Cultural Competence Standards in Managed Care Mental Health Services: Four Underserved/Underrepresented Racial/Ethnic Groups

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Introduction

As a nation, the United States continues to grow in diversity; our face, voice, and beliefs are forever changing. Not only are we changing as a Nation, so too is the way health care is being provided, in large part due to the ongoing managed care revolution. Despite the pace at which change in the healthcare marketplace is occurring, in many ways, the Nation's health delivery systems have not kept pace with our growing diversity. A significant disconnect has arisen between health care need and the availability and accessibility of relevant, culturally competent care for people who need it. Perhaps nowhere is the importance of culturally competent care greater than in the delivery of mental health services, where cultural issues and communication between consumer and provider are a critical part of the services themselves.

Cultural Competence Standards in Managed Care Mental Health Services: Four Underserved/Underrepresented Racial/Ethnic Groups is designed to provide readers with the tools and knowledge to help guide the provision of culturally competent mental health services within today's managed care environment. While not necessarily representing the specific views of the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration or the Center for Mental Health Services, this document melds the best thinking of expert panels of consumers, mental health service providers, and academic clinicians from across the four core racial/ethnic populations: Hispanics, American Indians/Alaska Natives, African Americans, and Asian/Pacific Islanders.* Developed for States, consumers, mental health service providers, educators, and organizations providing managed behavioral health care, the volume provides state-of-the-science cultural competence principles and standards - building blocks to create, implement and maintain culturally competent mental health service networks for our diverse population.

This volume is divided into five sections. This introductory section sets a context, providing a demographic and health profile of people of African Descent, Asian and Pacific Islanders, Latinos and American Indian, Native Alaskan and Native Hawaiians. The balance of the text guides the perspectives of these four ethnic/racial groups, moving from the articulation of 16 guiding principles that should underlie the establishment of cultural competence in a managed care environment (Section I - Guiding Principles) to specific system and clinical standards and implementation strategies. By focusing on principles - such as culturally competent approaches to integrated services, consumer empowerment, and appropriate outcomes - health care providers and provider organizations can help ensure success in reaching and responding to the needs of underserved racial and ethnic populations.

Sections II and III present overall system and clinical standards and implementation guidelines, placing a clear emphasis not only on cultural competence, but also on the contribution of cultural competence to quality of care. The standards also reflect generally accepted principles for the best way to provide clinical care for persons with mental illnesses. They also describe expected levels of culturally competent system and clinical behavior as well as courses of action necessary to achieve culturally competent care. These consensus-built standards also serve as a yardstick against which to measure managed care systems' cultural proficiency in meeting the mental health care needs of the target populations.

The volume concludes with a review of the necessary and highly critical provider competencies, the application of knowledge and the interpersonal decision-making and psychosocial skills expected for the practice role (Section IV), and a glossary of terms.

* Other terms are used throughout this volume to describe these four ethnic/racial populations. The words chosen reflect the consensus of the panel members. The terms are intended to be interchangeable with current Federal terminology.

Increasing Diversity of the Consumer Population

America's population is growing and changing dramatically. Present and projected changes in America's ethnic composition challenge the capabilities of mental health systems. The U. S. population has always been multi-ethnic and its composition in flux (Bogue, 1985; Sutherland, 1966). However, popular awareness of different cultural groups has increased in the last few decades. Shifts in ethnic diversity are not just about numbers, but are also about the impact of cultural differences. It is important to note that culture is not simply determined by ethnicity and a particular set of beliefs, norms, and values. Culture also involves the historical circumstances leading to a group's economic, social, and political status in the social structure. Culture involves the circumstances and experiences associated with developing certain beliefs, norms, and values (Charon, 1995; APA, 1996). More specifically, this is especially true about the socioeconomic and political factors which have a significant impact on a group's or its members' psychological well-being (Muñoz & Sanchez, 1997).

In relation to mental health systems, new approaches are needed in service delivery to address cultural differences among consumers. The essential point for mental health providers is that people develop different approaches in response to their life circumstances. Mental health providers are beginning to realize that cultural competence in diversity is an important component in providing effective mental health services. Therefore, it is important that mental health providers are aware of the underlying pattern and history of America's diversity (Muñoz & Sanchez 1997).

Total Population by Race/Ethnicity
(in millions/ percentage of total population)

Populations	**1996**	**2050**
Hispanics	27.8 (10.5%)	96.5 (24.5%)
African American	32.0 (12.1%)	53.6 (13.6%)
Asian and Pacific Islander	9.1 (3.4 %)	32.4 (8.2%)
American Indian, Eskimo, Aleut	2.0 (0.7%)	3.5 (0.9%)
White	194.4 (73.3%)	207.9 (52.8%)
Total	**265.4 (100%)**	**393.9 (100%)**

Source: U.S. Bureau of the Census, 1996. Hispanic can be of any race; data for all other groups are non-Hispanic.

Latino (Hispanic) Populations

Demographic and Health Profile

The term "Latino(s)," as used in this publication, refers to all persons of Mexican, Puerto Rican, Cuban, or other Central and South American or Spanish origin. Latinos comprise significant populations in virtually all the United States, now numbering more than 27,800,000 people, or 10.5% of the national population, a 50% increase over 1980. It is projected to grow to 29 million by the year 2000 and 96.5 million by the year 2050. At that time, Latinos will clearly be the largest ethnic group in the United States. Latinos, or Hispanics, are widely recognized as being a major part of the fabric of the Southwestern United States, such as California, Texas, New Mexico, and Arizona. However, they can also be found in significant numbers and percentages in such diverse states as Florida, Colorado, Nevada, New Jersey, Illinois, Utah, and Washington State. Latinos also have a significant presence in 25 metropolitan areas of the country.

The Latino population in the United States is not homogenous, but is composed of an extremely diverse group of nationalities of origin. These include 13.4 million of Mexican origin, 2.4 million of Puerto Rican heritage, Cuban, 1.1 million, and 2.9 million from Central and South American countries. Their cultural backgrounds are diverse, including Spanish, Aztec, Mayan, Incan, and Caribbean cultures, and Native American, White, and African American racial/ethnic origins. Despite their common language and link with Spanish culture, Latinos' diverse religious, folk, family, and health beliefs and values as well as diverse linguistic idioms make them one of the most culturally rich groups in America.

Latinos have been adversely affected by under-education, under-employment, inadequate housing, and insufficient access to health care insurance. They also have disproportionately low rates of outpatient mental health service utilization and rates of adminission for care. Latinos often perceive historic U.S. mental health models as unnecessary, unwelcoming, or not useful. A national conference held in Denver, Colorado in May 1995, attended by more than 100 Latino mental health professionals, concluded that Latinos, while affected by numerous socioeconomic stressors, remain likely to use mental health services primarily in crisis circumstances, drop out of services sooner, and have undesirable treatment outcomes. From that conference, a national panel was created to begin developing a set of national standards for delivering mental health services for Latino populations in a managed care setting. When the panel began its work in January 1996, several concepts were self-evident. Latinos have disproportionately less access to the full range of mental health services normally expected within any given state. They do not have comparable rates of use of ongoing outpatient services, have lower rates of voluntary hospitalization, and use crisis and other higher-cost services at higher rates than other populations.

Mental health staff who have trained in general practice often do not consider cultural competence as necessary or even valid. Thus, there is a tendency not to incorporate cultural competence principles in service development and planning models at the local and state level, nor to use those principles in direct service delivery. These factors are particularly important when comparing briefly a fee-for-service to a managed care service model. In a fee-for-service environment, any service provided to a client results in a revenue to the organization which provided the unit of service. In a managed care or capitated rate environment, delivery of a service to an individual becomes a cost; and the fewer the services delivered in a set rate environment, the higher the profits. If Latinos have low utilization rates of mental health services in a fee-for-service environment where there are incentives to the provider to deliver the service, it follows that Latinos are more at risk in a managed care environment. In the managed care context, service delivery becomes a cost to an organization which is paid a flat rate per person served, irrespective of what the total price of service might be.

In a private insurance setting, the fee-for-service versus managed care example is particularly true, in that there is the ability to limit costs by limiting services. When the total number of sessions or hospitalization days allowed by an insurance company is exhausted, the remaining costs become the responsibility or burden of the insured. In a public setting, governmental sponsors expect that provider organizations will deliver certain outcomes within a fixed or capitated rate and be financially at risk for costs above that. Thus it becomes critical that costs be managed by delivering services effectively rather than by limiting benefits. In this environment, it is important to understand access and utilization patterns, outcomes, outliers, and cost by groups and by types of service. Service groups' and subgroups' needs must be known to meet them effectively and attain desirable outcomes within a fixed cost.

The Latino national panel made several other assumptions:

- cultural competence results from a specialized practice development and not from having been born in, or having spent significant amounts of time in, a culture, or from a general practitioner using an interpreter, regardless of the interpreter's linguistic expertise;

- qualifications of Latino mental health specialists should include performance-based competency verification;
- developing specialized instruments, protocols, and outcome measures shall continue;
- additional methods for testing and confirming the viability of specialized practice shall also continue; and
- developing culturally competent standards augments the general body of knowledge, not at the expense of service to others.

People of African Descent

Demographic and Health Profile

The terms African American and Black are used interchangeably here to refer to people of African descent. Some scholars trace the history of African people in North America to 1619 (Bennett, 1966), while others propose that African people entered the Americas several centuries before that date (Van Sertima, 1976). During the period from 1619 to 1997, the proportion of people of African descent in North America has ranged between 10-19% (U.S. Department of Commerce, 1995) of the total population of the United States. In 1790, Blacks constituted their largest proportion (19%) of the total U.S. population, and their smallest proportion (9.7%) was recorded in 1930 (U.S. Department of Commerce, 1995). The Black population of the United States is growing at about 1.3% per year, one of the slowest growth rates of all populations in the country. In 1997, people of African descent numbered close to 33 million or 12.6% of the U.S. population. The majority (52.8%) of the Black population in the U.S. resides in the south (U.S. Department of Commerce, 1995), although this figure is considerably lower than in previous decades. The smallest proportion (9.4%) of people of African descent reside in the west.

Between 1619 and 1860, the majority of the people of African descent came to the United States from the western coast of Africa as part of the flourishing slave trade. Since 1860, growth in the population of people of African descent in the U.S. has come about primarily through births, which have continued to exceed the national family average. Although immigration of people of African descent into the country has increased over past decades, Black African immigrants remain the smallest number of all immigrants to the United States (U.S. Department of Commerce, 1995). Immigration of Black people in the past decade from Egypt, Ethiopia, Ghana, Nigeria, Haiti, Panama, Jamaica, Trinidad, Barbados, and other Caribbean nations has significantly increased the nationalistic, cultural, religious, and language diversity within the Black population in the United States (U.S. Department of Commerce, 1995).

Historical and current data about the health status of American populations confirm that there are significant differences in prevalence and incidence of physical and mental health problems among groups based on culture, color, income, and country of origin. Also noted are major differences in help-seeking patterns (Neighbors, 1986). In two special reports (Center for Health Economics Research, 1993; Robert Wood Johnson, 1991), it was noted that people of color, particularly residents of inner cities, showed major disparities in their health status when compared to other populations. The disparities cover the range of disorders from high neonatal mortality rates per live birth, higher rates of heart and circulatory problems, disproportionate rates of AIDS and related deaths, greater prevalence of chronic conditions, higher rates of toothlessness, and higher rates of admissions to psychiatric facilities (Center for Health Economics Research, 1993; Robert Wood Johnson, 1991). The high incidence of substance abuse, physical injuries, and deaths from violence characterize low income Black neighborhoods and communities in terms of potential and actual costs of health care. According to some reports, substance abuse is the most significant health problem in the nation (Institute for Health Policy, 1993). These populations also show lower availability of health insurance and a significantly lower proportion of health professionals within easy access of their neighborhoods.

Historic Patterns of Mental Health Service Use

From the time that state governments decided to provide and finance residential care for the long-term mentally ill, major public policy paradoxes have been raised and debated about race and mental illness (Jarvis, 1844). The first of these paradoxes centers on the incidence and prevalence of severe mental illness in populations of African descent, while the second centers on the extent to which these populations require and consume public and/or proprietary mental health services (Snowden & Cheung, 1990). A cursory review of the data on admissions to inpatient psychiatric facilities (Manderscheid & Sonnenschein, 1987; Scheffler & Miller, 1989; Snowden & Cheung, 1990) shows disproportionately high rates of admissions by African Americans to all types of inpatient facilities. These data (Manderscheid & Sonnenschein, 1987; Snowden & Cheung, 1990; Snowden & Holschuh, 1992) show that, between 1980 and 1992, the rate of admission for all persons to state hospitals in the United States was approximately 163.6 per 100,000. The rate for Whites was 136, while the rate for Hispanics was 146 and the rate for Native Americans and Asians was 142 per 100,000 (Manderscheid & Sonnenschein, 1987). The admission rate to state hospitals for those of African descent for that same year was 364.2 per 100,000 population. Admissions to general hospitals with psychiatric units showed similar patterns by race and ethnicity. For the population as a whole, the rate per 100,000 was 295.3 per 100,000, while the rate for the White population was 284.9. The rate during the same period for those of African descent admitted to general hospital psychiatric units was 386.6 per 100,000. While the national mean admission rate to Veterans Administration hospitals was 70.4 per 100,000, populations of African descent had a rate of 118.2 per 100,000. No other racial or ethnic population had an admission rate to the Veterans' Administration hospitals that approximated the rate for populations of African descent.

When age is examined, the relationship between admissions to psychiatric hospitals and race is more pronounced. For example, the rate of admissions to state psychiatric hospitals for those of African descent between the ages of 25-44 was 598 per 100,000, while the national mean was 163.6 (Manderscheid & Sonnenschein, 1987). The most excessive rate found was for those of African descent between the ages of 25-44 where 753 per 100,000 were admitted to state psychiatric hospitals (Manderscheid & Sonnenschein, 1987). Although admissions are not indicative of actual prevalence rates in the population, these data show clearly an inveterate pattern of service utilization differentiated by race and class.

Data from the National Institute of Mental Health (Manderscheid & Sonnenschein, 1987) show that Blacks were more frequently diagnosed on admission with severe mental illness than other ethnic or racial populations. According to data on admissions of Blacks to state mental hospitals, 56% of these individuals received a primary diagnosis of schizophrenia, while only 38% of all individuals received a similar diagnosis. Garretson (1993), Flaskerud and Hu (1992), Jones and Gray (1986), and Lawson and colleagues (1994) conclude that the primary reasons for the disproportionate rate of severe mental illness diagnoses are errors made by diagnosticians who are unfamiliar with mental illness as it is manifested in populations of color.

Decades of knowledge in the literature about how populations of African descent consume mental health services show that people of African descent:

- drop out of services at a significantly higher rate than White populations;
- use fewer treatment sessions for their mental health problems than White populations;
- enter mental health treatment services at a later stage in the course of their illness than do White populations;
- under-consume community mental health services of all kinds;
- over-consume inpatient psychiatric care in state hospitals at twice the rate of corresponding White populations;
- are more often misdiagnosed by mental health practitioners than White populations; and
- are more often diagnosed as having a severe mental illness than Whites.

Managed Behavioral Health Care and Race: Implications

These data reflect a number of conclusions that may be helpful as the nation sets its course towards managed behavioral health care in the public and private sectors. It is clear that under the prior and present systems of care, individuals of African descent with serious mental illness were and are not served well. Diagnoses were found to have been in error, inpatient admission rates were disproportionately high, involuntary admissions were used with great frequency; and the most severe mental illness labels were ascribed at a rate that appears higher than its expected frequency in the population. Of significance as well are the findings of different patterns of help seeking and help utilization on the part of African American populations. Populations of African descent tend to delay seeking help for psychiatric problems (as well as major health problems) from formal health systems until conditions have become more serious or chronic and most other community and familial resources have been exhausted. Those of African descent also do not continue to use outpatient services or as many service units as other populations, although their diagnoses are more severe. Each of these conclusions implies important clinical and marketing issues for managed behavioral health care processes and values. As new managed care policies and services are being developed to reduce unnecessary services and excessive costs, more attention should be given to the poorly understood service issues and dilemmas related to race and severe mental illness.

With the implementation of managed care policies, the paradoxes associated with race and mental illness are likely to impact disproportionately on low income communities of color. For managed care to serve consumers of African descent with severe mental illness effectively, significant focus must be on issues of access, as well as accuracy of diagnosis and quality of treatment. Too often clinical issues are not examined from an ethnic or racial perspective because they do not fit the dominant cultural perspective. Even those professionals who have been educated in urban areas with large concentrations of minority populations may be conditioned to assess consumers using standards and guidelines that are not culturally specific or sensitive. In a behavioral health care environment that seeks to penetrate the market of consumers who are of African descent, there is a need to establish standards and guidelines for managed care systems, organizations, and providers.

Asian and Pacific Islander People

The terms Asian, Asian Americans, or Asian/Pacific Islander will be used when referring to this group, which is the most diverse in terms of ethnic origin, cultural background, immigration history, and acculturation to U.S. culture. For example, Asian Americans comprise at least 31 ethnic groups. Yet, Asian and Pacific Islanders are often misunderstood to be a homogeneous ethnic group. Unfortunately, failure to make distinctions among the diverse ethnic, cultural, and language groups comprising Asian and Pacific Islanders, and tendencies to generalize their economic, social, and political circumstances, can lead to faulty conclusions about individuals' mental health needs.

In terms of percentage increase, Asian Americans are the fastest growing racial/ethnic group in the United States. The American Asian/Pacific Islander population grew 108% from 3,726,440 in 1980 to 7,273,662 in 1990, thus constituting 2.9% of the entire U.S. population according to the 1990 U.S. Census (U.S. Bureau of the Census, 1991). Projections are that by the year 2020, the Asian American population will be approximately 20.2 million, or about 8% of the total U.S. population.

Their diverse immigration history spanning over 200 years, the earliest immigrants came predominantly as indentured laborers, whereas many Asian/Pacific Islanders have of late come to the U.S. as refugees escaping persecution in their home countries. Many more have emigrated in search of better education and economic opportunities. Before World War II, the majority of Asian and Pacific Islander immigrants to the U.S. were from China and Japan. More recently, immigration has included many from diverse Asian groups, such as Nepalese and Tibetans from Central Asia, and from Southeast Asian groups, such as Burmese, Cambodians, Laotians, and Vietnamese, who in turn have many different subgroups, among which the Hmong are perhaps best known. American Samoans, Guamanians, and Filipinos have also come in more significant numbers. In 1990, 68% of Asian Americans were born outside the U.S. A myriad of issues surround this diverse immigration history, and contribute to a situation of economic polarity among Asian Americans. For example, disparate levels of language proficiency and education clearly contribute to this economic polarity. Unemployment among those of limited education and English language proficiency is double that of Asian Americans who are not disadvantaged in education and language.

Asian Pacific Islander American Mental Health Issues

The accumulating evidence suggests that Asian Americans are experiencing significant mental health problems. Their diversity (the many ethnic groups, languages, cultures, value and belief systems, and immigration histories, as well as differences in present-day social, economic, and political circumstances) produces an equally diverse range of mental health concerns. The extent to which these issues become problems and how distress is expressed are thought to be affected by multiple factors that may include, but are not limited to: residence area; generational status in the U.S.; degree of acculturation, religious beliefs and value orientations, native language facility, English language proficiency; age, education, economic status, family composition, and degree of family dispersion; immigration as an unaccompanied minor; degree of identification with the country of origin; perception of choice in emigrating to the U.S.; social-political identification; and connection with formal and informal local networks.

Unfortunately, rates of psychopathology have been difficult to assess. It is believed that most existing estimates, which are based on utilization rates among clinical samples, seriously underestimate the actual need in the general Asian American population. Moreover, it is not known to what extent Western diagnostic criteria may overlook culturally-specific symptom expression and culture-bound syndromes. Reports comparing Asian American service use rates to their proportion in the general population evidence disporportionatly low rates of admission for health services, regardless of service type. Several studies also report that Asian Americans exhibit more severe disturbances compared to non-Asians, suggesting that they are more likely to endure psychiatric distress for a long time, only coming to the attention of the mental health system at the point of acute breakdown and crisis. Further studies show that Asian Americans are more likely to drop out after initial contact or terminate prematurely from mainstream service settings. Studies have linked such under-use to the shame, stigma, and other cultural factors that influence symptom expression and conceptions of illness, as well as to limited knowledge about the availability of local mental health services, and a tendency to seek more culturally congruent care. The latter may include herbalist, acupuncturist, and other forms of healing. Increased utilization, longer treatment, consumer satisfaction, and positive therapeutic outcomes have been attained by culturally responsive, ethnic-specific services for Asian/Pacific Islanders which emphasize flexible hours, community-based facilities, bi-cultural and bilingual staff, and implementation of culturally congruent treatment plans.

Asian Pacific Islander Mental Health Service Delivery Issues

The data point to a great need for delivering more effective mental health services to Asian/Pacific Islander persons, and cultural competence is a fundamental component of such services. A respect for, and understanding of, diverse ethnic and cultural groups, their histories, traditions, beliefs, and value systems, cultural competence in mental health services is integrally important to all levels of care, including the structure and policies of service delivery systems, care planning for the individual consumer/family, and direct treatment intervention. As we move toward managed behavioral health care, the availability of care from culturally competent mental health specialists is a basic concern. In addition, coverage for family-oriented care plans, culturally appropriate interventions, linguistic interpreters, and alternative models of care are threatened.

American Indian, Native Alaskan, and Native Hawaiian Populations

Demographic and Health Profile

In the United States, the terms Native American, Indian, and American Indian are commonly used and have been considered interchangeable when referring to aboriginal people of the continental United States, i.e., American Indians, Eskimos, and Aleuts. In this document, Native American also includes the natives of Hawaii.

A rich diversity exists among the hundreds of tribes and villages, and within urban Native American communities. Among the better known tribes are the Apache, Cherokee, Navajo, Iroquois, and Sioux (Lakota). Lesser-known groups, of which there are many, include the Cahuilla, Gay Head Wampanoag, Mississippi Choctaw, Red Lake Chippewa, Shivwits, and Tlingit. Census data for 1990 reported approximately 1.9 million American Indian, Eskimo, and Aleut people in the United States (U.S. Bureau of the Census, 1991). About half live on Federal Indian reservations in 33 states, mostly located in the west. The other half live in urban areas, although some reside in small off-reservation communities. The Indian population is young; approximately half are 18 years of age or younger (Nelson, McCoy, Stetter, & Vanderwagen, 1992). Of the 211,014 Native Hawaiians living in the U.S. in 1990, the majority (138,742 or 66%) resided in Hawaii (U.S. Bureau of the Census, 1991). This population faces severely poor health conditions (Mokuau, 1990); Native Hawaiians have the shortest life expectancy of any ethnic group in Hawaii (State of Hawaii, 1987).

Many American Indian and Alaska Native groups have sovereign nation status with the Federal government. For most Indian tribes, sovereignty was specifically retained when they signed treaties with the United States. They are recognized as distinct political entities operating within the American government system, the "nation within a nation" concept. Hawaiian Natives are now seeking to restore their sovereign nation status, which was lost at the time of the overthrow of the Hawaiian monarchy.

The importance of mental health services to Native people can be understood in historical, geographical, educational, and tribal contexts. It is import to understand the impact of colonization on Native people and corresponding issues of mental health (Duran & Duran, 1995). Although some early contacts between Native peoples and Europeans were positive, most were not. From the point of initial contact with Europeans, when there were several million Native Americans, holocaust conditions led to the annihilation of some, and near destruction for other tribes across the Americas and the Hawaiian Islands. Diseases foreign to Native people wiped out over half of the American Indian population, and the impact of these diseases is still being felt. Disease killed many leaders and elders, thus cutting off tribal leadership, as well as the sources for knowledge and tradition. Furthermore, the power of the medicine people was undermined, because there were no cures for alien diseases about which they had no knowledge. Memories remain among Native Americans about what Whites did through deliberately providing them with infected blankets as "gifts" - an early form of germ warfare (Vogel, 1972).

Forced relocation was another factor which caused many deaths as well as numerous other problems, many of which were mental health related. Dealing with the reality of being conquered, shamed, forced into dependency upon the U.S. government, and the stripping of traditional roles from men, women, and children has impacted tribes for centuries. The pain of the "Trail of Tears," or long treks to forced relocation areas, remains in the hearts and minds of American Indians today. Other impacts include dealing with broken treaties, being restricted to reservations (historically, an Indian had to have a permit in order to leave the reservation), poverty conditions, and the consequences of not relocating, which often meant destruction and death (O'Sullivan & Handal, 1988; Vogel, 1972). Alcohol was another devastation (Berkhofer, 1978) and is considered to be the current number one problem in Native American areas.

Forced education through boarding schools caused considerable damage to the structure and function of tribal societies as well as to the mental health of Natives. Historically, Native American children were taken from their tribal homes to attend boarding schools sometimes hundreds or thousands of miles away. They were forbidden to speak their tribal language, given new names, and usually a uniform. Their hair was shorn, and they were taught the ways of White society. The early charters for Native American education were the same: to remove the child from the influence of his or her "savage" parents. Today, approximately 25% of Native children attend boarding schools. The effects of boarding schools on tribes extend to the undermining of tribal ways of parenting and traditional child-rearing, to negative messages about Natives, to the forced assimilation of White ways, and to the use of language. There are many stories about a child finally returning home and being unable to speak to his or her parents. Even today, there are counseling groups specifically designed to address the effects of boarding school education experiences.

Through the obligations of many treaties, the U.S. government has had the responsibility for the health care of Native Americans. Typically, these obligations were carried out through the Bureau of Indian Affairs (BIA) of the Department of the Interior, and the Indian Health Service (IHS) of the Public Health Service, which in 1955 assumed primary responsibility for providing health care to Native Americans. Currently, the IHS services approximately 60% of the Indian population (Johnson, 1995). IHS services include clinical care as well as environmental health, facility maintenance, and critical public health functions. The hope was, that once this was fully developed and comparable to the nation's health care systems, Congress could relinquish its responsibilities to American Indians. This goal was part of the termination policy formulated by Congress during the Truman and Eisenhower administrations. Under the self-determination policy developed during the Nixon administration, tribes were encouraged to take over governing their health care programs (Flack, 1995). Under Public Law 93-638, 300 tribes across the nation now compact or contract with the Federal government to provide part or all of the health care for their tribal members. In addition, 41 urban Indian health clinics attempt with severely limited funds to serve the most disadvantaged Indians and those from distant tribes who may not be eligible for IHS contract services. Presently, there are numerous agencies/departments involved to varying degrees in providing mental health services to Native Americans. However, there is a lack of clarity regarding the roles of the IHS, the BIA, states, counties, cities, and tribes in mental health care. There are relatively few working agreements among these service delivery systems (WICHE, 1993).

Native Americans appear to be at higher risk for mental disorders than most ethnic groups in the United States (Nelson, McCoy, Stetter & Vanderwagen, 1992). Of great concern is the high prevalence of depression, anxiety, substance abuse, violence, and suicide. Other common mental health problems of Native American individuals are psychosomatic symptoms and emotional problems resulting from disturbed interpersonal and family relationships (Neligh, 1990).

The Native American Panel has many concerns about managed care as a model of health care delivery for Native Americans. Of particular concern is the use of a prepaid or capitated approach to service payment. Issues affecting Native American people are complex and linked to historical events and current experiences which are perpetuated by current events that, on the surface, do not seem related. However, because of the historic trauma experienced by many Native Americans, subtle messages that communicate a lack of belonging to contemporary American society and the continuing assault on Indian sovereignty serve to perpetuate mental health problems. Managed care organizations which do not address these complex issues in a careful and thoughtful manner with Native American consumers, sovereign tribal nations, native organizations, and relevant Federal agencies will only add to the oppression experienced by Native Americans for decades.

The Native American Panel offers the following guidelines toward the goal of developing culturally competent managed care organizations which would serve Native Americans in ever-increasingly effective and respectful ways. In reviewing the system and clinical guidelines, the panel agreed that guidelines for provider competencies would be the same regardless of the setting (urban, suburban, rural, or reservation). All other guidelines were reviewed, with rural-reservation managed care settings kept separately in mind from urban-suburban settings. It is highly likely that the urban-suburban managed care settings would be non-Native American and most likely, non-minority specific. In considering the rural/reservation situation, the panel found it useful to use the Navajo Nation as a reference point. The Navajo Nation has sovereign nation status over its membership residing on or near the reservation, a very large geographic area located in three states (Arizona, New Mexico, and Utah). This illustrates the complexity in developing culturally competent health care for one tribal nation.

Managed Care in the Delivery of Mental Health Services

The transition into managed care in the delivery of health care services has had an impact on both private and public behavioral health systems. As this transition is taking place, a number of potential risks have surfaced. Professionals and organizations representing individuals from the four groups have concerns about how these major shifts will affect all ethnically diverse populations. Some of these concerns include:

- Cost-cutting that potentially threatens the quality of care;
- Restructuring of services away from local, community-based approaches;
- Relocation of services threatening accessibility;
- Services provided to consumers from the four groups by mental health professionals not familiar with the language, cultural values, and multiple needs of the different groups;
- Consumer lack of knowledge about how the health care system works; and
- Language differences interfering with communication and access to resources.

The authors of this document acknowledge that this shift to a new health care delivery system offers a number of potential opportunities for behavioral service delivery as well as for the racial/ethnic communities. Some of these potential opportunities include:

- Increased accountability for services provided;
- Flexibility of care options to consumers;
- Competition for service providers to provide maximum value for the Medicaid consumer dollar;
- Greater cost-efficiency through more accurate assessment and effective treatment;
- Use of culturally competent, less restrictive community-based treatment approaches;
- A shift from more restrictive and expensive services to earlier use of services, leading to secondary prevention;
- Use of traditional healers in conjunction with traditional western mental health approaches; and Partnership with community organizations for health promotion; and
- Greater acceptability through culturally friendly location and ambiance and community input in design and governance.

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I. Guiding Principles

1. ***Principle of Cultural Competence:***
   Cultural competence includes attaining the knowledge, skills, and attitudes to enable administrators and practitioners within systems of care to provide effective care for diverse populations, i.e., to work within the person's values and reality conditions. Recovery and rehabilitation are more likely to occur where managed care systems, services, and providers have and utilize knowledge and skills that are culturally competent and compatible with the backgrounds of consumers from the four underserved/underrepresented racial/ethnic groups, their families, and communities. Cultural competence acknowledges and incorporates variance in normative acceptable behaviors, beliefs, and values in:
   - determining an individual's mental wellness/illness, and
   - incorporating those variables into assessment and treatment.

2. ***Principle of Consumer-Driven System of Care:***
   A consumer-driven system of care promotes consumer and family as the most important participants in the service-providing process. Whenever possible and appropriate, the services adapt self-help concepts from the racial/ethnic culture, taking into account the significant role that mothers and fathers play in the life of consumers from the four groups.
3. ***Principle of Community-Based System of Care:***
   A community based system of care includes a full continuum of care. The focus is on: including familiar and valued community resources from the minority culture; investing in early intervention and preventive efforts; and treating the consumer in the least restrictive environment possible.
4. ***Principle of Managed Care:***
   The costs of a public managed health care delivery system are best contained through the delivery of effective, quality services, not by cutting or limiting services. Effective systems provide individualized and tailor-made services that emphasize outcome-driven systems and positive results. Such systems acknowledge the importance of added-value inclusion of ethnic/cultural groups as treatment partners. The system includes an emphasis on managing care, not dollars. It recognizes that dollars will manage themselves if overall care is well managed. It recognizes racial/ethnic group-specific variables which have significant implications for individualized assessment and treatment.
5. ***Principle of Natural Support:***
   Natural community support and culturally competent practices are viewed as an integral part of a system of care which contributes to desired outcomes in a managed care environment. Traditional healing practices are used when relevant or possible, and family is defined by function rather than bloodlines, as individuals from the four groups generally conceive of family much more broadly than nuclear family.
6. ***Principle of Sovereign Nation Status:***
   Systems of health care for Native Americans who are members of sovereign nations shall acknowledge the right of those sovereign nations to participate in the process of defining cultural competent managed care.
7. ***Principle of Collaboration and Empowerment:***
   Consumers from the four groups and their families have the capacity to collaborate with managed care systems and providers in determining the course of treatment. The greater the extent of this collaboration, the better the chances are that recovery and long-term functioning will occur and be sustained. The risk of psychological dependency and lower functioning increases with a decrease in collaboration with consumers and families. Empowering consumers and families enhances their self esteem and ability to manage their own health.
8. ***Principle of Holism:***
   Consumers from the four groups are more likely to respond to managed care systems, organizations, and providers who recognize the value of holistic approaches to health care and implement these in their clinical work, policies, and standards. Where holistic approaches are absent, there is greater risk that

consumers from the four groups will over-utilize mental health services, resulting in increased costs.

9. ***Principle of Feedback:***
   Managed care systems, organizations, and providers shall improve the quality of their services and enhance desired outcomes of their service delivery to consumers from the four groups through legitimate opportunities for feedback and exchange. Where such opportunities for feedback are absent, there is a greater likelihood that the system of managed care services and policies will not be congruent with the needs of consumers from the four groups and will not result in high levels of consumer satisfaction. Managed care systems that lack opportunities for this feedback limit their chances of making culturally specific corrections in their approaches to services while simultaneously increasing their risks.
10. ***Principle of Access:***
    For consumers from the four groups to seek, utilize, and gain from mental health care in a Managed Health Plan, services, facilities, and providers shall be accessible. Where services and facilities are geographically, psychologically, and culturally accessible, the chances are increased that consumers from the four populations will respond positively to treatment for mental illness. Inadequate access to services will result in increased costs, limited benefit to the consumer, and a greater probability that services will not result in the outcomes desired.
11. ***Principle of Universal Coverage:***
    Populations of the four groups have higher than average frequencies of unemployment and receipt of transfer payments, along with lower disposable income. Where health care coverage, benefits, and access are based on employment or ability to pay, consumers from the four groups are more likely to be medically underserved. The greater the extent to which health care is universally available without regard to income, the greater the likelihood that the health status of consumers from the four groups will be enhanced.
12. ***Principle of Integration:***
    Consumers from the four groups have higher than expected frequencies of physical health problems. Integrating primary care medicine, mental health, and substance abuse services in a Managed Care Plan increases the potential that consumers from the four groups will receive comprehensive treatment services and recover more rapidly, with fewer disruptions due to a fragmented system of care.
13. ***Principle of Quality:***
    The more emphasis that managed care systems place on ensuring continuous quality culturally competent service to consumers from the four groups, the greater the likelihood that relapse will be prevented; with sickness treated appropriately and costs lowered. The less emphasis placed on providing quality services to consumers from the four groups, the greater the chances that costs will increase.
14. ***Principle of Data Driven Systems:***
    The quality of decision making, service design, and clinical intervention for consumers from the four groups in managed health care is increased where data

on prevalence, incidence, service utilization, and treatment outcomes are used to inform and guide decisions.

15. ***Principle of Outcomes:***
    Consumers from the four groups and their families evaluate services on the basis of actual outcomes relative to the problems that stimulated help seeking in a managed care environment. The greater the extent to which managed care plans, organizations, and providers emphasize and measure these outcomes in comparison to the expectations of consumers from the four groups, the higher the degree of consumer satisfaction.
16. ***Principle of Prevention:***
    States, managed care organizations, and provider organizations should provide community education programs about mental illness and the risk factors associated with specific disorders. The goal should be to increase the capacity of families to provide a healthy environment and to identify the early warning signs of mental health problems. Early problem identification and intervention can prevent the exacerbation and reduce the disabling effect of mental illness.

II. Overall System Standards and Implementation Guidelines

Cultural Competence Planning

Standard

A Cultural Competence Plan for both public and private sectors shall be developed and integrated within the overall organization and/or provider network plan, using an incremental strategic approach for its achievement, to assure attainment of cultural competence within manageable but concrete timelines.

Implementation Guidelines

The Cultural Competence Plan shall include:

1. Development and integration with the participation and representation of top and middle management administrators, front-line staff, consumers and/or their families, sovereign tribal nations, and community stakeholders;
2. An individual at the executive level with responsibility for and authority to monitor implementation of the Cultural Competence Plan;
3. Individual managers accountable for the success of the Cultural Competence Plan based on his/her level within the organization;

4. A process for integrating the Cultural Competence Plan into the overall state and/or department plan, and for including the principles of cultural competency in all aspects of organizational strategic planning and in any future planning process;
5. A process for determining unique regionally-based needs and ecological variables within the communities/populations served using existing agency databases, surveys, community forums, and key informants;
6. Identification of service modalities and models which are appropriate and acceptable to the communities served (i.e., urban, frontier and rural), population densities and targeted population subgroups, (e.g., children, adolescents, adults, elders, sexual minorities, and individuals with co-occurring conditions);
7. Identification and involvement of community resources, (e.g., tribal and community councils or governing bodies, family members, clans, native societies, spiritual leaders, churches, civic clubs, and community organizations) and cross-system alliances (e.g., corrections, juvenile justice, education, social services, substance abuse, developmental disability, primary care plans, public health, and tribal health agencies) for purposes of integrated consumer support and service delivery;
8. Identification of natural supports (e.g., family members, religious and spiritual resources, traditional healers, churches, civic clubs, community organizations) for purposes of reintegrating the individual within his/her natural environment, keeping in mind that for some, this may also include migratory patterns to and from a reservation or reservations, state to state, or country to country;
9. Assurance of cultural competence at each level of care within the system (e.g., crisis, inpatient, outpatient, residential, home-based, health maintenance, community health liaison services);
10. Stipulation of adequate and culturally diverse staffing and minimal skill levels (including gender, ethnicity, and language as well as licensing, certification, credentialing, and privileging) for all staff, clerical through executive management;
11. The use of culturally competent indicators, adapted for specific minority cultural values and beliefs, in developing, implementing, and monitoring the Cultural Competence Plan;
12. Development of rewards and incentives (e.g., salary, promotion, bonuses) for cultural competence performance, as well as sanctions for culturally destructive practices (e.g., discrimination). Cultural competence performance shall be an integral part of the employee-provider performance evaluation system, and provider organization performance evaluation system;
13. Development of a plan to integrate ongoing training and staff development into the overall Cultural Competency Plan; and
14. Development and ongoing plan monitoring of indicators to assure equal access, comparability of benefits, and outcomes across each level of the system of care and for all services provided through the Health Plan.

Recommended Performance Indicators

1. Presence of a Cultural Competence Plan and defined steps for its integration at every level of organizational planning.
2. Presence, within the Cultural Competence Plan, of related policy/procedure changes.
3. Percentage/number of staff receiving initial and ongoing cultural competence training.
4. Presence of established links with community resources.
5. Demonstration of staff knowledge and skills regarding group values, traditions, expression of illness, cultural competence principles (e.g., credentialing and performance based testing).
6. Demonstration of a cultural competence system evaluation (e.g., Mason, 1995, Cultural Competence Self Assessment Questionnaire: A Manual for Users).
7. Demonstration of staff and consumer awareness and acceptance of the Cultural Competence Plan.
8. Presence of a plan for recruitment, retention, and promotion of staff of racial/ethnic backgrounds representative of target population served.

Recommended Outcomes

1. Percentage of consumers from the four groups compared to overall representation in the community.
   Benchmark: Comparable to overall general population.
2. Percentage of consumers from the four groups served by or under direct supervision of culturally competent staff.
   Benchmark: 100% served.
3. Consumer satisfaction with services, measured in culturally competent manner.
   Benchmark: 90% satisfaction.
4. Proportionality of access to, and length of service of, the full range of treatment services offered.
   Benchmark: Comparable to overall service recipients for access to specific levels and types of services.
5. Reduced restrictiveness of placement (including incarceration/detention) for consumers from the four groups.
   Benchmark: Comparable restrictiveness to the general population and overall reduced restrictiveness.

Governance

Standard

Each Health Plan's governing entity shall incorporate a board, advisory committee, or policy making and influencing group which shall be proportionally representative of the consumer populations to be served and the community at large, including age and ethnicity. In this manner, the community served will guide policy formulation and decision making, including Request for Proposals development and vendor selection. The *governing entity responsible for the Health Plan shall be accountable for its successful implementation, including its cultural competence provisions.*

Implementation Guidelines

The Health Plan shall:

1. Include formal procedures for decision-making related to policies, practices, and grievances in accordance with state and Federal law with racial/ethnic community and professional input, participation, and involvement at all levels, including fair hearings. Consumers shall be informed of this procedure in their own language at intake and supported linguistically at the time of any steps in the complaint and grievance process;
2. Make available a culturally competent group of ombudspersons (minimally comprised of consumer, family member, and regional representatives) to be involved in all appeals and concerns from the community served. The group of ombudspersons shall have independence from the Health Plan, and there shall be formalized procedures for resolving differences of opinion between the ombudsperson and the Health Plan administration's governance;
3. Have a governing entity that shall determine for each Health Plan an equitable percentage of profit or savings to be reinvested in racial/ethnic community-based services and preventive programs on an ongoing basis. A financial penalty or termination of contracts is applicable when inequities exist to access and/or comparability of benefits;
4. Develop interagency and cross-system agreements or pooled funding to coordinate services with other agencies (e.g., public health, social services, corrections and juvenile justice, youth services, education, substance abuse, developmentally disabled services);
5. Distribute financial and liability risks for the Health Plan such that culturally competent smaller scale providers and organizations will be able to continue to deliver services;
6. Develop policies governing practitioner ethics and behavior (e.g., gift giving by consumers, interactions with consumers outside the service setting, confidentiality) that shall provide for differences relevant to the context of racial/ethnic cultural values; and
7. Provide that contract continuation and renewal shall be contingent upon successful achievement of performance standards which demonstrate effective service, equitable access and comparability of benefits for populations of the four racial/ethnic groups.

Recommended Performance Indicators

1. Racial/ethnic consumer awareness of and participation in Health Plan benefits, appeals procedures, and ombudspersons, as demonstrated by the comparability of the rate of grievances and complaints.

2. The percentage of complaints and grievances of individual practitioners tracked and factored into performance evaluations.
3. Presence of culturally-informed policies of practitioner behavior and performance-based demonstrations of implementation.

Recommended Outcomes

1. Final disposition of grievances and appeals for consumers from the four groups.
   Benchmark: Comparable to overall service population..
2. Percent of consumers from the four groups receiving blended, coordinated, or wrap-around services.
   Benchmark: Comparable to overall service population and increasing over time.
3. Percentage of reports of unethical practitioner behavior for practitioners serving populations of the four groups.
   Benchmark: Comparable to overall service population..
4. Sanctions and incentives reinforce progress toward the delivery of culturally competent services.
   Benchmark: Decreased rates of sanction over time.
5. Composition of the governing board, advisory committee, other policy-making and influencing groups, and consumers served reflects service area demographics.
   Benchmark: 90% of expected representation.
6. Consumer awareness of plan.
   Benchmark: 80% of surveyed respondents aware of plan.
7. Culturally-based policies shaping practitioner behaviors and measuring performance.
   Benchmark: Presence of policies.

Benefit Design

Standard

The Health Plan shall ensure equitable access and comparability of benefits across populations and age groups. Coverage shall provide for access to a full continuum of care (including prevention programs) from most to least restrictive in ways which are comparable, though not identical, acknowledging that culturally competent practice provides for variance in individualized care.

Implementation Guidelines

The Health Plan shall:

1. Make no arbitrary restrictions and limitations in benefit level. For example, in some regions, post traumatic stress disorder (PTSD) has been eliminated from the eligible list of treatable disorders. Southeast Asian refugees who suffer disproportionately from PTSD are therefore not eligible for treatment. Cost-

effectiveness shall be accomplished through care management and utilization review mechanisms;

2. Have coverage incorporating and integrating innovative treatment modalities, including alternative healers, and primary prevention and health promotion to all levels of care to enhance the acceptability and cost-effectiveness of care;
3. Have coverage incorporating services delivered by qualified racial/ethnic mental health specialists when available, or non-minority culturally competent mental health specialists when culturally competent specialists from the appropriate racial/ethnic group(s) are not available;
4. Have coverage incorporating the coordination of services across service agencies and systems serving the consumer in order to ensure cost sharing for consumer services;
5. Provide to consumers and families in their primary language(s) information, community education, and written and oral materials regarding covered services and procedures for accessing and utilizing services. Such information shall be made available through partnerships with community organizations in addition to conventional means of dissemination. Written correspondence or audio presentations regarding eligibility shall be in consumers' and families' primary language(s), with alternative methods of communication also developed and utilized;
6. Develop eligibility and level of care criteria for service provision and/or receiving services by or under the guidance of culturally competent bilingual, bi-cultural providers. These criteria shall be defined primarily by the assessment of behavior and functioning and secondarily by diagnosis, given the limitations of diagnostic systems in cross-cultural applications. Utilization review and eligibility determinations shall be performed by culturally and linguistically competent staff;
7. Provide for consumer choice of individual provider. All providers shall be responsible for comparable levels of service to sponsored (insured) and unsponsored (uninsured) persons;
8. Provide for the needs of both sponsored and unsponsored populations of the four groups and shall provide access for service to unsponsored individuals in proportion to general industry standards and practice;
9. Make provisions in the benefit design for people who leave the Health Plan, including service planning and a transition process to new plans;
10. Work with private plans to provide for instances when a privately insured individual becomes uninsured and probably will require services from the Public Health Plan; and
11. In order to ensure adequate funding for more intensive services, provide benefits that include adequate culturally competent risk-adjustment strategies specifically for consumers at-risk for serious and persistent mental illness, emotional disturbance and/or other multiple, long-term service needs.

Recommended Performance Indicators

1. Culturally competent eligibility and level of care criteria are formally established.

2. Eligibility determinations and service planning are performed by, or under the supervision of, linguistically and culturally competent bilingual/bi-cultural specialists.
3. Consumers from the four groups receive direct services provided by or from culturally competent bilingual/bi-cultural personnel, or by personnel supervised by culturally competent bilingual/bi-cultural racial/ethnic mental health specialists.
4. Consumers receive consumer-friendly bilingual materials on Health Plan benefits.
5. Percent of consumers receiving services by traditional healers.
6. Treatment plans incorporate individual, familial, and community strengths and appropriate interagency resources.
7. Prevention strategies and action plans are implemented.
8. Use of flexible funding for consumers from the four groups, comparable across groups.

Recommended Outcomes

1. Benefit distribution and service provision for consumers from the four groups.
   Benchmark: Comparable to overall service population.
2. Percent of covered consumers who know benefits and how to access them.
   Benchmark: 80%, as measured by consumer survey.
3. Consumer and family satisfaction with services.
   Benchmark: 90% satisfaction.
4. Proportionality of racial/ethnic consumer access to full range of benefits.
   Benchmark: Comparable to overall service population.
5. Focused prevention, education, outreach & services planning for consumers from the four groups.
   Benchmark: Increased specialized and preventive services to at-risk consumers.

Prevention, Education, and Outreach

Standard

Each Managed Care Mental Health Plan shall have a prevention, education, and outreach program which is an integral part of the Plan's operations and is guided in its development and implementation by consumers, families, and community-based organizations.

Implementation Guidelines

Managed care plans shall:

1. Develop mechanisms that increase the provider's knowledge of what the community wants and needs, how and in what form it obtains new information, and its experiences with existing services;

2. Ensure that the location of behavioral health services shall be a joint decision between managed care plans, providers and consumers;
3. Document, before the development of prevention, education, and outreach programs, how they assess and plan to apply information and knowledge about risk factors associated with consumers from the four groups and their families;
4. Ensure that prevention, education, and outreach approaches include specific services for at-risk youth in the family of the primary consumer;
5. Provide consumers from the four groups and their families with education and information about the available service benefits and how to access them;
6. Ensure that prevention, education, and outreach approaches consider the family and community systems in which the primary consumer lives;
7. Ensure that prevention, education, and outreach plans and methods include linkages with religious organizations in the community and training of members of the faith community to assist in educating consumers about mental health service;
8. Offer programs to educate professionals and consumers about how consumers and their families from the four groups can be more responsible for their own health and preventing illness; and
9. Develop and maintain an updated listing of community resources that may be beneficial in providing prevention, education, and outreach services to consumers from the four racial/ethnic groups and their families.

Recommended Performance Indicators

1. Activities and material, including an updated listing of community resources, are provided in the language(s) of the population(s) being served.
2. Education and training linkages are made with faith-based organizations in the community.
3. The Managed Care Mental Health Plan assesses the existence of racial/ethnic groups in the population being served, assesses the needs and risk factors associated with those populations, and takes these factors into consideration in prevention, education, and outreach activities.
4. The organization coordinates education and outreach activities with community cultural organizations.

Recommended Outcomes

1. Documentation that activities and material are provided in the proportion of the primary language(s) in the population served.
2. The Managed Care Mental Health Plan maintains a list of cultural community organizations and documents the utilization of these organizations to assist in education and outreach.

Quality Monitoring and Improvement

Standard

The Health Plan shall have a regular quality monitoring and improvement program that ensures (1) access to a full array of culturally competent treatment modalities, (2) comparability of benefits, and (3) comparable successful outcomes for all service recipients.

Implementation Guidelines

The Quality Monitoring and Improvement Plan shall include:

1. Sampling approaches of current and past utilization patterns, by modality (including pharmacological therapy), and level of care;
2. Quality improvement teams with proportionate representation of consumers from the four groups and culturally competent specialists which review data from quality indicators relating to these populations. Procedures shall be in place to ensure that if irregularities or deficiencies in care are found, special quality studies and corrective actions shall be undertaken to identify causes and address root causes/processes;
3. Consumer satisfaction surveys, translated orally and in written format into local languages and dialects, implemented by members of the community independent from the Health Plan. Surveys shall be available in various formats to facilitate the participation of consumers at all socioeconomic and educational levels. Sampling shall include involvement of Health Plan drop-outs. Evidence of a pattern of discrimination shall be a reason for termination of contract;
4. Periodic assessment of functional outcomes which are valid and applicable to populations of the four groups, for consumers and families receiving services, as well as the entire covered population. Outcomes shall be quantifiable objectives, not just process variables, and shall be collected independent of agency billing records;
5. Quality and outcome data related to service provision for consumers from the four groups and their families that are identified by the provider. Data shall be reported on a regular basis to the governing entity and used as a basis for determining contract renewal;
6. Credentialing and privileging standards, specific to various disciplines, which include cultural and linguistic competence, knowledge, skills, and attitudes relevant to the racial/ethnic population. These standards shall include a continuing education requirement and performance based competency evaluation;
7. A record of, and regular reporting on, all appeals, grievances, and law suits, as well as informal complaints, differentiated by ethnicity of the complainant and the specific provider. Disproportionate trends by ethnicity shall require measurable and timely corrective action;
8. Criteria for the removal of providers from provider panels and tracking for providers and practitioners which are open for review, analyzed by ethnicity and gender of provider and able to account for differing service needs of diverse populations;
9. Tracking of consumer movement across levels of care, of the use of intrusive, specialized or restrictive interventions, and of unusual occurrences by age,

gender, ethnicity, and specific practitioner, with sanctions for desirable and unacceptable performances; and
10. Identification and tracking of high-cost consumers resulting in the review and adaptation of their individualized treatment plans to more effectively address their needs.

Recommended Performance Indicators

1. Presence of a Quality Improvement Plan.
2. Proportional representation of consumers from the four groups, providers, and community members on the quality improvement team.
3. Occurrence of quality studies focusing on the use of best practice in resolution of deficiencies in the care of consumers from the four groups.
4. Linguistically and culturally factored consumer satisfaction surveys which are independently administered and include Health Plan drop-outs and short term recipients.
5. Regular reporting of racial/ethnic specific quality assurance data to the governing entity, including appeals and grievances.
6. Systematic tracking of high-cost consumers with support to treatment teams to identify and implement successful interventions.
7. Systematic tracking and open reporting of persons, removed from provider panels, by ethnicity.

Recommended Outcomes

1. Consumer and family satisfaction with services for the four groups.
   Benchmark: Comparable to overall service population.
2. Rates of drop-out, grievances, restrictive care, unusual occurrences, and adverse events for consumers from the four groups.
   Benchmark: Comparable to overall service population.
3. Match between level of care/restrictiveness of modality and level of treatment need for consumers from the four groups.
   Benchmark: Level of match comparable to overall population.
4. Functional outcomes in domains of daily living (e.g., housing, access to primary health care, family role, vocational/educational/employment, community tenure).
   Benchmark: Improvement over time, rates comparable to overall community.
5. Comparability of access and benefit from service.
   Benchmark: Comparable rates of access, consumer satisfaction, and clinical results across overall service population.
6. Rates of recidivism into restrictive level of care or other restrictive placements.
   Benchmark: Comparable to overall population served and significant reductions where inequities exist.

Decision Support and Management Information Systems

Standard

The Health Plan shall develop and maintain a database which shall track utilization and outcomes for the four groups across all levels of care, ensuring comparability of benefits, access, and outcomes. The Health Plan shall also develop and manage databases of social and mental health indicators on the covered population from the four groups and the community at large.

Implementation Guidelines

The Health Plan shall:

1. Manage a database that includes qualitative and quantitative data that accurately reflect the four groups and are collected and interpreted in a culturally competent manner at national, state, and local levels. Findings from these data shall be used in a culturally competent manner to continually assess, improve, and inform strategic planning for services to racial/ethnic group consumers and families;
2. For purposes of accountability, report to the governing entity, in a regular and timely manner, performance and outcome data specific to consumers and families from the four groups;
3. Establish aggregated data linkages by ethnicity with primary care plan, public health, substance abuse, developmental disability, education, courts, corrections, and juvenile justice to provide cross-system utilization information on the mental health status of the four groups as the federal, state, and local levels;
4. Ensure that data are current, accurate, and include gender, age, ethnicity, socioeconomic status, linguistic proficiency, geographic area, sexual orientation (at the consumer's option), and health insurance status;
5. Ensure that, for purposes of data collection, each of the four groups is broad and inclusive, including a capacity to code all and multiple subgroups and those of mixed race/ethnicity. Each of the four categories shall be distinct and monitored separately even when consistent with U.S. Census Bureau practice;
6. Collect and track (independently from billing data) aggregated diagnostic and assessment information, service utilization trends and costs, drop-outs, and utilization patterns, and behavioral and functional outcomes. Each category shall be computed across modalities, using standardized units of measurement across modalities;
7. Ensure that individual consumer data are kept confidential with data sets coded in such a manner that clients cannot be readily identified; and
8. Seek formal input from the consumers' communities on adequacy of proportional mix of culturally competent mental health professional staff, including adequacy of culturally competent staff from their own racial/ethnic group.

Recommended Performance Indicators

9. Presence of a data system inclusive of the above mentioned elements.
10. Use of a unified clinical record across all levels of care that legally allow for sharing of information to facilitate data collection and tracking.
11. Regular reporting to the governing entity of performance and outcome indicators.

Recommended Outcomes

12. Timely and accurate consumer data which provides for tracking across age and race ethnicity.
13. Timely transition of data to enhance continuity of care.
    Benchmark: Real time authorizations for services.
14. Focused preventive and service planning for consumers.
    Benchmark: Increased specialized and preventive services to at-risk consumers.

Human Resource Development

Standard

Staff training and development in the areas of cultural competence and racial/ethnic mental health shall be implemented at all levels and across disciplines, for leadership and governing entities, as well as for management and support staff. The strengths brought by cultural competence form the foundation for system performance rather than detracting or formulating separate agendas.

Implementation Guidelines

The Health Plan shall:

15. Ensure that certification of Mental Health Specialists is done locally and is based on performance-based qualifications as determined by a local panel of culturally competent experts consistent with state, local, and tribal laws.
16. Have a clinical workforce that includes and makes special effort to recruit and retain at least a proportional representative percentage of mental health professionals from each of the four groups and their subgroups being served;
17. Establish career ladders for the development and advancement of racial/ethnic staff and for clinical and administrative supervisory and senior positions;
18. Develop and implement differential pay rates for specialized skills in cultural and linguistic competence in general, and for racial/ethnic Mental Health Specialists in particular;
19. Provide regularly required cultural competence training for all staff (see section on Cultural Competence Planning). Funding shall be designated for this purpose;

20. Establish specific continuing education requirements and performance-based standards for the development, maintenance, and continuance of clinically and culturally competent mental health providers to serve individuals from any of the four groups; and
21. Advocate that all states that license or certify providers of mental health services shall require cultural competency training prior to licensing or certification and for renewals. States shall establish accreditation standards for licensing bodies.

Recommended Performance Indicators

22. Establishment and evaluation of a credentialing process for racial/ethnic Mental Health Specialists.
23. Recruitment, retention, and career development plan for racial/ethnic and other culturally competent mental health professionals.
24. Use of language fluency examinations to determine the level of competence of clinicians and interpreters to provide comprehensive clinical and preventive care.

Recommended Outcomes

25. Percentage of consumers from the four groups served in their preferred language. *Benchmark: 100%.*
26. Percentage of consumers from the four groups served by, or under the supervision of, culturally competent bilingual/bi-cultural Mental Health Specialists.
    Benchmark: 100%.
27. Proportionality of racial/ethnic staffing to the needs of the four populations.
    Benchmark: There is a 1:1 match between need (not strict percentage of population) and staffing.
28. Percentage of staff receiving at least five hours of training annually in cultural competence awareness.
    Benchmark: 100%.

III. Clinical Standards and Implementation Guidelines

Access and Service Authorization

Standard

Services shall be provided irrespective of immigration status, insurance coverage, and language. Access to services shall be individual- and family-oriented (including client-

defined family) in the context of racial/ethnic cultural values. Access criteria for different levels of care shall include diagnosis, health/medical, behavior, and functioning. Criteria shall be evaluated in six areas: psychiatric, medical, spiritual, social functioning, behavior, and community support.

Implementation Guidelines

The Health Plan shall:

1. Include specific procedures to ensure comparability of access and receipt of benefits across populations. Racial/ethnic Mental Health Specialists shall be involved in the development and ongoing implementation and evaluation of these procedures;
2. Ensure that gatekeeping, service authorization, and critical service junctures for consumers from the four groups shall be performed by or under the supervision of a culturally competent mental health professional;
3. Ensure that restrictive placements for consumers from the four groups shall be made only with prior cultural consultation. Restrictive placements include inpatient, residential, and involuntary treatment;
4. Ensure that access is decentralized and facilitated through multiple outreach and case-finding approaches. These approaches shall include strategic co-location within racial/ethnic community organizations, social service agencies, community action agencies, health centers, churches, mosques, schools, and neighborhood locales which are accessible through public transportation and in-home, in-community, and mobile care. They shall be publicized by culturally and linguistically appropriate information which allows client choices;
5. Ensure that agencies have the flexibility of providing services to consumers from the four groups who may not reside in the agency's geographic service area, when this is in the best interest of the clients;
6. Provide that access to traditional healers and self-help services shall be covered by the benefits package;
7. Ensure that the use of telephone numbers (e.g.,. 1-800) for access shall not be exclusive of other points of entry for 24 hour crisis service and shall be accompanied by education of consumers from the four groups in the use of such access procedures;
8. Ensure that legal documentation for immigrant groups is not a requirement for service and does not serve as a barrier to service access (Legal status shall not be confused with sponsored and unsponsored status.);
9. Ensure that confidentiality requirements, by incorporating the values of consumers, including family decisions about services when appropriate, do not serve as a barrier to care;
10. Ensure equal availability of telephone and other communication means of access for consumers and families from the four groups. Staff who provide telephone access services shall be culturally and linguistically competent, and have access to racial/ethnic mental health professional staff for consultation;

11. Ensure that programs serving consumers and families of the four groups provide culturally inviting environments (e.g., decor, ambiance) as measured by consumer satisfaction surveys;
12. Provide to all consumers, families, and providers a culturally based and linguistically complete orientation and ongoing education about access to managed care; and
13. Ensure that ability to pay is not a barrier to accessing services in a managed health care environment.

Recommended Performance Indicators

1. Procedures for access in place with specific provisions for consumers from the four groups.
2. Time from point of first contact through service provision for all levels of care are tracked by age, gender, ethnicity (i.e., particular subgroup and mixed origins), primary language, and level of functioning.
3. Rate and timeliness of response to telephone calls by consumers from the four groups.

Recommended Outcomes

1. Tracking of authorization decisions including denials, rationale, and disposition by ethnicity.
   Benchmark: Comparability across ethnic groups served.
2. Tracking of access and utilization rates for populations of the four groups across all levels of care in comparison to the covered population.
   Benchmark: Proportional to covered population.
3. Consumer and family satisfaction with access and authorization services.
   Benchmark: 90% satisfaction.

Triage and Assessment

Standard

Assessment shall include a multi-dimensional focus including individual, family, and community strengths, functional, psychiatric, medical, and social status as well as family support.

Implementation Guidelines

The Health Plan shall:

1. Address cultural and demographic factors in the assessment process relating to age, gender, sexual orientation, and relational roles in the assessment of consumers from the four groups (both consumers and families);

2. Identify beliefs and practices; family organization and relational roles (traditional and non-traditional); effects of ethnically-related stressors such as poverty and discrimination; beliefs related to health/mental health; attribution of condition; spirituality; and history at help-seeking and treatment. History of immigration, assimilation, or acculturation also shall be part of the assessment;
3. Ensure that clinical and functional assessment scales utilized by managed mental health care systems, organizations, or providers are culturally competent, reliable, and validated for use with racial/ethnic consumers and their families;
4. Address systemic cultural and ethnic factors to ensure accurate assessment and service planning (e.g., linguistic differiences, differences in symptom expression, culture-bound syndromes);
5. Ensure that racial/ethnic Mental Health Specialists are involved, either directly or via consultation, especially at the time of care determination and prior to more restrictive placements, particularly with involuntary placement and treatment;
6. Consider, prior to initiating service, the consumer's preference for therapeutic linkages with the racial/ethnic community or family;
7. Encourage the use of family members as culturally informed individuals, including children when appropriate; and
8. Use linguistically and culturally appropriate admission/entrance forms and procedures.

Recommended Performance Indicators

1. Presence of specialized assessment procedures for consumers from the four groups.
2. Inclusion of cultural factors in the assessment of consumers from the four groups.
3. Inclusion of family members, as appropriate, and significant community stakeholders in the assessment process for consumers from the four groups. Documentation of efforts to include family and significant others, or rationale when not done.
4. Involvement of culturally competent racial/ethnic Mental Health Specialists in assessment and treatment planning process and at other critical treatment junctures.
5. The recognition of differentiating culture from a person's psychopathology.

Recommended Outcomes

1. Consumer, family, and stakeholder satisfaction with the assessment process.
   Benchmark: 90% satisfaction.
2. Consistency of service authorizations with utilization management practice for consumers from the four groups.
   Benchmark: Comparable across the four groups, and in general, increasing over time.
3. Reduction of frequency of treatment plan revisions resulting from inadequate diagnosis and assessment.
   Benchmark: Comparable across the four groups and decreasing over time.

4. Compliance with Guidelines for assessment.
   Benchmark: 90% compliance.

Care Planning

Standard

Care plans for consumers from the four groups shall be compatible with the cultural framework and community environment of consumers and family members. When appropriate, care plans shall involve culturally indicated family leaders and decision makers.

Implementation Guidelines

The care plan shall:

1. Ensure that care planning and other critical treatment decisions for consumers from the four groups are performed, or supervised directly, by racial/ethnic Mental Health Specialists;
2. Incorporate consumer-driven goals and objectives that are functionally defined and oriented toward measurable recovery and rehabilitation outcomes;
3. Address culturally-defined and socioeconomic needs relevant to the consumer's condition and stressors when appropriate;
4. Incorporate family and cultural strengths, traditional healers, religious and spiritual resources, natural support systems, community organizations, racial/ethnic self-help organizations, and interagency resources, except when clinically and/or culturally contraindicated;
5. Address and coordinate the mental health needs of the individual within the context of the entire family, including coordination among multiple providers with a single point of clinical accountability;
6. Include consumer and family education about problems and conditions being addressed. Plans shall also include treatment modalities, particularly those addressing cultural beliefs and attitudes about health and mental health, as well as education about preventive approaches;
7. Address coordination of mental and physical health, as well as other needed social and treatment services (e.g., housing, transportation, education, services for substance abuse and other addictive behavior), according to the health beliefs and practices of the consumer and family; and
8. Develop specialized approaches to maintain continuity of care, prevent symptom relapse, and reduce recidivism to more restrictive and expensive services, including flexible purchase of wrap-around services.

Recommended Performance Indicators

1. Consumer and family involvement and investment in the development of, and agreement with, the Care Plan.

2. Culturally defined needs addressed in the care plans of consumers from the four groups.
3. Leadership by racial/ethnic Mental Health Specialists in the care planning process for consumers from the four groups.
4. Inclusion of traditional healers in the Care Plan for consumers or family from the four groups, except when contraindicated.

Recommended Outcomes

1. Consumer and family satisfaction with Care Plan.
   Benchmark: 90% satisfaction via an independent evaluator.
2. Consumer and family involvement with Care Plan.
   Benchmark: 100% documented involvement.
3. Functional outcomes in domains of daily living (e.g., housing, restrictiveness of placement, access to primary health care, family role, vocational/educational/employment, community tenure, and community engagement).
   Benchmark: Comparable to overall community and significant improvement in at least one domain of function for over 75% of consumers.

Plan of Treatment

Standard

The Treatment Plan for consumers from the four groups shall be relevant to their culture and life experiences. It shall be developed by or under the guidance of a culturally competent provider in conjunction with the consumer and family, where appropriate.

Implementation Guidelines

The Treatment Plan shall:

1. Include consumer and family involvement, when appropriate, in its development and agreement;
2. Monitor group homes (utilized as least restrictive placements) for compliance with state and local standards, regulations, and laws, as well as protocols for services. Best practices shall be encouraged in the process. Where such protocols do not exist, they shall be developed to ensure that group homes do not become holding facilities;
3. If authorized by the consumer, include contact with and utilization of racial/ethnic community organizations;
4. Conduct psychotherapeutic modalities within the context of the value system of consumers from the four groups and their families (e.g., egalitarian, participatory, family-focused, spirituality), and address issues specific to their life experiences (e.g., racism, discrimination, violence, gender role conflicts, and life transitions);

5. Be based on knowledge and skills derived from culturally competent interventions and models of care. These shall include concepts of recovery and rehabilitation that also consider cultural norms, values (e.g., spirituality, community, family), and critical life experiences (e.g., racism and discrimination);
6. Ensure that care planning and other critical treatment decisions for consumers from the four groups shall be performed or supervised directly by a culturally competent mental health professional. Managed care plans shall include culturally competent independent mental health practitioners within their networks;
7. Incorporate consumer-driven goals and objectives that are functionally defined and oriented towards measurable recovery and rehabilitative outcomes;
8. Address culturally defined and socio-economic needs;
9. Reflect awareness of the mental health needs of the entire family, especially when children are the consumers. Coordination among multiple providers, with a single point of clinical accountability, shall occur and be documented;
10. Address coordination of mental health and physical health, substance abuse, as well as other needed clinical services such as housing, transportation, employment, and education;
11. Ensure that interventions provide for least restrictive placements, continuum of care, discharge, and cultural competence in treatment modalities and medication usage;
12. Provide that level of care decisions are based on established protocols that are culturally relative to the consumer. These protocols shall be reviewed periodically with the consumer, and involved family as appropriate, by providers. Placement considerations shall include consumer and family preferences. Placement within or supported by the family shall be the preferred arrangement unless otherwise clinically contraindicated;
13. Develop creative or innovative options and interventions for consumers from the four groups who, for whatever reason, have been labeled historically as non-compliant to treatment;
14. Include broad based culturally competent educational programs that explain the problems or conditions being treated, treatment methods, concepts of recovery, rehabilitation, prevention, and self-help approaches in communication styles understandable to the consumer;
15. Be developed by a culturally competent staff. In the absence of a culturally competent staff, external consultation with a culturally competent mental health professional shall be obtained;
16. Ensure that decisions to go forward with treatment are based on a mutually agreed upon written understanding or contract between the consumer and provider;
17. Ensure that, in cases where consumers have acute mental illnesses requiring psychopharmacological interventions, the provider discuss medications and their effects with the consumer and family as soon as the consumer is able. A statement signed by the consumer and counter-signed by the provider that this guideline has been followed shall be inserted in the case record;
18. Reflect specialized approaches to maintain continuity of care, prevent symptom relapse, and reduce re-hospitalization;

19. Provide for distribution of culturally specific literature, in the communication style, language, and appropriate to the literacy level of the consumer, on the prevalence of psychiatric disorders, treatment options, and psychopharmacological interventions; and
20. Ensure that informed consent is obtained prior to dispensing medication. The informed consent document shall be specific regarding the nature of the medication and its potential and demonstrated benefits and side effects. The physician prescribing the medication shall be responsible for ensuring that medication information is explained in a culturally specific and clear manner. The consumer shall acknowledge, by signature, that he/she understands the medication prescribed and its potential benefits and side effects. The signed forms shall be dated and included in the consumer's chart. The prescribing physician shall be knowledgeable regarding the physiologically-specific effects of psychotropic medication on consumers from the four groups.

Recommended Performance Indicators

1. The Treatment Plan reflects both consumer and family involvement in its development and agreement. The degree of family involvement depends on the wishes of the consumer.
2. The organization has a written policy and a demonstrated practice linking families to advocacy and education groups.
3. The organization has a written policy which expressly targets least restrictive environments for residential placement in or near the community.
4. There is evidence in the Treatment Plan that proposed psychotherapeutic modalities address specific cultural issues and are conducted with specific cultural values.
5. There is evidence in the Treatment Plan of the use of racial/ethnic community services and resources.
6. The Treatment Plan was developed with a culturally competent clinician (defined in chapter on Human Resource Development) or consultation from such a clinician.
7. The Treatment Plan is oriented towards measurable recovery and rehabilitation outcomes.

Recommended Outcomes

1. Documented level of involvement of racial/ethnic consumers, and family when appropriate, in the development of, and agreement, with the Treatment Plan. The level of involvement is at least comparable with non-racial/ethnic groups.
2. Evidence of a policy linking families to advocacy and education groups.
3. Documentation of the level of referrals of families to advocacy and education groups.
4. Evidence of a policy which expressly targets least restrictive environments for residential placement in or near the community. Evidence that the policy has been approved by culturally competent consultants.

5. Documentation that illustrates how critical life issues such as racism, discrimination, violence, gender role conflicts, and life transitions are addressed. Documentation that illustrates how values such as spirituality, community, and family are addressed.
6. Evidence that a culturally competent clinician was involved in the development of the Treatment Plan, e.g. signature.
7. Evidence that outcomes are re-evaluated by a culturally competent clinician when goals have been achieved.

Treatment Services

Standard

The Health Plan shall assure that the full array of generally available treatment modalities are tailored such that they are culturally acceptable and effective with populations of the four groups (e.g., psycho-education, psychosocial rehabilitation, family therapy, specialized group therapy, behavioral approaches, use of traditional healers, and outreach).

Implementation Guidelines

The Health Plan shall:

1. Ensure that consumers and families are informed about treatment choices available under the Health Plan, as well as about medications and other treatments not available in the Health Plan. The final decision to be treated rests with the consumer;
2. Provide that treatment is consumer-driven and performed or guided by culturally competent Mental Health Specialists;
3. Ensure that assignment of clinicians is based on a match between clinician skills, including cultural competency, and the consumer's clinical, cultural, and linguistic needs;
4. Provide for the optimal utilization of the racial/ethnic clinical workforce by affording these clinicians a variety of clinical experiences including service to consumers other than consumers from similar backgrounds;
5. Ensure that the workforce meets the needs of these consumers and their families while maintaining comparability in overall workload with other clinical providers. This shall take into consideration requests for interpretation and use of other specialized skills, so that they are not in addition to regular duties;
6. Contract with, and utilize, local racial/ethnic community-based organizations and independent practitioners in its network and include them in the provider's network or panel. Such providers shall demonstrate cultural competence;
7. Ensure that psychotherapeutic modalities address psychological issues specific to consumers, e.g., current and historical trauma, acculturation, inter-generational and gender role distinctions, and life transitions;

8. Ensure that psychological evaluations are conducted by qualified practitioners trained in ethnic-specific biological, physiological, cultural, socioeconomic, and psychological variables. Psychological evaluations also shall be provided based on the use of culturally and linguistically competent literature and other specialized approaches. Specific knowledge concerning the norms, biases, and limitations of each instrument used shall be demonstrated; and
9. Provide that the principle of least restrictive levels of care shall govern treatment and placement decisions, with family placement preferable unless otherwise indicated. Level of care decisions shall be governed by protocols to ensure timely and accurate decision-making and shall be designed and carried out by, or in consultation with, qualified culturally competent Mental Health Specialists.

Recommended Performance Indicators

1. Protocols for level of care decisions for consumers from the four underserved/ underrepresented groups.
2. Distinction and equivalence of services for consumers from the four underserved/ underrepresented groups.
3. Specialized protocols for prevention of symptom relapse and reduction of recidivism for consumers from the four groups.
4. Culturally and linguistically competent literature on prevalent psychiatric disorders, medical treatment options, and pharmacological interventions distributed to all consumers from the four groups and their families.
5. Consumers receive services by traditional healers, when appropriate and accepted.

Recommended Outcomes

1. Consumer and family satisfaction with treatment services.
   Benchmark: 90% satisfaction.
2. Inclusion of culturally specific activities and domains of daily living (e.g., housing, access to primary health care and maintenance, family role, behavioral/developmental, vocational/ educational/employment, and community tenure) in treatment services.
   Benchmark: Comparable to overall population served and significant improvement in at least one domain of function for more than 75% of consumers.
3. Rates of symptom relapse and recidivism into restrictive level of care or other restrictive placements.
   Benchmark: Comparable to overall population served and significant reductions over time.
4. Rates of medication side effects, adverse incidents, and utilization of latest pharmacological interventions.
   Benchmark: Comparable to overall population served and reduction of medication side effects and adverse incidents.
5. Rates of adverse occurrences during treatment (e.g., suicide, homicide, self-injury, accidents, physical and sexual abuse) within comparable age groups.
   Benchmark: Comparable to overall population served and decreasing over time.

6. Demonstrated incorporation of value of cultural identity, including ethnicity (subgroup membership and mixed origin) and other relevant factors in treatment services.

Discharge Planning

Standard

Discharge planning for consumers and families from the four underserved/underrepresented racial/ethnic groups shall include involvement of the consumer and family in the development and implementation of the plan and evaluation of outcomes. Discharge planning shall be done within a culturally competent framework and in a communication style congruent with the consumer's values. The plan shall allow for transfer to less restrictive levels of care in addition to termination of treatment based on accomplishment of mutually agreed upon goals in the treatment plan.

Implementation Guidelines

Discharge planning shall:

1. Involve the consumer, family, or legal guardian who have participated in supporting the consumer's treatment course;
2. Include case management and aggressive outreach to assure that contact is made with the consumer and family to minimize "administrative" termination which typically results from culturally inappropriate services;
3. Ensure that steps are taken to address linkages to the next level of care. Documentation shall also demonstrate that a reasonable effort to define the next steps in treatment is made. The provider of case management services shall communicate, discuss, and facilitate linkage to the next level of care;
4. Acknowledge and recognize the skills needed and the resources available to facilitate a successful recovery program;
5. Include the identification of personal, familial, community, and other support systems to help them improve and maintain healthy lifestyles;
6. Include an assessment of the biopsychosocial environment to ensure minimum disruption in their quality of life;
7. Include identification of a case manager or primary provider to act as the single point of responsibility for coordinating care; and
8. Include assurances that consumers who fail to return to treatment will receive active follow-up to assure their level of care needs are met.

Recommended Performance Indicators

1. Consumer and family involvement in development of treatment plan.
2. Documented provision of case management services designed to facilitate linkage to next level of care.

3. Involvement of consumers and their identified support systems in improving and maintaining the consumer's health.
4. Documented efforts to contact consumers who fail to return for treatment.

Recommended Outcomes

1. Consumer and family satisfaction with discharge plans.
   Benchmark: 90% satisfaction via an independent evaluator.
2. Consumer involvement with discharge plan.
   Benchmark: 100% documented involvement.
3. Consumer remains connected to health care system in accordance with treatment plan.
   Benchmark: 100% documented involvement.
4. No more than 10% of consumers from the four groups in the plan who receive restrictive level of care services experience recidivism.
   Benchmark: No more than 10% documented recidivism.

Case Management

Standard

Case management shall be central to the operation of the interdisciplinary treatment team and shall be based on the level of care needed by the primary consumer. Case managers for consumers from the four groups shall have special skills in advocacy, access of community-based services and systems, and interagency coordination. Case management shall also be consumer- and family-driven. Case managers shall be accountable for the cost and appropriateness of the services they coordinate. The Managed Care Plan shall maintain responsibility for the successful and appropriate implementation of the Case Management Plan and providing adequate administrative resources and endorsement.

Implementation Guidelines

The Case Management Plan shall:

1. Ensure that case managers demonstrate their level of cultural competence as part of their privileging and credentialing standards within the Plan;
2. Ensure that case managers are knowledgeable about the four groups and their subgroups, their resources, and natural supports;
3. Ensure that case managers have access to flexible funds for the provision of wrap-around services;
4. Provide that case management is continuous and proportional to the degree of the consumer's need, level of impairment, and person/family resilience. The case manager shall act as a single point of contact in the Plan and have support for coordinating service across all levels of the system of care;

5. Ensure, through enforcement, that caseloads for case managers are consistent with industry standards, accounting for severity of consumer impairment/case mix and associated cultural stressors. It shall be recognized that case or care management for patients who have limited English proficiency and/or have a broadly defined "client-defined family" and/or social network (e.g., clan leader) relevant to their care, may required additional time for planning and coordination;
6. Afford case managers practice privileges across the entire system of care, including settings such as inpatient facilities;
7. Provide that each member of the consumer's Treatment Plan has responsibility for developing progress notes and reports as appropriate; and
8. Ensure that the primary provider/case manager periodically reviews the consumer's progress in accordance with the Treatment Plan. Changes in the Treatment Plan's components shall be reviewed with the consumer before implementation.

Recommended Performance Indicators

1. Cultural competence requirements commensurate with level of responsibility, including culturally competent supervision of case managers who serve consumers from the four groups.
2. Cultural competence training for all case managers as part of a credentialing process.
3. Community resources and natural supports included in all care plans.
4. Use of flexible funding for consumers from the four groups, comparable to others.
5. Sufficient numbers of case managers to support caseload and workload standards for consumers from the four groups.
6. Consumer and case manager involvement in treatment decisions across all levels of care.

Recommended Outcomes

1. Consumer and family satisfaction with services selection and coordination.
   Benchmark: 90% satisfaction.
2. Reduction in utilization of and lengths of stay in more restrictive levels of care.
   Benchmark: Comparable to overall community and decreasing over time.
3. Access to culturally competent mental health care across all levels of care within the system.
   Benchmark: Comparable to overall community and increasing over time.

Communication Styles and Cross-cultural Linguistic and Communication Support

Standard

Cross-cultural communication support to participate in all services shall be provided at the option of consumers and families at no additional cost to them. Access to these *services shall be available at the point of entry into the system and throughout the course of services.*

Implementation Guidelines

The Health Plan shall:

1. Ensure that bilingual mental health staff and interpreters are certified or otherwise have formally demonstrated their linguistic competence. Use of family members as interpreters, especially children, shall be strictly prohibited;
2. Ensure that policy and procedures are present and implemented which demonstrate performance-based clinical, cultural, and linguistic competence of designated trained interpreters;
3. Discourage the use of tertiary telephone interpreters because of inconsistent availability of interpreters and lack of mental health training accuracy and reliability. Although not optimal, video telecommunication shall be considered acceptable for improving accuracy and reliability. In areas with limited linguistic support resources, qualified telephone interpreters with training in mental health shall be considered acceptable, but only in emergency situations;
4. Provide that interpreters and translators are trained in formal interpretation techniques and supervised by culturally competent racial/ethnic Mental Health Specialists;
5. Provide to all clinicians training in the use of interpreters for consumers from the four groups and their families. This training shall emphasize linguistics and culture;
6. Ensure that all pertinent written and oral and symbolic consumer and family materials (including consent forms, statement of rights forms, posters, signs, and audio tape recordings) are interpreted from the appropriate cultural perspective, as measured by consumer satisfaction surveys. Questions and concerns shall be actively solicited;
7. Ensure that restricted or residential settings have the capacity to communicate effectively with monolingual, non-English speakers and individuals with culturally different or unique communication styles;
8. Ensure that the mental health organization maintains an annual updated directory of paid trained interpreters who are available within 24 hours for routine situations and within one hour for urgent situations; and
9. Designate a single fixed point of administrative responsibility for cross-cultural communication support services.

Recommended Performance Indicators

1. To minimize the use of interpreters, sufficient numbers of professional staff competent in the communication styles of consumers from the four groups.
2. Yearly updated directory of trained interpreters available within 24 hours for routine situations and within one hour or less for urgent situations.

3. Time between point of first contact and communication support services, across all levels of care, and to all consumers and their families.
4. Existence of core curriculum and training program for interpreters and staff.

Recommended Outcomes

1. Linguistically competent services are provided to racial/ethnic consumers. *Benchmark: 100% of limited English-proficient individuals served.*
2. Satisfaction rates related to communication styles and linguistically competent services by racial/ethnic consumers.
   Benchmark: 90% satisfaction.
3. Elimination of misdiagnosis and inadequate treatment plans resulting from failure to communicate effectively with consumers from the four groups.
   Benchmark: Comparable to standards of care for general population and improving over time.
4. All levels of care meet the standards for the provision of linguistically competent services.
   Benchmark: Comparable across groups and increasing over time.

Self Help

Standard

Culturally competent self help groups shall be created to provide services to consumers from the four groups and their families. The self help groups shall function as part of a continuum of care. Self help groups for consumers from the four groups shall incorporate consumer-driven goals and objectives that are functionally defined and oriented towards rehabilitative and recovery outcomes. Equal consideration and support shall be given to family and primary consumer self help groups.

Implementation Guidelines

The Health Plan shall:

1. Include resources to enable consumers from the four groups and their families to conduct self help groups;
2. Ensure that consumers from the four groups and their families shall design, implement, and evaluate self help programs. Culturally competent mental health professionals shall serve in a consultative or educational role at the request of the consumer group;
3. Provide that existing self help entities (programs, agencies, and organizations) that provide services to consumers from the four groups and their families are identified, acknowledged, and supported to ensure that they meet these standards;
4. Ensure that self help planning for consumers from the four groups and their families includes consumer and family education about problems and conditions being treated, and preventive and treatment approaches; and

5. Provide that consumer self help groups are given opportunities to help ensure that benefit packages, changes in benefits, alterations in services, location of service programs, and changes in providers are congruent with consumer needs.

Recommended Performance Indicators

1. Resources are expended on self-help groups.
2. In-kind support is expended on self-help groups including such items as meeting rooms, advertising, and/or conducting mailings.
3. Consumers and family participate in self-help or support groups.
4. The agency provides information about disorders and treatment approaches to consumers and family in a culturally competent manner.
5. The Managed Care Mental Health Plan supports the involvement of consumer and family self-help groups in planning for services.

Recommended Outcomes

1. The total amount of expenditures on consumer-run mental health services in one year, divided by expenditures on mental health services.
2. The estimates expenditures on consumer-run mental health services in one year, divided by expenditures on mental health services.
3. Documentation of the level and proportion of racial/ethnic consumers and family who participate in self-help groups or support groups. This should be comparable with the participation of non-racial/ethnic groups.

IV. Provider Competencies

Knowledge, Understanding, Skills, and Attitudes

Standard

Essential components of core continuing education to ensure cultural competence among clinical staff and to promote effective response to the mental health needs of individuals from the four groups include the following areas of knowledge and/or skills: understanding of consumer populations' backgrounds, clinical issues, how to provide appropriate treatment, agency/provider role, communicating effectively across cultures, providing quality assessments, formulating and implementing quality treatment plans, providing quality treatment, using one's self and knowledge in the treatment process, and attitudes.

Consumer Populations' Backgrounds

Continuing education shall include:

1. Factors which define cultural differences between and among different racial/ethnic populations, including differences related to history, traditions, values, belief systems, acculturation and migration patterns, reasons for immigration/migration, and dialect and language fluency;
2. Particular psychosocial stressors and traumas relevant for consumers from the four groups. These include war, trauma, violence, migration, unique aspects of cultural survival and maintenance, socioeconomic status, political unrest, racism, discrimination, and culturally-based belief systems;
3. The effects of the acculturation process on individuals from the four groups; and
4. How class, ethnicity, social status, and racism influence behavior, attitudes, values, belief systems, and mental health of consumers from the four groups.

Clinical Issues

Continuing education shall include:

1. Differences in symptom expression, symptom language, and symptomatic patterns of individuals from the four groups with mental illness/emotional disturbance;
2. Culture-bound syndromes associated with the four groups and their subcultures;
3. Differences in thresholds of psychiatric distress in consumers from the four groups and tolerance of symptomotology by their natural support systems;
4. Nuances of verbal and nonverbal language, speech patterns, and communication styles in the four groups and their subgroups;
5. Dynamics of language use and conceptual frameworks among monolingual and bilingual consumers from the four groups;
6. Differences in the attribution of mental illness (religious, supernatural, etc.) and issues of stigma specific to specific racial/ethnic groups and subgroups;
7. Differences between "culturally acceptable" behaviors and psychopathology within the four groups and their subgroups;
8. Help-seeking behaviors of individuals from the four groups;
9. Role and manifestation of spiritual, tradition, values, and practice beliefs and their integration into treatment;
10. Consumers from the four groups within a family life cycle and intergenerational conceptual framework in addition to individual identity development framework;
11. The varying effects of commonly used medications on individuals from the four groups;
12. Assessment tools and their limitations, particularly their uses and limitations for the four groups; and
13. The impact of psychosocial stressors versus intrapsychic stressors in consumers from the four groups.

How to Provide Appropriate Treatment

Continuing education shall include:

1. Differences in the acceptability and effectiveness of various treatment modalities for individuals from the four groups;
2. Use of culturally informed and qualified interpreters for monolingual consumers when qualified bilingual clinicians are not available;.
3. Use of culturally informed individuals, including family members when appropriate, by clinicians serving consumers from the four groups;
4. Social, political, and economic conditions in the community when developing, implementing, and evaluating programs for consumers and families from the four groups;
5. Use of natural community supports and other community resources for consumers from the four groups; and
6. Indigenous healing practices and the role of belief systems (religion and spirituality) in the treatment of consumers from the four underserved/ underrepresented groups.

Agency/ProviderRole

Continuing education shall include:

1. Personal and cultural biases of staff and how they may affect benefits and service design and delivery;
2. The role and types of power relationships within the community, agency, or institution and their effect on consumers from the four groups;
3. Ways that mainstream professional values may conflict with, or be responsible to, the needs of consumers from the four groups;
4. Effects of institutional racism and historical barriers on social service policies for individuals from the four groups, and knowledge of how to reduce barriers through use of and participation in systems change efforts; and
5. Resources (agencies, persons, informal helping networks, research) that shall be utilized on behalf of consumers from the four groups and their communities.

Communicating Effectively Across Cultures

Continuing education shall include:

1. Communicating and listening effectively across cultures, and across all levels of care; and
2. Engaging and establishing rapport with individuals from the four groups using socially and culturally appropriate conventions.

Providing Quality Assessments

Continuing education shall include:

1. Conducting culturally competent interviews which take into account the psychological, social, biological, physiological, cultural, political, spiritual, and environmental aspects of the consumer's experience;
2. Assessing consumers with an understanding of cultural differences in symptom expression, thresholds of psychiatric distress, and culture-bound syndromes; and
3. Appropriately referring for assessment and using assessment tools, recognizing the limitations of psychological tests and testing procedures when used with consumers from the four groups.

Formulating and Implementing Quality Care and Treatment Plans

Continuing education shall include:

1. Formulating culturally competent service plans (case management and treatment) that fit consumer and family's concept of mental illness;
2. Creating and implementing multidimensional service plans (case management and treatment) that include culture, family, and community;
3. Utilizing culturally appropriate community resources (e.g., family, clans, societies, church, community members, and other groups); and
4. Providing psychotherapeutic and psychopharmacological interventions with an understanding of different biological and physiological responses to medications based on physical, cultural, and racial/ethnic differences.

Providing Quality Treatment

Continuing education shall include:

1. Providing psycho-educational interventions which promote consumer and family voice and ownership in shaping the service delivery system;
2. Empowering and advocating for consumers, families, and communities;
3. Using consumer's preferred language and dialect to elicit the range and nuances of emotions, feelings, dynamics, etc.;
4. Referring to providers who use consumer's preferred language/dialect;
5. Knowing when and how to use trained interpreters; and
6. When indicated, appropriately addressing racial/ethnic issues in treatment.

Using One's Self and Knowledge in the Treatment Process

Continuing education shall include:

1. Recognizing one's own limitations, and knowing when to refer consumers to consultants from the four groups; and
2. Evaluating applications of new techniques, exemplary practices, research, and knowledge as to their validity and applicability in working with the four groups.

Attitudes

Continuing education shall include:

1. Demonstrating attitudes that indicate a respect for the consumer's immigration, migration, colonization, and acculturation experiences;
2. Demonstrating attitudes that indicate a respect for the diverse heritages, cultures, and experiences of consumers from the four groups;
3. Demonstrating attitudes that indicate a willingness to work with culturally, ethnically, and racially diverse populations; and
4. Demonstrating an understanding of and respect for how, as provider/therapist, one's self (especially the degree of one's cultural, ethnic, and racial match to the consumer) may influence the therapeutic relationship; and recognizing the need to process this dynamic, and in some cases refer the consumer for his/her treatment benefit.

Recommended Performance Indicators

1. Ongoing program planning and implementation of behavioral health services which meet the needs of consumers from the four groups and their communities.
2. Human Resource Development Plan inclusive of recruitment, retention and development of staff at all levels to enhance and ensure quality culturally competent services to consumers from the four groups and their communities.

Recommended Outcomes

1. Provider shall demonstrate ongoing assessment of behavioral health needs of consumers from the four groups and their communities.
   Benchmark: Documented annual assessment and service planning process.
2. Provider services and programs that reflect the needs of consumers from the four racial/ ethnic groups and their communities.
   Benchmark: Implementation of services and programs which are commensurate with the (changing) needs of the consumer and community using consumer and community assessment data..
3. Human Resource Development Plan to enhance culturally competent mental health services for the four racial/ethnic groups is established and implemented.
   Benchmark: Documented participation of all provider staff in annual training sessions.

APPENDIX A - Glossary

Access: Accessibility of mental health services in a manner that facilitates their use by people who need them; providing the opportunity for people to obtain mental health services from behavioral health providers; providing an active program of community information and outreach to motivate participation in mental health services.

Alternative/Traditional Healer (folk healer): An individual, respected by the community, who has cultural knowledge and training to relieve people of their physical and emotional afflictions within their cultural beliefs, and who sometimes uses physical approaches, spirituality, herbs, and other techniques as a form of healing; an individual recognized by a cultural group or tradition with the authority and power to perform rituals, ceremonies, or utilize medicinal substances for physical and spiritual healing.

Bi-cultural: The ability to understand and function effectively in two or more cultural environments. An individual who is bi-cultural is not necessarily culturally competent.

Bilingual: The ability to speak effectively in two or more languages. Individuals who are involved in serving limited English-proficient persons shall be certified to do so.

Comparability of Benefits: Benefits, which are relatively equal to each other, afforded to various cultural/ethnic or socioeconomic groups; relatively the same services provided across all populations served, including any adaptations necessary to reach equal access and utilization.

Competence: The application of knowledge and the interpersonal, decision-making, and psychomotor skills expected for the practice role (National Council of State Boards of Nursing, Inc. 1996).

Competent: Properly or well qualified and capable.

Critical Service Junctures: Critical service junctures include crisis, evaluation/assessment, treatment planning, treatment plan review/renewal, crisis planning, placement in residential or restrictive settings (including inpatient) and discharge determinations.

Cultural Competency: An acceptance and respect for difference, a continuing self-assessment regarding culture, a regard for and attention to the dynamics of difference, engagement in ongoing development of cultural knowledge, and resources and flexibility within service models to work towards better meeting the needs of minority populations.

Cultural Consultation: Consultation from an individual knowledgeable about a particular culture. Having to do specifically with culture but not necessarily with mental health clinical issues.

Culture: The integrated pattern of human behavior that includes thought, communication, actions, customs, beliefs, values and institutions of a racial, ethnic, religious, or social group. Culture defines the preferred ways for meeting needs.

Folk Healer: See Alternative/Traditional Healer.

Grievance: A problem or complaint presented formally, orally and/or in writing in a prepaid Health Plan for information, action, or resolution.

Health Plan/Plan: Managed Care Plan or network; equally applies to public agencies delivering managed services; a care system, public or private, based on capitated rates in which costs shall be managed through effective care.

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

Management Information System: A system (almost universally automated or computer based) which collects the necessary information in proper form and at appropriate intervals for managing a program or other activities. The system shall afford indicators which measure program progress toward objectives, identify discrete costs, and facilitate identifying problems that need attention.

Mental Health Cultural Specialist: A mental health professional who is certified culturally competent and has demonstrated skill and in-depth knowledge of a specific racial/ethnic group, including skills and knowledge of mental health needs, to serve as a resource person for this particular culturally distinct population.

Provider: An organization or individual, such as a hospital or physician, that provides and is reimbursed for behavioral health care service.

Quality Assurance: Systematic efforts to review and improve the caliber of services provided; activities and programs intended to assure the improvement of care in a defined medical setting or program. Such efforts shall include educational or other approaches intended to remedy identified deficiencies in services and methods, as well as the components necessary to identify such deficiencies (such as peer or utilization review components); the intended objective shall be to assess the program's own effectiveness.

Sponsored: Describing a person covered by a particular health plan.

Standards: The generally accepted principles for the best/most appropriate way to provide clinical care for patients with mental illness; the criteria or set of rules that describe the expected levels of clinical and system behavior as well as courses of action based on research and experience.

Traditional: Time-honored practices, which vary among groups.

Translator: An individual trained to render written or spoken information from one language to another.

Unsponsored: Describing a person not covered by a particular health plan.

Value Added: Greater clinical or cost-effectiveness in a service when it is provided in a specialized or modified manner. For example, a person with skills to perform in more than one capacity (e.g. professionally serves both English-speaking and Spanish-speaking consumers).