receiving group counseling for his co-occurring disorders, one of his first steps toward recovery was to reconnect with his elderly mother who had not heard from him in 10 years.

## Vignette — Assertive Community Treatment

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

One year before, an ACT team member reached out to local ministers to tell them about the program. The ACT team realized that better communication and referrals were needed. Stronger connections across organizations would improve chances for recovery by enhancing social support and adherence to treatment. Some consumers, however, believed that treatment was against their religion.

The ACT team member obtained a court order to allow authorities to enter the Jamaican mother's home. They discovered the traumatized 25-year-old daughter locked in the basement, actively psychotic, and bearing marks of physical abuse. The team diagnosed the daughter with schizophrenia and arranged suitable housing for her.

The team arranged for appropriate medications, individual and group therapy, trauma care, social skills training, and suitable housing. Through links to the church and the community, the team helped the daughter get clothing and spiritual support.

The team discovered that the mother's ethnic group from Jamaica believed that her daughter's mental illness was a sign of possession by the devil. The team reached out to the mother to educate her about schizophrenia.

## Vignette — Illness Management and Recovery

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

The psychiatrist tried to communicate with Lupita's anxious parents who were waiting in the visitor area, only to learn that they spoke Spanish, not English. The psychiatrist had mistakenly assumed that because Lupita, a second-generation Mexican American, was highly acculturated, so were her parents. She contacted the hospital's bilingual Illness Management and Recovery (IMR) practitioner who learned that the parents felt powerless for months as they watched their daughter sink into a severe depression, as she was not taking her medications.

The IMR practitioner, whose family had similarly emigrated from a rural region of Mexico, knew to gently ask the parents if they could read and understand the dosage directions for Lupita's medication. Finding that the parents had limited literacy in both English and Spanish, they tailored the treatment program so that it would not depend on the written word. They also introduced Lupita and her family to the IMR program. The hospital had organized programs for Spanish-speaking families because of the large number of Latinos in the area.

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

## Vignette — Family Psychoeducation

In times of difficulties, many Native Hawaiians rely on their elders, traditional healers, families, or teachers to provide them with wisdom and cultural practices to resolve problems. One such practice is *ho`oponopono,* which is a traditional cultural process for maintaining harmonious relationships among families through a structured discussion of conflicts. Ho`oponopono is also used by people for personal healing and guidance in troubled times.

When Kawelo lost his job as an electrician, his mental health practitioner asked him if he had a family elder who knew of community elders who were familiar with traditional Hawaiian healing practices. Kawelo's practitioner recognized the importance of tapping into this community support and suggested that his family seek out ho`oponopono.

Kawelo and his practitioner contacted the family and elders to arrange a meeting. At the meeting, the practitioner provided information about Kawelo's illness. They discussed symptoms and warning signs of relapse.

The therapist asked the elders how the group could support Kawelo's recovery. After lengthy deliberations, the family decided that one way to help Kawelo was to participate in ho'oponopono to understand the types of problems that he was experiencing and identify how the family could help him heal himself. Some members of the family also agreed to participate in a Family Psychoeducation (FPE) program to learn more about his mental illness and ways to support his recovery.

Through the FPE program, the family participated in structured multi-family group sessions. Because an important level of healing in Native Hawaiian culture involves sharing positive and negative emotions in an open, safe, and controlled environment, the family's participation in a combination of ho'oponopono and FPE was successful in helping Kawelo.

## Vignette — Supported Employment

Jing is a bilingual employment specialist. By informally surveying her caseload, she estimates that about 30 percent of the consumers with whom she works are Asian, but they come from vastly different backgrounds, ranging from Taiwan to Cambodia, with different educational levels.

One of the consumers with bipolar disorder with whom she works recently immigrated from China. He has a high school education, but speaks Mandarin and very little English. Fluent in Mandarin, Jing is able to conduct a careful assessment of the consumer's job skills and a rapid, individualized job search.

Jing identifies several import-export businesses in the area that have monolingual Mandarin-speaking employees. She and the consumer secure a position, but it pays less than one the consumer would qualify for if he spoke English. Jing and the consumer decide to take the position while, at the same time, participating in a quick-immersion night program in English as a Second Language.

Jing provides follow-along job support during the next few months. When the consumer's English is better, Jing and the consumer search for and find a higher paying job. Jing continues follow-along services to support the consumer in his adjustment to the greater demands of the new position.

## Vignette – Supported Education

Josh is 40-years old. He was ambivalent about finishing college when he began working with a Supported Education specialist. Josh experienced panic attacks in the classroom, which caused him to drop out of college after his first year.

The Supported Education specialist spent several sessions talking with Josh about his goals and interests. After much consideration, Josh decided that he would like to return to school for a degree in Information Systems.

The Supported Education specialist worked with Josh to find a university that was the right match for him. They looked at the curriculum from several universities to find the ones with strong programs in Information Systems. The Supported Education specialist identified universities that departments that offered students' individualized supports and accommodations. As an orthodox Jew, it was also important to Josh to be in an environment that respected his religious practices and holidays.

Josh selected a university that met his interests and needs. The Supported Education specialist assisted him with the application process and they visited the campus together. She helped Josh connect with the Office of Disability. Arrangements were made for Josh to take tests in private to reduce the likelihood of future panic attacks in the classroom. The professors also allow Josh to tape record class lectures to remove the pressure on note-taking.

The Supported Education specialist continued to meet with Josh every month to offer support and encouragement. She checked in with Josh more regularly during finals and other busy periods of the academic year. Supported Education was successful in helping Josh complete his degree in 5 years.

## Selected resources on cultural competence

The following resources on cultural competence apply to all evidence-based and promising practices. These resources are for consumers and families, mental health authorities, administrators, program leaders, and practitioners. For resources related to each specific practice, see *The Evidence* in each KIT.

### National resources for consumers and families

**Center for Mental Health Services**
Substance Abuse and Mental Health Services Administration
SAMHSA's Health Information Network
Rockville, MD 20857
*Phone:* (877) SAMHSA-7 (1-877-726-4727)
(English and Español)
http://store.samhsa.gov

**First Nations Behavioral Health Association**
Box 55127
Portland, OR 97238
*Phone*: (503) 953-0237
http://www.fnbha.org

**National Alliance on Mental Illness (NAMI)**
3803 N. Fairfax Drive
Suite 100
Arlington, VA 22203
*Phone:* (800) 950-NAMI (6264)
*Fax:* (703) 524-9094
*TTY:* (703) 516-7227
http://www.nami.org

**National Asian American Pacific Islander Mental Health Association**
1215 19th Street, Suite A
Denver, CO 80202
*Phone:* (303) 298-7910
*Fax:* (303) 298-8081
http://www.naapimha.org

**National Institute of Mental Health (NIMH)**
Office of Communications
6001 Executive Boulevard
Room 8184, MSC 9663
Bethesda, MD 20892-9663
*Phone:* (866) 615-NIMH (6464)
*Fax:* (301) 443-4279
*TTY:* (301) 443-8431
http://www.nimh.nih.gov

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

**National Leadership Council on African American Behavioral Health**
615 Wellington Way
Jonesboro, GA 30238
*Phone:* (770) 472-7814
http://www.nlcouncil.com

**Mental Health America**
2001 North Beauregard Street, 6th Floor
Alexandria, VA 22311
*Phone:* (800) 969-6642
*Phone:* (703) 684-7722
*Fax:* (703) 684-5968
*TDD:* (800) 433-5959
http://www.nmha.org

## Resources for mental health authorities


Aponte, C., & Mason, J. (1996). A demonstration project of cultural competence self-assessment of 26 agencies. In M. Roizner (Ed.), *A practical guide for the assessment of cultural competence in children's mental health organizations* (pp. 72–73). Boston, MA: Judge Baker Children's Center.

California Mental Health Ethnic Services Managers with the Managed Care Committee. (1995). *Cultural competency goals, strategies and standards for minority health care to ethnic clients*. Sacramento: CA: Mental Health Directors' Association.

Carpinello, S. E., Rosenberg, L., Stone, J., Schwager, M., & Felton, C. J. (2002). Best practices: New York State's campaign to implement evidence-based practices for people with serious mental disorders. *Psychiatric Services*, *53*(2), 153–5.

Chorpita, B. F., & Nakamura, B. J. (2004). Four considerations for dissemination of intervention innovations. *Clinical Psychology: Science and Practice,* 11, 364–367.

Dillenberg, J., & Carbone, C. P. (1995). *Cultural competency in the administration and delivery of behavioral health services*. Phoenix, AZ: Arizona Department of Health Services.

Knisley, M. B. (1990). *Culturally sensitive language: Community certification standards*. Columbus, OH: Ohio Department of Mental Health.

National Implementation Research Network. (2003). *Consensus statement on evidence-based programs and cultural competence.* Tampa, FL: Louis de la Parte Florida Mental Health Institute.

New York State Office of Mental Health. (1998). *Cultural competence performance measures for managed behavioral healthcare programs*. Albany, NY: New York State Office of Mental Health.

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

Pettigrew, G. M. (1997). *Plan for culturally competent specialty mental health services*. Sacramento, CA: California Mental Health Planning Council.

Phillips, D., Leff, H. S., Kaniasty, E., Carter, M., Paret, M., Conley, T., & Sharma, M. (1999). *Culture, race and ethnicity (C/R/E) in performance measurement: A compendium of resources;* Version 1. Cambridge, MA: The Human Services Research Institute (Evaluation Center@HSRI).

Siegel, C., Davis-Chambers, E., Haugland, G., Bank, R., Aponte, C., & McCombs, H. (2000). Performance measures of cultural competency in mental health organizations. *Administration and Policy in Mental Health*, *28*, 91–106.

U.S. Department of Health and Human Services. (1996). *Consumer mental health report card. Final report: Task force on a consumer-oriented mental health report card*. Rockville, MD: Substance Abuse and Mental Health Services Administration.

U.S. Department of Health and Human Services. (2000). Cultural competence standards in managed mental health care services: Four underserved/underrepresented racial/ethnic groups. HHS Pub. No. SMA 00-3457. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration.

U.S. Department of Health and Human Services. (1999). *Mental health: A report of the Surgeon General.* Rockville, MD: Author.

Western Interstate Commission for Higher Education (WICHE) and Human Services Research Institute (The Evaluation Center@HSRI). (1999). *Notes from a roundtable on conceptualizing and measuring cultural competence.* Boulder, CO: WICHE Publications.

Western Interstate Commission for Higher Education (WICHE). (1997). *Cultural competence standards in managed mental health care for four underserved/ under represented racial/ethnic groups.* Boulder, CO: WICHE Publications.

**Center for Mental Health Services**
Substance Abuse and Mental Health Services Administration
SAMHSA's Health Information Network
Rockville, MD 20857
*Phone:* (877) SAMHSA-7 (1-877-726-4727)
(English and Español)
http://store.samhsa.gov

**Hogg Foundation for Mental Health**
The University of Texas at Austin
P.O. Box 7998
Austin, TX 78713-7998
*Phone:* (800) 404-4336
*Fax:* (512) 471-5041
http://www.hogg.utexas.edu

## Resources for mental health administrators

Lopez, L., & Jackson, V. H. (1999). *Cultural competency in managed behavioral healthcare: An overview.* In V. H. Jackson, L. Lopez (Eds.). Cultural competency in managed behavioral healthcare. Providence, RI: Manisses Communications Group, Inc.

**Center for Mental Health Services**
Substance Abuse and Mental Health Services Administration
SAMHSA's Health Information Network
Rockville, MD 20857
*Phone:* (877) SAMHSA-7 (1-877-726-4727)
(English and Español)
http://store.samhsa.gov

**Multiethnic Advocates for Cultural Competence**
1335 Dublin Road, Suite 105C
Columbus, Ohio 43215
*Phone:* (614) 221-7841
*fax:* (614) 487-9320
http://www.maccinc.org

**National Alliance of Multi-Ethnic Behavioral Health Associations**
3 Bethesda Metro Center
Bethesda, MD 20814
*Phone:* (301) 941-1834
http://www.nambha.org

**National Center for Cultural Competence**
Georgetown University Center for Child and Human Development
3300 Whitehaven Street, NW
Suite 3300
Washington, DC 20057
*Phone:* (202) 687-5387
*TTY:* (202) 687-5503
http://nccc.georgetown.edu

**The Evaluation Center @ HSRI**
2336 Massachusetts Avenue
Cambridge, MA 02140
*Phone:* (617) 876-0426
http://tecathsri.org

**Western Interstate Commission for Higher Education (WICHE)**
Mental Health Program
P.O. Box 9752
Boulder, CO 80301-9752
http://www.wiche.edu

## Resources for program leaders


Barrio, C. (2000). The cultural relevance of community support programs. *Psychiatric Services*, *51*, 879–874.

Issacs, M. R., & Benjamin, M. P. (1991). *Toward a culturally competent system of care: Programs which utilize culturally competent principles*. Washington, DC: Georgetown University Child Development Center.

Leong, F. (1998). Delivering and evaluating mental health services for Asian Americans. In *Report of the roundtable on multicultural issues in mental health services evaluation*. Tucson, AZ: Human Services Research Institute (The Evaluation Center@HSRI).

Musser-Granski, J., & Carrillo, D. F. (1997). The use of bilingual, bicultural paraprofessionals in mental health services: Issues for hiring, training, and supervision. *Community Mental Health Journal 33,* 51–60.

Phillips, D., Leff, H. S., Kaniasty, E., Carter, M., Paret, M., Conley, T., & Sharma, M. (1999). *Culture, race and ethnicity (C/R/E) in performance measurement: A compendium of resources;* Version 1. Cambridge, MA: Human Services Research Institute (The Evaluation Center@HSRI).

Ponterotto, J. G., & Alexander, C. M. (1996). Assessing the multicultural competence of counselors and clinicians. In L. A. Suzuki, P. J. Meller, & J. G. Ponterotto (Eds.) *Handbook of multicultural assessment: Clinical, psychological, and educational applications* (pp. 651–672). San Francisco: Jossey-Bass.

Tirado, M. D. (1996). *Tools for monitoring cultural competence in health care.* San Francisco: Latino Coalition for a Healthy California.

U.S. Department of Health and Human Services. (1999). *Mental health: A Report of the Surgeon General.* Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health.

U.S. Department of Health and Human Services. (2001). *Mental health: Culture, race, and ethnicity. A supplement to mental health: A report of the Surgeon General.* Rockville, MD: Author.

## Instruments to assess cultural competence

### Consolidated Culturalogical Assessment Toolkit (C-CAT)

Ohio Department of Mental Health, 2003.

- Measures cultural competence in mental health systems and organizations
- Includes comprehensive training and promotional materials

For more information:

Multiethnic Advocates for Cultural Competence
1335 Dublin Road, Suite 105C
Columbus, OH 43215
*Phone:* (614) 221-7841
http://www.maccinc.net

### Cross-Cultural Counseling Inventory (CCCI)

- Measures knowledge, attitudes, and beliefs about cultural diversity
- Measures cross-cultural counseling skills

For more information:

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

### Cultural Acceptability of Treatment Survey (CATS)

Human Services Research Institute (HSRI), 1998.

- Measures the cultural competency of services
- Measures organizational accommodations and practices
- Measures consumer preferences and satisfaction

For more information:

Human Services Research Institute
2336 Massachusetts Avenue
Cambridge, MA 02140
*Phone:* (617) 876-0426
*Fax:* (617) 492-7401
http://www.hsri.org

### Cultural Competency Assessment Scale (CCAS)

Nathan S. Kline Institute for Psychiatric Research, 2000.

- Assesses organization's level of cultural competence
- Consistent with EBP fidelity instruments

For more information:

Nathan S. Kline Institute for Psychiatric Research
140 Old Orangeburg Road
Orangeburg, NY 10962
*Phone:* (845) 398-5500
*Fax:* (845) 398-5510
http://www.rfmh.org/nki/

### Multicultural Counseling Awareness Scale (MCAS)

- Assesses cultural awareness, knowledge, and skills
- Self-report of 45 items

For more information:

Ponterotto, J. G., & Alexander, C. M. (1996) Assessing the multicultural competence of counselors and clinicians in L. A. Suzuki, P. J. Meller, J. G. Ponterotto (Eds.) *Handbook of multicultural assessment: Clinical, psychological, and educational applications* (pp. 651–672) San Francisco, CA: Jossey-Bass.

### Multicultural Counseling Inventory (MCI)

- Assesses awareness, knowledge, skills, and relations
- Self-report of 43 items

For more information:

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

## Resources for practitioners


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

Alvidrez, J. (1999). Ethnic variations in mental health attitudes and service among low-income African American, Latina, and European American young women. *Community Mental Health Journal, 35,* 515–530.

American Psychiatric Association. (2000). Appendix I: Outline for cultural formulation and glossary of culture-bound syndromes. In *Diagnostic and statistical manual of mental disorders,* Fourth Edition, Text Revision (DSM-IV-TR). Washington, DC: Author.

Aranda, M. P. (1990). Culture friendly services for Latino elders. *Generations 14*, 55–57.

Atkinson, D. R., Morten, G., & Sue, D. (1983). *Counseling American minorities* (2nd ed.). Dubuque, IA: Wm. C. Brown.

Atkinson, D. R., & Gim, R. H. (1989). Asian-American cultural identity and attitudes toward mental health services. *Journal of Counseling Psychology, 36,* 209–212.

Baldwin, J. A., & Bell, Y. R. (1985). The African Self-Consciousness Scale: An Afrocentric personality questionnaire. *The Western Journal of Black Studies 9*, 61–68.

Bauer, H. M., Rodriguez, M. A., Quiroga, S., Szkupinkski, S., & Flores-Ortiz, Y. G. (2000). Barriers to health care for abused Latina and Asian immigrant women. *Journal of Health Care for the Poor and Underserved*, *11*, 33–44.

Belgrave, F. Z. (1998). *Psychosocial aspects of chronic illness and disability among African Americans.* Westport, CT: Auburn House/ Greenwood Publishing Group, Inc.

Berkanovic, E. (1980). The effect of inadequate language translation on Hispanics' responses to health surveys. *American Journal of Public Health 70*, 1273–1276.

Bichsel, R. J. (1998). Native American clients' preferences in choosing counselors. *Dissertation Abstracts International: Section B: Science and Engineering, 58,* 3916.

Brach, C. & Fraser, I. (2000). Can cultural competency reduce racial and ethnic health disparities? A review and conceptual model. *Medical Care and Research Review,* (Suppl. 1), 181–217.

Browne, C. T. (1986). An anguished relationship: The white institutionalized client and the non-white paraprofessional worker. *Journal of Gerontological Social Work Special Issue: Ethnicity and Gerontological Social Work*, *9*, 3–12.

Bull Bear, M., & Flaherty, M. J. (1997). The *continuing journey of Native American people with serious mental illness: Building hope*. Boulder, CO: WICHE Publications.

Carter, R. T., & Qureshi, A. (1995). A typology of philosophical assumptions in multicultural counseling and training. In J. G. Ponterotto, J. M. Casas, C. M. Alexander (Eds.), *Handbook of multicultural counseling* (pp. 239–262). Thousand Oaks, CA: Sage Publications.

The Chinese Culture Connection. (1987). Chinese values and the search for culture-free dimensions of culture. *Journal of Cross-Cultural Psychology 18,* 143–164.

Cross, T. L., Bazron, B. J., Dennis, K. W., & Issacs, M. R. (1989). *Toward a culturally competent system of care.* Washington, DC: Georgetown University Child Development Center.

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

Dana, R. H. (1998). *Understanding cultural identity in intervention and assessment*. Thousand Oaks, CA: Sage Publication, Inc.

Davies, J., McCrae, B. P., Frank, J., Dochnahl, A., Pickering, T., Harrison, B., et al. (1983). The influence of client-clinician demographic match on client treatment outcomes. *Journal of Psychiatric Treatment and Evaluation, 5*, 45–53.

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

Gallimore, R. (1998). Accommodating cultural differences and commonalities in research and practice. In *Report of the roundtable on multicultural issues in mental health services evaluation*. Cambridge, MA: Human Services Research Institute. (The Evaluation Center@HSRI).

Gaw, A. C. (Ed.) (1993). *Culture, ethnicity, and mental illness.* Washington, DC: American Psychiatric Press.

Gaw, A. C. (Ed.) (2001). *Concise guide to cross-cultural psychiatry.* Washington, DC: American Psychiatric Press.

Gilvarry, C. M., Walsh, E., Samele, C., Hutchinson, G., Mallett, R., Rabe-Hesketh, S., et al. (1999). Life events, ethnicity and perceptions of discrimination in patients with mental illness. *Social Psychiatry and Psychiatric Epidemiology, 34*, 600–608.

Gopaul-McNicol, S. A., & Brice-Baker, J. (1998). *Cross-cultural practice: assessment, treatment and training*. New York, NY: John Wiley & Sons, Inc.

Healy, C. D. (1998). African Americans' perceptions of psychotherapy: Analysis of barriers to utilization. *Dissertation Abstracts International: Section B: Science and Engineering, 58*(9-B), 5121.

Helms, J. E. (Ed.) (1990). *Black and white racial identity: Theory, research, and practice*. New York: Greenwood Press.

Hernandez, N. E. (1999). The relationship between ethnic matching and non-matching of Black, Hispanic, and White clinicians and clients and diagnostic and treatment decisions. *Dissertation Abstracts International: Section A: Humanities and Social Sciences, 60*, 550.

Herrera J., Lawson, W., & Sramek, J. (1999). *Cross cultural psychiatry*. West Sussex: John Wiley Sons, Ltd., U.K.

Hinkle, J. S. (1994). Practitioners and cross-cultural assessment: a practical guide to information and training. *Measurement and Evaluation in Counseling and Development Special Issue: Multicultural Assessment*, *27*, 103–115.

Jenkins, J. H. (1992). Too close for comfort: Schizophrenia and emotional over involvement among Mexican families. In A. D. Gaines, (Ed.) *Ethnopsychiatry: The cultural construction of professional and folk psychiatries* (pp. 203–221). Albany, NY: SUNY Press.

Kohn, L. P., Oden, T., Munoz, R. F., Robinson, A., & Leavitt, D. (2002). Adapted cognitive behavioral group therapy for depressed low-income African American women. *Community Mental Health Journal, 38*(6), 497–504.

Lefley, H. (1990). Culture and chronic illness. *Hospital and Community Psychiatry, 41*, 277–286.

Lewis, R. (1996). Culture and DSM-IV: Diagnosis, knowledge and power. *Culture, Medicine and Psychiatry, 20*, 133–144.

Lin, T. Y., & Lin, M. L. (1978). Service delivery issues in Asian-North American communities. *American Journal of Psychiatry, 135*, 454–456.

Lopez, S. R. (1997). Cultural competence in psychotherapy: A guide for clinicians and their supervisors. In C. E. Watkins, Jr. (Ed.), *Handbook of psychotherapy supervision* (pp. 570–588). New York: John Wiley & Sons, Inc.

Marin, G., Sabogal, F., Marin, B. V., Otero-Sabogl, R., & Perez-Stable, E. (1987). Development of a short acculturation scale for Hispanics. *Hispanic Journal of Behavioral Sciences 9*, 183–205.

Mezzich, J., Kleinman, A., Fabrega, H., & Parron, D. (Eds.) (1996). *Culture and psychiatric diagnosis:* A DSM-IV perspective. Washington, DC: American Psychiatric Press.

Miranda, J., Chung, J. Y., Green, B. L., Krupnick, J., Siddique, J., Revicki, D. A., & Belin, T. (2003). Treating depression in predominantly low-income young minority women: A randomized controlled trial. *Journal of the American Medical Association, 290*(1), 57–65.

Nader, K., Dubrow, N., & Stamm, B. H., (Eds.). (1999). *Honoring differences: Cultural issues in the treatment of trauma and loss*. Philadelphia, PA: Brunner/Mazel, Inc.

Okpaku, S. O. (Ed.) (1998). *Clinical methods in transcultural psychiatry*. Washington, DC: American Psychiatric Press.

Parker, R., Williams, M., & Weiss, B. (1999). Health literacy: Report of the Council on Scientific Affairs. *JAMA*, *281*, 552–557.

Phinney, J. S. (1990). Ethnic identity in adolescents and adults: Review of research. *Psychological Bulletin, 108*, 459–514.

Phinney, J. S. (1992). The Multigroup Ethnic Identity Measure: A new scale for use with adolescents and young adults from diverse groups. *Journal of Adolescent Research, 7*, 156–176.

Pina, A. A., Silverman, W. K., Fuentes, R. M., Kurtines, W. M., & Weems, C. F. (2003). Exposure-based cognitive-behavioral treatment for phobic and anxiety disorders: Treatment effects and maintenance for Hispanic/Latino relative to European-American youths. *Journal of the American Academy of Child & Adolescent Psychiatry, 42*, 1179–1187.

Ponterotto, J. G., Rieger, B. P., Barrett, A., Harris, G., Sparks, R., Sanchez, C. M., & Magids, D. (1996). Development and initial validation of the multicultural counseling awareness scale. In G. R. Sodowsky & J. C. Impara (Eds.), *Multicultural assessment in counseling and clinical psychology* (pp. 247–282). Lincoln, NE: Buros Institute of Mental Measurements.

Ponterotto, J. G., Casas, J. M., & Alexander, C. M. (Eds.) (1995). *Handbook of multicultural counseling.* Thousand Oaks, CA: Sage Publications.

Rossello, J., & Bernal, G. (1999). The efficacy of cognitive-behavioral and interpersonal treatments for depression in Puerto Rican adolescents. *Journal of Consulting and Clinical Psychology, 67*, 734–745.

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

Saldana, D. H., Dassori, A. M., & Miller, A. L. (1999). When is caregiving a burden? Listening to Mexican American women. *Hispanic Journal of Behavioral Sciences, 21*, 283–301.

Samaan, R. A. (2000). The influences of race, ethnicity and poverty on the mental health of children. *Journal of Health Care for the Poor and Underserved, 11*, 100–110.

Sanchez, A. M., & McGuirk, F. D. (1994). *The journey of Native American people with serious mental illness: Building hope*. Boulder, CO: WICHE Publications.

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

Shinagawa, L. H., & Jang, M. (1998). *Atlas of American diversity.* Walnut Creek: AltaMira Press.

Smith, M., & Mendoza, R. (1996). Ethnicity and pharmacogenetics. *Mount Sinai Journal of Medicine, 63*, 285–290.

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

Straussner. (Ed.) (2001). *Ethnocultural factors in substance abuse treatment.* New York, NY: Guilford Press.

Strickland, W. J., & Strickland, D. L. (1996). Partnership building with special populations. *Family and Community Mental Health, 19*, 21–34.

Sue, S. (1981). Programmatic issues in the training of Asian-American psychologists. *Journal of Community Psychology, 9*, 293–297.

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

Sue, D. W., Carter, R. T., Casas, J. M., Fouad, N. A., Ivey, A. E., Jensen, M., et al. (1998). *Multicultural counseling competencies: Individual and organizational development*. Thousand Oaks, CA: Sage Publications, Inc.

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

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

Trevino, F. M. (1986). Standardized terminology for Hispanic populations. *American Journal of Public Health, 77*, 69–72.

Tseng, W. S. (Ed.) (2001). *Handbook of cultural psychiatry*. San Diego, CA: Academic Press.

Tseng, W. S., & Seltzer J. S. (Eds.) (2001). *Culture and psychotherapy: A guide to clinical practice.* Washington, DC: American Psychiatric Press.

Uba, L. (1994). *Asian Americans: Personality patterns, identity, and mental health*. New York, NY: Guilford Press.

U.S. Department of Health and Human Services. (1999). *Cultural issues in substance abuse treatment*. Rockville, MD: Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment.

Vega, W. A., & Rumbaut, R. G. (1991). Ethnic minorities and mental health. *Annual Review of Sociology, 17*, 351–383.

Yeh, M., Eastman, K., & Cheung, M. K. (1994). Children and adolescents in community health centers: Does the ethnicity or the language of the therapist matter? *Journal of Community Psychology, 22*, 153–163.

## Scales for practitioners to recognize cultural identity

### Acculturation Rating Scale for Mexican-Americans (ARSMA)

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

**African Self-Consciousness Scale**

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

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

Helms, J. E. (Ed.). (1990). *Black and White racial identity: Theory, research, and practice*. New York: Greenwood Press.

**Chinese Values Survey**

The Chinese Culture Connection. (1987). Chinese values and the search for culture-free dimensions of culture. *Journal of Cross-Cultural Psychology, 18,* 143–164.

**Cultural Adaptation Pain Scale (CAPS)**

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

**Cultural Information Scale (CIS)**

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

**Multidimensional Measure of Cultural Identity for Latino and Latina Adolescents**

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

**Multidimensional Racial Identity Scale (MRIS)-Revised**

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

**Multigroup Ethnic Identity Measure (MEIM)**

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

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

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

**Short Acculturation Scale for Hispanics (SASH)**

Marin, G., Sabogal, F., Van Oss Marin, B., Otero-Sabogl, R., & Perez-Stable, E. (1987). Development of a short acculturation scale for Hispanics. *Hispanic Journal of Behavioral Sciences, 9,* 183–205.

**White Racial Identity Attitude Scale (WRIAS)**

Helms, J. E. & Carter, R. T. (1990). Development of the White Racial Identity Inventory. In J. E. Helms (Ed.) *Black and White racial identity: Theory, research, and practice* (pp. 67–80). New York, NY: Greenwood Press.

HHS Publication No. SMA-11-4654
Printed 2011

27510.1210.8712010402