

FOCAL POINT

A National Bulletin on Family Support and Children's Mental Health



Assessing and Addressing Cultural Competence



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**Building on Family Strengths Conference
June 26–28, 2003**

See the Call for Presentations, page 37 of this issue!

The 10th Annual Building on Family Strengths Conference, showcasing culturally competent, family-centered research and innovative programs and practices, is scheduled for June 26–28, 2003 at the Hilton Hotel in Portland, Oregon. See the Call for Presentations on page 37 in this issue of *Focal Point*. Updated information will be available on our website throughout the winter and spring. The 2002 Conference Proceedings will be available in late spring 2003 on our website and in print.



At our website: www.rtc.pdx.edu

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We invite our audience to submit letters and comments: Janet S. Walker, Editor, janetw@pdx.edu



Research and Training Center
on Family Support and
Children's Mental Health (RTC)





ASSESSING AND ADDRESSING CULTURAL COMPETENCE IN SYSTEMS OF CARE

In 1988, and again in 1994, *Focal Point* examined cultural competence in children's mental health. In the intervening years, much has changed, yet much also remains the same. For example, in the lead article in the Fall, 1988 issue, Terry Cross outlined the "cultural competence continuum." Cross' definition of the continuum continues to be influential, as does his description of cultural competence as an ongoing developmental process during which organizations and individuals are continually challenged to do more. The articles in the current issue clearly build from this theoretical foundation, and demonstrate the extent to which these ideas have permeated discussions of systems of care for children and their families.

Articles in earlier *Focal Point* issues cited a variety of indicators pointing to a lack of cultural competence in child-serving systems. The current issue cites similar indicators; in fact, research from the last few years has provided us with much better data regarding populations served and the extent of disparities for racial and ethnic minorities as compared to Whites.

At the same time, the articles of the current issue demonstrate how we have been challenged to increase our sophistication in interpreting this data, and in using it as a means to help us target our efforts for change.

Another recurring theme in the earlier issues was the need for the meaningful involvement of family and community members in efforts to increase cultural competence. This theme too is reiterated throughout the current issue. The current articles go beyond simply calling for involvement, however. The articles describe a variety of strategies communities have used to systematically engage the perspectives of family and community members. With these strategies in place, family and community members have the opportunity to play a central role in making and monitoring concrete action plans for increasing cultural competence.

Yet with all that is shared across these issues, there is nevertheless a very different feel to each of them. The articles in *Focal Point* in 1988 were primarily concerned with developing definitions and theory. The 1994 issue contained more discussion about

how to apply the theory in real life, but there was a sense that this was all still prospective: initiatives were being planned, efforts were preliminary, research was proposed. What makes the current issue different is the energy that flows from discussions of the wide variety of specific approaches and strategies for increasing cultural competence that have been implemented by our contributors. The authors fully acknowledge that experience has not simplified the process—if anything, additional knowledge and information reconfirm the magnitude of the need, as well as the complexity of assessing and addressing cultural competence in systems of care. But responses to these challenges have also grown in their sophistication. We now have a record of efforts that have produced improvements that are not only measurable but also palpable to the people who receive services from systems of care *and* the people who work in them.

Janet S. Walker, Ph.D., is Associate Director for the Research and Training Center and Editor of *Focal Point*.

REFLECTING ON CULTURAL COMPETENCE: A NEED FOR RENEWED URGENCY

In the document, *Towards a Culturally Competent System of Care*, Cross, Bazron, Dennis and Isaacs (1989) first presented a model of cultural competence that in the past thirteen years has gained widespread recognition, provoked changes in thinking about serving diverse communities, provided the framework for numerous training efforts, stimulated attempts to measure and assess this construct, and infused cultural competence into the lexicon of mental health and human services. At the time, this was a landmark monograph. Thirteen years after, where are we?

While the concept of cultural competence has permeated children's services and bold efforts have been made to improve the system of care for culturally diverse children and their families, significant barriers to access, quality, and positive outcomes of care still remain. The Surgeon General's recent supplemental report, *Mental Health: Culture, Race, and Ethnicity* (U.S. Department of Health and Human Services, 2001) detailed striking disparities in mental health services for racial and ethnic minorities compared to Whites. Minority populations had less access to and availability of mental health services, were less likely to receive needed mental health care, often received poorer quality care when in treatment, and were underrepresented in mental health research.

Many of the barriers that deter communities of color from accessing and engaging in treatment pertain to all populations: fragmentation of services, lack of availability, cost of services, and societal stigma about mental illness. However, additional barriers deter people of color from seeking services, including mistrust and fear of treatment, different cul-

tural conceptualizations of illness/health and help-seeking, differences in language and communication patterns, and racism and discrimination at the personal and institutional levels. As a result, racial and ethnic minorities experience collectively a greater disability burden from emotional and behavioral disorders than do Whites. This higher burden arises from receiving less care and poorer quality of care as opposed to the disorders being inherently more severe or prevalent in these populations (U.S. DHHS, 2001).

A key message in the Surgeon General's supplemental report was the pivotal role of culture in mental health, mental disorders, and mental health services. Culture is critical in determining what people bring to the clinical setting, how they express and report their concerns, how they seek help, what they develop in terms of coping styles and social supports, and the degree to which they attach stigma to mental health problems. This concept, however, is not just limited to the child and family; it is also relevant to the providers. Each group of providers and each system of service delivery embodies a "culture" with shared beliefs, norms, values and patterns of communication. Each of these provider groups may tend to perceive strengths, weaknesses, help-seeking behavior, symptoms, diagnosis, assessment and intervention in ways that diverge from each other and from that of the child and family.

There is a renewed sense of urgency for children of color in our current systems of care. This is fueled by several factors. First, there is a demographic imperative documented by census data clearly showing that racial and ethnic minority populations are growing as a proportion of the total US population. There is no doubt

that, as we progress into the 21st century, more youth of color will be involved in child-serving systems.

Second, numerous studies indicate that children of color are faring poorly in our current systems of care. While the prevalence of mental health issues appears to be similar to that of the mainstream population, the unmet need for culturally diverse groups is significant. For youth of color, who often do not access a specialty mental health system, other systems such as juvenile justice, child welfare, and special education become the de facto mental health service. In these systems, they often tend to be unserved, under-served or inappropriately served (Hernandez, Isaacs, Nesman & Burns, 1998). In juvenile justice or child welfare systems, treatment may be based more on social control and removal from the family than on support for positive growth and development (U.S. DHHS, 2001). The need for mental health services among youth involved in juvenile justice is increasingly well documented. Yet studies indicate that youth of color fare even worse than their White counterparts. For example, studies suggest a dual pathway for White and minority youth who commit delinquent offenses with the former more likely to be diverted from the juvenile justice system into the mental health system for "treatment" while minority youth are more likely to be processed in the juvenile justice system for "punishment" (Dembo, 1988; Hutchinson, 1990). [Ed. Also see the article by Breda on page 10 in this issue for a examination of this topic.]

An examination of the child welfare system reveals several significant findings with implications for children of color. First, these children and their families are disproportionately represented in child

welfare, and experience poorer outcomes and receive fewer services than their White counterparts (Courtney, et al., 1996); second, mental health disorders are prevalent and an estimated 30% to 80% of children in foster care have severe emotional problems (Blatt, Saletsky, Meguid, Church, & Critzet, 1997). Children of color have the least chance for mental health service recommendations, are least likely to have plans for family contact and are most likely to be in out-of-home placements.

In terms of mental health services, numerous studies find disparities between the types of services received by minority children and those received by their White counterparts. African American children receive less treatment in schools and in psychiatric inpatient care and receive more services from publicly funded residential treatment centers. American Indian children rarely receive services in specialty mental health and more likely through juvenile justice, schools and residential settings. Latino youth are underrepresented in outpatient mental health facilities and limited service utilization data exist for Asian American youth.

The third factor underscoring the urgency for culturally competent care is highlighted in isolated yet recurring stories of tragic outcomes for children of color. In August 2002, the *Fresno Bee* reported a string of youth suicides in the Fresno, California Hmong (Asian refugees from Laos) community. Emerging from their intergenerational and intercultural confusion and distress, parent leaders in the Hmong community appealed to public systems to help prevent further suicides. Different plans were proposed and discarded due to various bureaucratic obstacles and lack of appropriate providers. While the local district was as-



sembling its plan, four more children killed themselves.

In spite of a rather dismal national picture, there are pockets of innovation and culturally responsive services that are contributing to positive outcomes for these youth. However, we need a broader cross-system action agenda that consistently produces good outcomes. This effort must translate the principles and practices put forth in the 1989 cultural competence model to build a policy agenda, programs, and a workforce to reduce racial and ethnic disparities.

A national policy agenda would address several critical areas.

(1) Building a primary mental health care system to integrate mental health services into education and primary health care represents a fundamental shift in service delivery, drawing upon a public health approach to reach the children where they live and function. Frontline providers for children are the schools and primary health care providers; these systems are more readily accessible to children of color, who rarely utilize the specialty mental health system. Furthermore, this approach would converge well with patterns of help-seeking in diverse communities, reduce barriers to mental health care, and further the building of appropriate systems of care. For ethnic minor-

ity clients who receive referrals from primary care to mental health, there is usually poor follow-through on these referrals. Thus, policies that integrate culturally-appropriate mental health services into schools and primary health and policies that build partnerships between these providers to provide early identification, prevention and intervention may be more effective in reaching children of color.

(2) Restructuring financing of mental health

services is necessary to promote equity in mental health care for children of color. Families of color are grossly uninsured, with rates ranging from 21% for Asian Americans and Pacific Islanders to 37% for Latinos. Black children are 20% more likely and Latino children twice as likely to be uninsured than White children (U.S. DHHS, 2001; Kaiser Foundation, 2000). Current state prioritization for mental health funding is ranked as a high priority in only seven states and state appropriations for mental health have increased at a much lower rate than total state spending and spending for corrections (Lutterman, Hirad and Poindexter, 1999). While Medicaid is an invaluable funding source for public mental health services, it is founded on a medical model of treatment that is not designed for community-based services and supports or the complex array of non-medical services needed by children of color with mental health needs.

(3) Assessing quality and increasing accountability of services for minority youth and their families is consistent with the widespread emphasis on results, outcome data, performance requirements, and standards of care that have become an integral part of the operations of human service agencies on both the state and federal levels. In 2000, the federal Center for

Mental Health Services published Cultural Competence Standards in Managed Mental Health Care Services: Four Underserved/Underrepresented Racial/Ethnic Groups (CMHS, 2000). Standards such as these should provide the benchmarks for providers serving children of color. Minority populations are vulnerable to discriminatory practices and systemic racism. Policies and procedures must be developed to systematically document the service access, treatment plans, and outcomes for these children.

(4) Including racially and ethnically diverse populations in mental health research is imperative to gaining a

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better understanding of the epidemiology of mental health problems, building the evidence base for these groups, and understanding the impact of mental health services. Without basic epidemiological data, we lack understanding of the breadth of problems and the data necessary to advocate on behalf of these populations. Without their inclusion in studies of evidence-based practices, we don't really know what works for these groups and therefore what constitutes "quality" services. Youth of color are rarely included in efficacy or effectiveness studies. Community-based and ethnic-specific agencies have been providing services to diverse populations for several decades but have not developed an evidence base to support their practice. Because payers and purchasers of services will increasingly be guided by the "evidence-base," these agencies need to be involved in a services research endeavor. Additionally, proven evidence-based practices need to be disseminated to those community programs that have an established infrastructure for delivery of care that is accessible, acceptable, and affordable to communities of color.

(5) Developing strategic plans for cultural competence at the state and local level may provide policies and incentives that potentially change the delivery of mental health interventions and supports at multiple levels. Several states have statewide operational cultural competence plans. For example, Pennsylvania's plan, adopted by the Department of Public Welfare's Office of Mental Health and Substance Abuse Services, aims to improve cultural and clinical competence at administrative and provider levels throughout the state's behavioral health system. The plan calls for regular training in cultural competence; articulating policy and program objectives, and providing monthly reporting on these objectives; and for incorporating cultural competence standards into policies, training, programs, and initiatives of each state mental health facility. Other states' plans

also address human resource issues, a critical piece in developing culturally competent systems of care.

Dr. David Satcher, the recent U.S. Surgeon General, states, "To the extent that we meet the health needs of the most vulnerable among us, we actually do the most to promote and protect the health of the nation. Whether we're talking about children or ethnic minorities, the extent to which we respond to the needs of our most vulnerable citizens and the degree to which we make changes to alleviate the unique needs of our least protected says a great deal about how well we are promoting and protecting the health of the nation" (Carter Center, 2000, p. 13).

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NATURAL HELPERS FROM THE NEIGHBORHOOD

“**M**aria has a heart big enough to help many families in need. As she walks around her neighborhood, she often sees families who look as if they may need help. She sees children running down a sidewalk when they should be in school. She sees a mother with young children standing on a street corner looking distressed. In these situations, Maria reaches out, offering her help as well as the Center's. She helped to changed the life of that mother on the corner. The mother told Maria that she had no way of providing for her family and was even considering taking the lives of her children, and then her own. Maria quickly stepped in. Through her own connections, she found a job for the mother, offered her ongoing emotional support, and encouraged her to become involved with the different programs offered at Abriendo Puertas Family Center. The professionals at the Family Resource Center assisted by finding her a home, helping to enroll the children at school, addressing her immigration status, and linking her to counseling.” (Miller, 1998, p. 3)

As we develop comprehensive neighborhood systems of care, it is

important for us to recognize that professionals and the formal service delivery systems in which they work have not always been able to resolve problems facing families. When we overly rely on professional helpers, formal agencies, and system solutions, we may fail to create strategies fully relevant to specific communities or we may fail to produce experiences that result in increased self-efficacy and empowerment among families seeking help. In addition, a lack of partnership between formal services and informal support systems may constrain the opportunities for families to receive support on a 24-hour, seven-days-a-week basis. Families may be left to seek out support from relatives and neighbors who may not have the skills and resources necessary to respond to a crisis. Professionals may experience frustration at setbacks that families experience after office hours, when professionals are unable to respond. Often, there is a significant disconnect between formal and informal systems, between formal service providers and natural helpers. Efforts to create neighborhood-based systems of care will fail unless the assets of formal and informal systems are

brought together to work in partnership, with full value placed on what each has to contribute to the well-being of children and families.

Child and family service systems are moving from institution-based to community-based services and supports, from individual- to family-centered approaches, from a deficit-driven to a strengths-based model, from a strictly clinical approach to a combined social support model, and from a mono-cultural approach to cultural competence. To support this movement, training and ongoing support are needed. The implementation of comprehensive, neighborhood-based systems of care requires developing and supporting partnerships between formal service systems and informal supports in the community. At its heart, this process involves establishing and nurturing partnerships between service providers and natural helpers (Lazear, Pires, Pizarro, Orrego, Lara, & Lavernia, 2001).

This article describes EQUIPO, a front-line practice strategy to form professional/natural helper partnerships. EQUIPO was originally developed to serve families and providers in Miami, Florida's East Little Havana

neighborhood. EQUIPO (which means “team” in Spanish) was developed through the Annie E. Casey Foundation’s Mental Health Initiative for Urban Children with the Abriendo Puertas Family Center as the hub for system-building efforts. EQUIPO del barrio, as it is called at Abriendo Puertas, was originally designed to be responsive to the strengths and issues raised by Latino families. Currently, the EQUIPO approach is being implemented in other diverse Annie E. Casey and Center for Mental Health Services (CMHS) grant communities, including Hillsborough County, Florida, where the two communities of focus are primarily African American and Latino; and Seattle, Washington, in a primarily Latino neighborhood.

EQUIPO operationalizes the principle of engaging, linking and supporting formal services and informal supports to work in partnership in a community-based system of care. The EQUIPO approach begins with the acknowledgment that families and neighbors historically have provided critical supports to one another in a myriad of informal ways. When family members first recognize that they cannot solve a health or mental health problem by themselves, they typically turn first to family, friends, neighbors, or co-workers. The instinct to seek help from people close to us or provide help to those in our own family or community has been evident in areas such as birthing children, rearing and protecting children, providing shelter and meals, celebrating achievements and holidays, and sharing grieving over the loss of loved ones. Informal supports also play a critical role in supporting personal development and in coping with a significant change in family life, such as separation or divorce. This capacity for mutual support and the practice of providing informal supports by natural helpers in neighborhoods are essential to child and family well being.

First and foremost, EQUIPO is a front-line practice change strategy with the objective to form professional/natural helper partnerships. It



is also concerned about mobilizing existing community resources and developing new ones. EQUIPO is a strategy to increase the capacity to reach families that have been underrepresented in our formal systems of support and involve them in meaningful ways. It is a family centered, culturally competent, individualized process which supports the planning and coordinating of services and all helping efforts. Through the EQUIPO process, participants are acknowledged as leaders in their community, learning together with professional service providers ways of sustaining a neighborhood system of care.

To support the implementation of EQUIPO in Miami, a training program was developed using a “training of trainers” approach. The EQUIPO training process encourages both the natural helpers and professional service providers to learn to recognize, respect, and utilize the strengths that each can bring to the community. The training uses a variety of interactive and participatory team building methods, including use of real family stories, opportunities to practice skills and tools, and same-day evaluation to adjust curriculum content and presentation. Through these methods, the training assists the process of building trust and developing the partnerships between natural helpers and professionals. The EQUIPO training process in East Little Havana was implemented in five phases: (1)

planning and engagement of participants, (2) preparing natural helpers and providers, (3) training and implementing, (4) debriefing, and (5) training of trainers (Lazear, et al. 2001).

The first group of natural helpers in East Little Havana included eight community residents. Some members of this first group had utilized the services of the Abriendo Puertas Family Center, while others were concerned residents who wanted to become more involved with their community and the Abriendo Puertas Family Center. In order for the natural helpers to participate in the EQUIPO training, they first had to complete leadership and advocacy training in Abriendo Puertas’ *Madrina* and *Padrino* program. In addition to being natural helpers, some of the *Madrinas* and *Padrinos* also held volunteer positions at the Center. The formal service providers in the first EQUIPO training at Abriendo Puertas included the family center’s case manager, clinical director, registration coordinator, and family coordinator. Other formal service providers included the family service coordinator and therapist from Miami Behavioral Health Center.

In Miami’s East Little Havana, the EQUIPO training process helped both natural helpers and providers recognize, respect, and utilize each other’s strengths to support families in the community. According to the program’s evaluator, improvements among families served by the new,

integrated approach were noted in just six months after the training. With the common bond of living in the same area as the families receiving services, the natural helpers in East Little Havana's EQUIPO related easily to the families. The training helped them become informal caseworkers and make the initial assessment of concerns and needs. They could then encourage families to seek supports and services offered at the center (Miller, 1998).

Two promising approaches to evaluating EQUIPO's natural helper model have been undertaken at two different sites. The first was a process aimed at engaging members of the community to assist in the design and implementation of an interactive participatory evaluation process so that they become active participants as designers, data collectors, analyzers, and, ultimately, users of the data produced by the evaluation. This approach was conducted by members of Neighborhoods United of Plant City, Inc., Florida, a grassroots organization representing a neighborhood with primarily African American families, in partnership with the University of South Florida. The program evaluated through a participatory evaluation process was the CHANGE-Maker natural helper initiative, where all members of the evaluation team were CHANGE-Makers themselves. The distinctions and connections between the participant evaluators, the evaluation, and the evaluated initiative were firmly established and honored in this evaluation approach (Contreras, 2002).

The other EQUIPO natural helper evaluation collected data through interviews with families who had received services and support from the EQUIPO project in Miami, interviews with the natural helpers in Miami called Madrinas and Padrinos, file reviews, and a network analysis conducted under the auspices of the Casey Urban Mental Health Initiative and the OMG Center for Collaborative Learning. A network analysis examined the relations among 204 indi-

viduals who participated in one form or another in EQUIPO, including recipients of services and supports, Madrinas and Padrinos, formal service providers and informal supporters of EQUIPO participants. The network analysis revealed that almost every person from whom data were collected showed more linkages in their network of support after the EQUIPO had been in place than before the EQUIPO was in place. The report also highlighted the importance of the process of becoming a natural helper after being a recipient of services: "An important aspect of the role of natural helpers illustrated by the network analysis is the reciprocity of help. A majority of the Madrinas who were working with families in this study were, at one point receiving services from Abriendo Puertas; one of them was an EQUIPO participant during the first round of the evaluation. She went from not having anyone to list in her pre-EQUIPO network, to a dense post-EQUIPO network, to becoming the Madrina to a participant in the third round of the study one year later." (Gutierrez & Wolfe, 2001, p. 23)

The EQUIPO approach and the training program that supports it provide a model for community-based services that are strengths based, culturally competent, and family centered. Yet, as a frontline practice change strategy tied to larger systems reform, the EQUIPO approach takes time and constant nurturing. Many natural helpers in our communities, whether or not they are formally recognized as Madrinas and Padrinos, or CHANGE-Makers, or other informal service providers, often work in isolation, although they have a wealth of supports to offer families. For their part, the professionals providing the formal services often do not know how to partner with and use the natural helpers to support and enhance their work with families. While EQUIPO offers a frontline practice strategy to strengthen neighborhood systems of family sup-

port and is at its essence a culturally competent service delivery model, there remain many lessons to be learned about developing, nurturing, and sustaining natural helper and professional partnerships.

"Limitations on these sources of help derive less from their lack of willingness to help than from our lack of imagination in arranging it." Nicholas Hobbs

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SERVICE ACCESS THROUGH JUVENILE COURTS



Culturally competent systems of care must assure that all youth have access to services that appreciate their culture and respond effectively to their unique needs. Juvenile courts have long been challenged to respond to the needs of ethnically diverse populations of youth. Among the various responses courts can offer on behalf of young offenders is treatment referral, either to community-based mental health (MH) or alcohol and drug-related (A&D) services. This article describes a recent study that examined the role youths' ethnicity plays in courts' decisions to provide offenders access to MH or A&D services. The study also provides an example of how a series of complex issues—legal, moral, political, and methodological—come into play in interpreting data, and in deciding how to use the data to inform efforts to increase cultural competence.

A Current Study

The Juvenile Court Study (JCS), conducted through Vanderbilt University's Center for Mental Health Policy sheds light on the role of the court in facilitating mental health and substance abuse services to juvenile offenders and, in particular, whether such service-related decisions are influenced by youth's ethnicity. State-wide data from Tennessee were obtained on all youth referred to any of 98 courts for either delinquency or status offenses during 1997. Based on the nearly 40,000 Black and White youth between five and eighteen years of age, data suggest that courts refer, on average, 3% of young offenders

to formal MH services, and about 4% to formal A&D services. Service-related referrals vary widely between courts and are low relative to even the more conservative estimates of service need for this population of youth (Otto, Greenstein, Johnson, & Friedman, 1992).

At first glance, the data suggest different rates of service referral for Black and White offenders, particularly for A&D service referrals. About 2.2% of Blacks and 2.7% of Whites are referred to formal MH services (e.g., counseling); 2.2% of Blacks and 4.7% of Whites are referred to formal A&D services. However, Black and White offenders differ on various measures that can influence court decisions, including the nature of the current offense and the youth's prior offense history—two legal criteria that research finds predict court outcomes most consistently (Marshall & Thomas, 1983). Thus, a key question is whether any ethnic differences observed in service access might be attributable to ethnic differences on other factors salient for decision making.

Mental Health (MH) Service Referrals

Study findings suggest that youth's ethnicity has little direct effect on the court's use of MH services independent of its relationship to other variables. Rather, as prior research on other types of court decisions has found, legal criteria predict MH referrals better than characteristics of youth's social profile. For example, the least (status) and most (crimes against person) serious offenders are more likely than other offenders to be referred to care. Relatively high rates of referral for status offenders may reflect the court's interest in intervening in early stages of delinquency before problems become more intractable. Elevated referrals for violent

youth may reflect the availability of specialized programs for violent youth (e.g., sex offender programs, conflict management) or the court's unwillingness to give up rehabilitative efforts for even the most serious of offenders.

While ethnicity has no independent effect on MH referrals, other aspects of youth's social profiles help predict who is referred to MH care. Offenders between 10 and 15 years of age are more likely than either those younger or older to be referred to formal services. Youth living in single-parent households are referred at a higher rate than youth living with both biological parents, which may indirectly improve service access for Blacks more than for Whites given the disproportionate number of Blacks who live with single parents.

Nearly all of the effects of variables on MH referrals are of the same magnitude for Black and White youth with one exception: for violent offenders. As noted above, violent offenders are more likely to be referred to MH care than other types of offenders (except status offenders, who are as likely as violent offenders to be referred). This is the case for both Black and White youth. However, the magnitude of the effect tends to be greater for Whites than for Blacks, such that White violent offenders are more likely to receive MH services through the court than their Black counterparts.

A&D Service Referrals

When we examine the court's decisions to refer offenders to formal A&D services, the picture remains generally the same as for mental health referrals. Legal factors, rather than social profiles, most strongly predict the court's use of A&D services for juvenile offenders. Youth charged with an A&D offense (e.g., sale or possession) are significantly

more likely than other types of offenders to be referred to A&D services. As with MH referrals, youth with a prior offense record are also more likely than those without a prior record to be service-referred. As with MH referrals, age matters, with older offenders generally more likely than younger offenders to be referred to A&D treatment.

Youths' ethnicity generally has little effect on the court's use of A&D services independent of its relationship to other variables. However, there are exceptions. One has to do with the nature of the offense. While youth with A&D offenses, both Black and White, are more likely than other types of offenders to be referred to A&D services, this increased service access is greater for Whites than for Blacks. This has to do with a decision the court makes at intake—whether to handle a case informally or file a formal petition against the youth. Results suggest that White offenders are more likely to be referred to A&D services than their Black counterparts, especially when cases are handled informally. When cases are handled formally, the ethnic disparity, while present, is not nearly as great.

Summary and Discussion

It is clear that juvenile courts must play a bigger role in providing access to community-based services to youth and their families who may benefit from them. Too few youth, Black and White, have the opportunity to access care through the courts, despite the fact that courts may represent a rare chance for receiving care that can help young offenders live more productive and happier lives.

Most of the tests for ethnic bias in courts' decisions to refer youth to services conducted in this study failed to find it. In a few instances, results suggest that youth's ethnic identification does matter for service-related decisions by courts, however its effect is not simple or direct. Rather, ethnicity seems inextricably linked to other variables that, in some circumstances, create greater service access for

Whites, while in other circumstances, greater access for Blacks. For example, courts appear more likely to refer youth from single-headed households to MH services compared to youth from other living arrangements, which indirectly provides greater service access for Blacks. To the extent that courts perceive single-headed households as more "symptomatic" or in greater need of therapeutic supports, this variable could alternately be viewed as a discriminatory factor or as a legitimate influence on court outcome. Legal scholars disagree about whether considering the social situation of the offender is appropriate during decision making in juvenile courts.

Findings also show that ethnicity *moderates* the effect other variables have on service-related decisions, indicating potential bias. For example, among violent offenders the increased odds of MH referral are higher for

Whites than for Blacks. Some of this ethnic difference, found only among violent offenders, may be attributable to the nature of violent crime committed. These data suggest that violent White offenders disproportionately commit sex-related offenses for which specialty mental health services are frequently available. On the other hand, Blacks are still less likely than Whites to be referred to mental health care when the most common types of violent offenses, including aggravated assaults, are involved.

It would seem that other factors must account for the ethnic disparity in service access for violent offenders. Bias is always a possibility. Attention must be given to why court officials seem to be less inclined to consider therapeutic options for violent Black youth, and whether and why they perceive this group to be less amenable to treatment than their White counterparts. The adequacy of research

RTC Project Updates

Family Participation. Dissemination activities include two completed manuscripts, "Family Participation: A Brief Measure," explaining the development of the Family Participation Measure and "Preserving Family Bonds: Comparing Parent Perspectives With Practice Standards For Out-Of-Home Treatment." "Voices of African American Families: Perspectives on Residential Treatment" is in press in the journal, *Social Work*. Contact Adjoa Robinson at (503) 725-4160 or robinsa@rri.pdx.edu. or www.rtc.pdx.edu/pgProjParticipation.php.

Common Ground? Families and Employers presented the paper "Employee AND Parent: Calling all Family Friendly Employers" at the 9th annual Building on Family Strengths conference. Click on the research link at the RTC website to view our presentation. Project staff are currently designing a questionnaire for family friendly employers based on descriptions provided by workers who filled out nomination forms. We hope to use this information to help parents caring for children with emotional and behavioral disabilities. Contact Kitty Huffstutter at (503) 725-4371.

Models of Inclusion in Child Care. Interview data from administrators, families, and staff at nine participating child care centers are currently being analyzed. Some preliminary findings are available in the research section on the RTC web site at www.rtc.pdx.edu. A comprehensive report of the findings will be presented in the monograph now being prepared by the research team. In addition, planning is underway for phase two of the research to examine inclusion in child care at the state level. For further information please contact the project manager, Jennifer Bradley, at (503) 725-4170 or bradleyj@pdx.edu.

More RTC Project Updates on page 20

tools must also be considered. For example, the measure used in this study for *prior offense record*, a significant predictor of outcome and a covariate of ethnicity, is based on youth's encounters over a single year with the same court. A different measure of prior record that reflects a longer timeframe or a broader scope of jurisdiction might help explain some of the difference found in courts' responses to violent Black and White youth. Too, there may be other aggravating or mitigating circumstances the data for which were not available in this study that may help account for ethnic differences in courts' responses when it comes to violent youth.

The study also finds that White A&D offenders are more likely to be referred to A&D services than their Black counterparts. Some of this disparity may be attributable to the specific type of A&D offense with which youth are charged. These data suggest that Whites are more likely than Blacks to have alcohol-related offenses (e.g., DUI, public intoxication). Higher treatment referral rates for White A&D offenders might reflect a heightened availability or awareness of services directed toward alcohol use rather than use of other substances. Data also suggest that Whites are more likely to be charged with *possession* of controlled substances, while Blacks are more likely to be charged with *sale*. Some (Peterson & Hagan, 1984) suggest that drug laws demonize nonwhite offenders to the extent that they are, or are defined to be, *pushers* rather than *users*, *villains* rather than *victims*. Similar distinctions can be found in laws regarding crack cocaine (associated with Blacks) versus powder cocaine (associated with Whites). Findings here suggest that the distinctions in legal codes which courts are bound to uphold find expression in significantly reduced chances for therapeutic responses for Black A&D offenders. Efforts to improve service access for A&D offenders will require advocacy on the legislative front regard-

ing drug laws. Also, as others have advocated, demands can be made for a public health response for *all* A&D offenders, regardless of the specific nature of the A&D offense.

Finally, the courts' decision at intake to handle a case more informally rather than file a formal petition against the youth tends to provide greater access to A&D services for Whites than for Blacks. This finding highlights the importance of viewing court outcomes not as decisions made at a single endpoint in time, but as the culmination of a series of interrelated decisions (Bishop & Frazier, 1988), such that the impact of ethnicity can be nonsignificant at any single point but can have a significant cumulative effect across multiple decision points throughout the judicial process. The finding also underscores the significance of discretion for court outcomes, and the need for vigilance, particularly in those situations where due process protections associated with more formal proceedings may be absent. However, it is noteworthy that the informality that seems to diminish access to A&D services for Black youth does not also diminish their access to MH services.

The critical question of ethnic bias in court decision making is longstanding, and receives greater import in the current context of efforts to develop *culturally competent* systems of care. Systems of care expressly recognize the key role juvenile courts must play in effecting the delivery of mental health services to youth, and in promoting the rehabilitative ideal of the courts' heritage (Breda, 2001). Culturally competent systems of care explicitly recognize potential differences in service needs based on youth's ethnic identification (as well as other characteristics such as gender) and, at least implicitly, the legal legitimacy of service-related decisions based on ethnicity in order to best meet the needs of culturally diverse youth. On the other hand, within the legal framework of the court system, ethnicity-based decisions typically indicate discrimination

(U.S. Dept. of Justice, 1999). Working creatively between these two imperatives represents a special challenge for juvenile courts—a challenge that must be met creatively if courts are to participate meaningfully in culturally competent systems of care.

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MEASURING THE CULTURAL PULSE OF SERVICE PROVIDERS

The importance of serving children and their families within a context that is congruent with their cultural values and beliefs gained increased attention with the emergence of the System of Care philosophy. The stage for the development of Systems of Care was set by the 1969 Joint Commission on the Mental Health of Children and by the 1984 Congressional funding of the Child and Adolescent Service System Program (CASSP). This effort resulted in a clearer definition of the System of Care core values and guiding principles (Stroul & Friedman 1994).

One of the core System of Care values calls for the implementation of services that are culturally competent. Originally, the need for cultural competence responded to an acknowledgment that children and families of color were underserved by the social service system (“Embracing the Dynamics of Difference,” 1997). Therefore, great emphasis was placed on ensuring that race, ethnicity, and religious preference would not impede access to services, but rather would be valued and considered in developing service delivery strategies that would best fit the cultural characteristics of children and families. Much has changed since then. While the notion of cultural competence still

tends to emphasize the cultural values and beliefs of people of color, greater consideration is being placed on other overarching cultural and social factors that impact all populations, such as socio-economic status, lifestyle, sexual orientation, geographic characteristics (for example, rural vs. urban), as well as multiple environmental factors. In addition, continued exploration among families regarding the cultural competence of their providers, using the System of Care Practice Review (SOCPR), has shown that families associate this value with service delivery based on care and true commitment.

The SOCPR

The emergence of the System of Care required a comprehensive change in the way services were traditionally delivered, both from the system and practice perspectives. It also required devising ways to measure the impact of the System of Care at the practice level. For this purpose, the Department of Child and Family Studies at the Louis de la Parte Florida Mental Health Institute developed the SOCPR using a case study methodology. The intention in developing this methodology was to find a way to capture the experiences of children and families in their interactions with the System of Care. The SOCPR was

developed using the System of Care core values and principles as its conceptual framework. These values were defined and operationalized into protocol questions in the SOCPR, which consists of a document review section, interviews for a child’s primary caregiver, a child, a service provider, and a family’s informal/natural helper; and a set of summative questions. Summative questions reflect the System of Care values and are rated on a scale from 1 (*disagree very much*) to 7 (*agree very much*). Interviewers rate these questions once all the interviews related to a family are completed. Table 1 summarizes the definition of cultural competence and its subdomains as it is used in the SOCPR.

The SOCPR was a component of the special studies of the National Evaluation of the Comprehensive Community Mental Health Services for Children and Families Program, led by ORC Macro to assist in developing service delivery systems using a System of Care approach. After some refinement, the SOCPR was also used in the Longitudinal Comparison Study (LCS) that followed and that is also part of the above-mentioned evaluation.

In the LCS, three System of Care sites and three non-system sites were selected for comparison purposes:

Youngstown and Canton in Ohio, East and West Baltimore in Maryland, and Austin, Texas and Santa Cruz, California. The System of Care sites (Canton, Santa Cruz and East Baltimore) were selected based on their high scores on an independent measure of systems development. The comparison sites were selected based upon similar geographic, demographic, and economic characteristics (for further details regarding the sample characteristics and research method, see Hernandez, et al., 2001). At each site, approximately 15-20 families were randomly selected for interviews. The LCS study tested the hypothesis that the adoption of System of Care principles at the organizational level compared to a traditional service organization, resulted in greater implementation of a System of Care at the level of service delivery.

Findings on Cultural Competence

Focusing more specifically on the System of Care value of cultural competence, qualitative and quantitative analyses of the data collected from the LCS indicated that services within the

System of Care sites were more culturally competent than in the matched comparison sites. In general, the cultural context of families was emphasized and considered throughout all services delivered by the System of Care. Sites scored in the medium to high range with regard to their sensitivity and responsiveness to the cultural diversity of the families served, but when it came to the inclusion of families' informal helpers in service planning and delivery, their scores dropped. These findings were helpful in determining the extent to which the cultural competence value was being implemented at the level of practice and in identifying specific aspects of program implementation needing attention.

Additionally, the findings served to increase our understanding of cultural competence from the families' perspectives, and to identify their own indicators for this value. We learned that the families' definitions of cultural competence tend to be based on their perceptions of providers' caring and commitment. This stands in contrast to the more academic and professional

understandings of cultural competence (like the definition outlined in Table 1) that appear in research and theory on Systems of Care. Families judged the cultural competence of their providers in terms of the respect, honesty, trust, support, equality, acceptance, and mutual growth that their relationships engendered. According to family members, the presence of these components in their relationships with providers produced positive effects in families and a sense of fulfillment on the part of providers.

When looking at the data using this framework we found that all providers demonstrated some degree of cultural competence, but that those rated higher by families more closely approximated the families' perspectives regarding cultural competence. The following examples help illustrate this point. One mother's response when asked whether her child's provider was respectful of their values stated, "[Provider] treated us very well and supported [us] even when we did not agree on pulling [child] out of school." Another parent stated, "[Provider]

Table 1. Cultural Competence

Agencies, programs, and services are responsive to the cultural, racial, ethnic, and social characteristics of the population they serve. Diversity is valued and acknowledged through service providers' efforts to meet the needs of culturally and ethnically diverse groups within the community.

Subdomain	Definition
Awareness	"Refers to the level of cultural awareness of service providers regarding the family's cultural background as well as their own...[S]elf awareness relates to [service providers'] ability to place themselves within a cultural context and describe how it impacts their lives. Awareness of the cultural background of the families served refers to service providers' ability to place families within the families' cultural and environmental contexts."
Agency Culture	"The families' understanding of the agency culture, meaning how the system operates, its rules and regulations, and what is expected of them, is central to the treatment process."
Informal Supports	"Refers to the inclusion of the families' informal/natural sources of support in formal service planning and delivery. Implementation of a culturally competent system of care requires that service providers become knowledgeable about the natural resources that may be utilized."
Sensitivity and Responsiveness	"Culturally competent service systems are aware of their own organizational culture and the culture of the families they serve. This implies that they accept cultural differences, understand the dynamics at play when persons from different cultural backgrounds come into contact with each other, and are able to adapt their services to the cultural context of their clients."

Note: Definitions are from Hernandez, Gomez, & Worthington (1998).

treats me with respect. I couldn't do this [treatment] if I didn't feel that." When asked whether families felt they had something in common with their children's provider, one parent said "That [provider] loves my kids, yeah," while another one mentioned "We [family] like [provider] a lot. We would be friends if we had met under other circumstances." When asked about providing examples about the cultural sensitivity and responsiveness of their service providers, one mother stated "[Provider] is very interested in me and in my son, [he/she] believes in me and wants to help us." Another mother mentioned, "[Provider] looks out for me, she is almost like my mother."

Service providers who were more in tune with families offered similar comments when asked to provide examples of their efforts to translate cultural competence into specific actions. One provider spoke about his/her efforts to be seen by families as equals. In this regard, the provider stated "I do everything I can not to appear as an agent of government but as a human with skills and experience to help; [I] work with a lot of humility." In terms of respecting families' values and beliefs, one provider stated "...go where the family is; don't change their beliefs, just work around them and make things better," while another mentioned that "People deserve respect no matter where they are coming from. Because we were able to respect [mother] we got where we are." Regarding the importance of values, one provider stated "Families have taught me a lot of values."

Similarly, families that found their providers to be less culturally competent expressed their views in terms of their relationships. One mother responded, "I don't know the man that way, we don't talk about that," when asked about sharing things in common with her child's provider. In terms of feeling respected by her child's provider one mother stated, "[Provider] sees me as an old-fashioned person that don't know anything." When asked whether their service provider

was sensitive to the family's life circumstances, a mother stated, "[Provider] don't live this life and so don't understand."

Service providers who were less concerned about the cultural and social characteristics of the families they served tended to view families using a deficit approach. For example, when referring to a family that needed a lot of support, their service provider labeled them as "dependent" and commented on his/her need to set limits. In addition, when speaking about the difficulties this family was experiencing in trying to access services due to a lack of transportation, the provider stated, "All they need is willingness." Some service providers tended to dismiss their need to be aware and responsive to the cultural diversity of their clients by simply stating "We are all the same."

The perspectives of families regarding cultural competence offer service providers an alternative vehicle for understanding and approaching the diversity of their client population. At the individual/family level, the definition of cultural competence goes beyond the ability of service providers to recognize and appreciate diversity, as shown in the examples provided. Instead, cultural competence becomes a feeling that cannot be measured just by asking providers about their specific knowledge about a culture or a group, or about the trainings they have received. Cultural competence exists in providers' sense of caring, commitment, and comfort that surrounds their interactions with children and their families. Using this understanding of cultural competence should help service providers feel less pressured by the need to be extensively knowledgeable about the multiple expressions of culture and sub-culture, which is an unrealistic expectation. Approaching cultural competence in the same manner as one would approach friendship building is like looking through a prism and constantly discovering new shapes and colors.

Measuring the cultural competence of systems and individuals requires



approaches which can appreciate both the academic and family perspectives on cultural competence. Because both are abstract and ambiguous concepts, measuring each of them is challenging. The main difference between the two is that true caring and commitment

are easily recognized and felt by children and families in their interactions with representatives of a system of care.

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FAMILIES AND COMMUNITIES IN EVALUATION

Most of us in Indian Country have had plenty to do with evaluation during our lifetimes. We have answered surveys, sat in on focus groups, filled out forms, and sometimes suffered from the erroneous results. We have been subject to study since the earliest periods in the history of research and evaluation. Many times those studies did nothing to benefit us; more times than not, they resulted in harm.

More and more programs want to involve consumers in the evaluation of their program and services. Not simply in the role of subjects on satisfaction surveys and focus group reports but at the very core of evaluation. From designing the questions to the dissemination of the results, family members are beginning to take their place at the table.

Until recently, families had little role in evaluation. If they were involved in an evaluation or research project, they were relegated to data collection. Without community and family member involvement in defining the questions, assisting in the selection of instruments and outcome measures, and consulting in the interpretation of the results, researchers are often left with an incomplete and sometimes inaccurate picture of what they are studying. This can lead to the production

of information that is not helpful to communities and sometimes even has detrimental results. For example, a research project conducted in an inner city neighborhood concluded that this particular neighborhood had the highest murder rate in the city. This left the impression that the neighborhood was dangerous and the residents were criminals. This did not reflect the experience of the members of that community. Upon their further investigation, it was found that not a single murder was committed by anyone in the neighborhood, nor were any of the victims from that neighborhood. In fact, murders were often committed elsewhere and the victims were transported to the neighborhood. As you can imagine, the second conclusion—arrived at with input from the community—differs greatly from the first.

When it comes to planning and delivering services to communities, research and evaluation are key. Research data are often used in the development of services. Evaluation data become essential in determining the necessity of a service and/or its need to change. In response to the information gathered, decisions are made that affect policies, programs, support, and the expansion or termination of services. It is imperative to have the most accurate and appropri-

ate information available in order to make those decisions.

One of the best ways to ensure the accuracy and appropriateness of the information gathered during research projects is to include the voices of family and community members meaningfully in the evaluation process. What is more, when researchers and evaluators work collaboratively with community members, the information that is produced can become an advocacy tool that validates the experiences of families and communities. This information can then be used to motivate policy and program decisions which reflect the community's sense of its own needs. On the other hand, research studies—especially when they are conducted without community input—may motivate decisions that have a negative impact.

Family perspectives are particularly crucial in determining what sorts of outcomes to include in research and evaluation. Families use a set of measures that are not often reflected in outcome studies. How many times did I get called from the school this week or how many meals were we able to share together without interruption? Did the meetings with all the various agencies in our lives, the intensive therapy sessions, and the various evaluation requirements allow us time

to be a family and to practice the suggested behavioral modification? Are we closer to a path of healing or further away? Are our days filled with crisis management and financial burden beyond our limits? Are our children headed toward a bright future with possibility and potential within the boundaries of their respective diagnosis or are they headed into the agency abyss to be lost to limited lives? Will they be alive? Will they survive the systems set in place to help?

These are the very real performance measures in our daily lives. First and foremost we seek safety for our children. We need to know that our children are not at the disposal of drug companies in collusion with research projects that experiment at the expense of our children's lives. We need to know that, when we find our sons or daughters in need of self-protection, the environments they are placed in will, first, do no harm. We need policies to ensure that suicide prevention means that our children are in a safe space without access to items that they could use for self harm, that one-to-one observation does not somehow become periodic checks at the discretion and convenience of staff. We need strict enforcement of standards around restraint and seclusion. We have measured the outcomes at the gravesites of our children. The first outcome we seek is for our children to live.

The next outcome we seek is for our children to have some quality of life that ensures their ability to be happy and productive members of their community. How do we measure that? We measure that by some of the same indicators that the research world uses. We measure that by success in school and progress in educational plans. We measure that by decreased involvement with juvenile justice and out-of-home placements. But we also measure that by the number of times we have had "emergency" visits to doctors and therapists in a month. We measure that by nights at the supper table together without conflict. We

measure by our own set of indicators: sharing a ceremony or celebration, being "in this together," making it through a school suspension or adjusting to a new medication. As family members we need our strengths acknowledged, our resources valued, and our children treated with love and respect.

We can tell you when systems are not working. We can tell you that giving up custody to the state in order to access financial support for services is not helpful. We can tell you that systems set up to punish and not instruct are not helpful. We can tell you that when our natural resources, our cultural norms, our definitions of family are not supported, it is not helpful.

In research and evaluation, many of us feel there should be "nothing about us, without us." We need to be at the table when the outcome measures and evaluation strategies are being developed. We need to "partner in order to prove" what our experience has taught us. We need our informal community supports to be included in the therapeutic measurements. We need the development of tools that fit with our cultures and communities. We need our strength and knowledge coupled with the skills and tools of the research and evaluation world to foster meaningful improvements in outcomes for our children.

Family members who want to be at the table can begin by learning about evaluation and research. What is being researched? Why is it being evaluated? Who is paying for the research? What will be done with the results? How do you know if the results are providing the true picture or telling the whole story? Who owns the information and how will it be used?

Researchers need to know if the question asked is the right question. Will the question itself create harm? Are the instruments used culturally appropriate? Can the methods of gathering data be used in the community? Once data is gathered, how is it analyzed? Who interprets it? Will it contribute to positive outcomes for

the community? The voice of the families is essential in both asking and answering these questions.

As we seek to have the conditions and circumstances within our communities addressed, we need to formulate our responses based on reliable information about outcomes that

Cultural Clash*

You say
There is no difference
between you and I.

Who gave you permission
to deny our
separateness?

You plead ignorance
as an excuse
and wear it like protective clothing
while I am to be examined
naked
at your minority board meetings.

I am to understand you.
your language
your practices
your protocol
Your history books tell
your story
mine
is nowhere to be found.

I have searched
the volumes bound and stacked
in your great buildings
of higher learning.

Don't tell me you know who I am
by those publications and admin-
istrations

Our elders
my teachers used to say bi-inabin
"Come, look"
Remember, this is our way.

You say there are no differences
between you and I
to accept that would be to see my
culture die.

—Shannon CrossBear

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matter to all of us. In order to be at the table together, both researchers and family members need to expand their knowledge base to include the other. Recent efforts are helping us move toward this end. The Federation of Families for Children's Mental Health is offering trainings on the evaluation process to family members. The three course series on "The World of Evaluation" (How to Understand It, How to Work in It, and How to Run It) prepares family members to be effective members of research-evaluation teams. The courses are co-trained by a family member and an evaluator to give full voice to the information and issues

from both perspectives. Collaboration like this can help us find ways to gather high-quality information that truly promotes positive outcomes in our communities.

Ultimately, the outcomes we seek will be measured by future generations. In my community, we have a belief that the decisions and actions of today will impact seven generations to come. Our children and our children's children will decide whether we have done that in a good way.

For more information on "The World of Evaluation" training, contact the Federation of Families For Children's Mental Health, 1101 King Street, Suite 420, Alexandria, VA 22314, (703) 684-

7710. The RTC is collaborating with the Federation of Families to evaluate "The World of Evaluation" trainings. For information about this research and to view recent presentations and products, visit www.rtc.pdx.edu/pgProjEvaluators.php.

Shannon CrossBear is a powerful, spiritual Ojibwe/Irish woman who provides facilitation and consultation through her business, *Strongheart Resource Development*. Mental health issues within her family of origin and community cement her commitment to improving conditions for children. *Strongheart Resource Development*: (218) 387-3112.

WORKING TOWARD CULTURAL COMPETENCE THROUGH FAMILY INVOLVEMENT

Nearly five years ago my friends called me to ask if I was applying for the newly created position for a parent in the Children's Mental Health Division at the Minnesota Department of Human Services. I had no such plans. Being the "mom" at this level of government seemed daunting. Would anyone listen? Would I understand what they were doing? Would I make a difference for children like my son or would I be the biggest token parent in my state? Since then I have learned that every caregiver who becomes involved makes a difference—not just for his or her own child and family, but also for all the others who have not yet raised their voices.

There was no research proving that a parent working inside government makes a difference. At the time, only two states had a caregiver representative working at the state level. Our state's Children's Mental Health Director simply knew it was the right thing to do. She had a vision of a culturally competent and family driven system of care. A parent of color in her office just made sense.

Now we know it makes a differ-

ence. Conversations have another dimension when the perspective of caregivers is included. People are more accountable when families are there to hear and contribute to the process. Decisions made by governmental bodies, county boards and directors, collaboratives, and service providers are not necessarily the same decisions when the perspective of caregivers is included. These decisions more accurately reflect and are sensitive to the preferences and needs of children and their families. Professionals need to include the family perspective in their work. From state level task forces to county advisory committees, parents are making a difference in places where they only dreamed of being a short while ago.

Cultural competence goes hand-in-hand with family involvement. Services are culturally appropriate when mental health providers respond knowledgeably to the unique needs and strengths of the individual family. The Children's Mental Health Division of the Minnesota Department of Human Services has made significant strides toward a culturally com-

petent, family-driven system of care. We are writing both clinical and organizational guidelines which weave together cultural competence and family-centered care. We have helped culturally specific providers form a Specialty Provider Network for mutual support and increased visibility and influence.

The Children's Mental Health Division has also made a serious commitment to developing parent leaders across Minnesota. In September 2000, 117 parent leaders met to discuss the direction of family involvement. It was the first meeting of parent leaders in Minnesota and the second such meeting in the country. Many parents continued to meet monthly, dragging their crock-pots to central Minnesota, to discuss how they could connect and empower other parents. They created the Minnesota Parent Leadership Network, set up an electronic mail group to facilitate communication and elected a culturally diverse Advisory Committee. Based on their work and guidance, the Children's Mental Health Division granted \$175,000 to a statewide parent organization to

Participants in the Minnesota Parent Leadership Advisory Committee

The Minnesota Parent Leadership Network has provided me with courage, self-esteem, and the wisdom to know that I can make a difference. They recognized in me something I never knew was in me. They are builders of new leaders. Now it is my turn to build someone else. My goal is to reach the African American community and let them know: You can accomplish anything. To do this, you must conceive (put it in your mind), believe (know that it can be done) and then receive (accept the reward of making a difference).

I once battled with depression. I did not believe in myself. I was afraid to say what I was thinking or feeling. My depression became worse after I found out I had a child with mental health issues.

After my child had been hospitalized five times, I was introduced to an individual who not only helped me get services for my child, but began to support and encourage me as I learned to express my thoughts and feelings. She recognized something in me. I began going to trainings and workshops. The skills I learned at a workshop on facilitation helped me to start my own parent support group, which landed me with the Minnesota Parent Leadership Network.

—**Tovarich Bourne**

St. Paul, Minnesota

Minnesota Parent Leadership Advisory committee
Representative to the African American community

As a parent leader and representative of one of the most rural areas of our state, my most important job will be to connect families and to support them in their struggles to raise a child with a mental health disorder in an atmosphere where stigma is a persistent and difficult barrier to overcome. In small towns, where everyone knows your business and discusses it over coffee, shame and blame are huge obstacles for families. As parent leaders this then becomes a two-fold problem. Support from other families walking the same path is a key element in surviving the struggle. We know that input from parents is crucial to refining systems to better serve children and families. The culture in rural areas gets in the way of parent-to-parent support and blocks the participation of families at the policy table.

Because of my involvement with the Parent Leadership Network, I was invited to sit on a state task



Walkers in the first annual Walk for Children's Mental Health in Duluth, Minnesota, June, 2001.

force for children's mental health system reform. This gave me the chance to share first hand with policy makers the struggles families face in the rural area. Without my involvement as a parent leader I would not have had this opportunity. I am pleased the recommendations reflect the input of our parent voices at the table.

—**Carolyn Strnad**

Moorhead, Minnesota

Minnesota Parent Leadership Advisory Committee
Representative to Region 2, Northwest area of
Minnesota

Chicanos Latinos Unidos en Servicio (CLUES) is an agency that provides services for the Hispanic community in Minnesota. We belong to the Specialty Provider Network, and we work with parents to help support and empower them. One of our Programs is Familia Nueva, a support group for parents who have children with severe emotional disorders. After three years of receiving training and leadership skills, some parents have become great advocates for other parents who are facing similar difficulties. Parents helping other parents has made a very important difference in the access that Hispanic families have to services, such as special education. The moral support and advocacy that some parents give to others have helped families to face the challenges of their life with hope and positive expectations about their future.

—**Sheila Rojas**

Family Advocate

Chicanos Latinos Unidos en Servicio

Having a parent liaison in our division has certainly made a huge difference in how we address parent involvement. Her influence has resulted in changes in our focus and priority for parent issues. The consistent input and reminders of the significance of the parent voice in our system of care have dramatically enriched our statewide case management training. Many more parents are now involved as trainers and, overall, our training has become more culturally competent and family-driven.

—**Sunday Olayinka**

Program Consultant

Children's Mental Health Division
Minnesota Department of Human Services

connect, support and train parent leaders. A significant emphasis is placed on connecting, expanding and developing leadership in communities of color.

Throughout the coming year parent leaders will have many opportunities to meet regionally for support and training. Parent leaders support each other through an e-group, and a web site is currently under construction. Computers for parent leaders are being sought. Training is being provided to administrators and service providers to give them the skills they need to collaborate more effectively with parents.

Members of the advisory committee of the Minnesota Parent Leadership Network sit on the board of the Specialty Provider Network to enable each network to help strengthen the efforts of the other. One parent leader recently said that because of her participation in the network: "I will never feel alone again." Parent leaders are ending the isolation families experience. They are expanding parents' knowledge and their ability to face the challenges of raising their children,

and they are influencing policy and services.

In a recent survey of parent leaders, parents indicated they feel more empowered, have better knowledge of the mental health system, know they are making a difference, and appreciate that their contributions are being validated and valued.

Meeting the needs of a child and family means understanding the culture of that family and the impact it has on how they raise their child with a mental health disorder. The family themselves can best tell providers about their culture. Meaningful involvement of parents and children of diverse cultures will ensure that the system of care will appropriately serve children from each of its various communities. Family members who participate in making the children's mental health system change are leaders who deserve training and support to be knowledgeable and strong.

The days of only inviting parents to a meeting are past. This alone does not create a meaningful parent voice. Children's mental health leaders must represent all the children affected by mental health disorders and they must

be prepared and empowered to do the important work ahead of them. The work of family involvement and cultural competency must be done together. It is indivisible.

Amelia Ortega, Parent Liaison with the Children's Mental Health Division, Minnesota Department of Human Services in St. Paul, MN, is the parent of a son with schizoaffective disorder.

Tovarich Bourne, Representative to the African American community on the Advisory Committee of the MN Parent Leadership Network, is the parent of a child with a mental health disorder.

Carolyn Strnad is the mother of seven. Her daughter has bipolar disorder. Carolyn sits on the Clay County Local Advisory Council for Children's Mental Health.

Sheila Rojas, Family Advocate, has done extensive work with the Latino community.

Sunday Olayinka, Program Consultant with the Children's Mental Health Division, MN Department of Human Services, is in charge of its annual mental health conference.

More RTC Project Updates

Guidance for Early Childhood Program Design staff spent the summer recruiting Head Start program staff, directors, mental health consultants, and parents to participate in a survey. We are now analyzing data from 79 Head Start programs across the nation. The survey was designed to explore the relationships between organizational features of mental health services and the perceived effectiveness of program outcomes for children's social-emotional health. Results of analyses, in combination with 2001 qualitative data, will inform creation of practical training materials in 2003. Contact: Maria C. Everhart at (503) 725-8465 or everhartm@pdx.edu.

The Context of Individualized Services. If a site wants to ensure quality implementation of the process of team-based individualized services planning (ISP, also often known as wraparound), what conditions must be present at the team, organization, and system levels? Project staff have completed an extensive review of a monograph manuscript describing a conceptual frame-

work incorporating these conditions. Using the conditions outlined in the conceptual framework, staff are formulating tools for sites that are implementing ISP to use as a part of their ongoing self-assessment and development. Contact Janet S. Walker at (503) 725-8236 or janetw@pdx.edu.

Teamwork in Practice staff have just completed work on an article entitled "Team-based individualized service planning: Meshing philosophical and effectiveness considerations in a wraparound planning process." The article contains six research-based recommendations for specific teamwork practices which simultaneously promote both effective planning and the philosophical principles of wraparound. Staff is also completing several reports on our observations of 70 team meetings around the country. User-friendly versions of our major findings will be available soon from the RTC publications department. Follow our progress at www.rtc.pdx.edu/pgProjTeamwork.php. Contact: Janet S. Walker, (503) 725-8236, janetw@pdx.edu.

More RTC Project Updates on page 11

A COMMUNITY RESPONDS: ON THE WAY TOWARD CULTURAL COMPETENCE

It did not take the release of the data from the 2000 Census for citizens of Guilford County, North Carolina to become aware of the increasing diversity of our community. In a grocery store anywhere in the county one will hear multiple languages spoken. On a visit to the reception areas of any of our human service agencies, one will see people representative of many nationalities. The public schools report that more than 80 different languages are native to the children enrolled throughout our educational system. Human service providers and educators are challenged to find the way to best meet the needs of our increasingly diverse population. Becoming culturally competent is critically important.

Guilford County has a rich and deep history as a Southern community attempting to address issues of social justice. Originally settled by the Presbyterians and the Quakers, the Underground Railroad, transporting the slaves traveling north to freedom, passed through our county, with the Quakers taking an active role in assisting the slaves in their travels. At our local Historical Museum is one of the original covered wagons with the false bottom that carried the slaves to freedom. Also, the Woolworth's store in downtown Greensboro, the largest city in the county, was the site of the first sit-ins, which were an important and integral part of the Civil Rights Movement of the 1960s. Throughout the history of this county, addressing concerns of racial and social equity has been a part of the community fabric.

In spite of this history, the traditional patriarchal and hierarchical service delivery system has been permeated with issues of racism and prejudice. A disproportionate number of African American youth are placed in foster care, suspended from

schools, and left without consistent health care. In recent years there has been increasing commitment among community leaders to address institutional racism and its impact on our human service delivery systems. Addressing these deep, continuing issues—as well as issues related to the recent growth in immigrant and refugee populations—has been significant in highlighting the importance of changing our service systems in order to better meet family needs. For example, the stress placed on the service system for translation services has been one small step in raising the awareness of the need for more cultural understanding.

As a site for the Comprehensive Community Mental Health Services for Children and Their Families grant awarded to North Carolina, the community human service system in Guilford County, North Carolina, has committed to the System of Care philosophy by incorporating the core values into the service system. As we strive to build a community-based system that provides family centered services, we increasingly recognize cultural competency as the central core value. Truly we must be culturally competent in order to be family-centered!

In Guilford County, a task force, representative of the agencies on the Community Collaborative and other members of our community, has been working for the past year and a half to develop a training plan that can help us become more culturally competent in our work with families and children. The site received technical assistance from the state office administering the grant in the development of a cultural competency training plan. After much discussion among the task force members, it was determined that in order for real change to occur within our service systems,

we must begin at the top of our organizations, gain commitment through awareness of need, and from there develop appropriate training opportunities for frontline staff members.

We took the first step in our plan with meetings to begin learning about the diversity of Guilford County's population. Family members receiving services met together with the management and leadership teams of the Departments of Social Service, Public Health, Guilford County Schools, Juvenile Justice and Delinquency Prevention, Guilford Center Mental Health, Developmental Disabilities and Substance Abuse Agency, Family Services of the Piedmont and the University of North Carolina at Greensboro's Center for the Study of Social Issues, and the Center for New North Carolinians/ACCESS. The large meeting room was packed with the directors of each agency and their respective leadership teams, family members dressed in native costume, and faculty from the university. The task force was thrilled at the prospect of our making an impact on our community's human service systems.

As people arrived, they were greeted with coffee, tea, and fruit juices, served with pastries of Greece, the Sudan, Vietnam, and Eastern Europe. The meeting opened with African drumming followed by "good morning" greetings from community citizens representing twelve different nationalities.

The purpose of our gathering was quickly defined, using headlines from the morning paper: "Census Figures Reveal Greater Diversity than Expected." Who would have thought that we could host such a significant meeting and have the local paper's lead story confirm the importance of our work? Putting this increasing diversity into context, a brief historical perspective on the settlement of our

region by immigrant and refugee groups was presented. It was explained why people had left their native lands to seek freedom and opportunity. This was compared and contrasted with how people had once been treated in this country and in our county. Although it is wonderful to have community support in re-settlement, many stories were recounted of incidents when language barriers and misunderstandings of culture resulted in inappropriate services or mis-diagnosis for people seeking services. Also presented was the picture of our county from a demographic perspective and how it has changed over the past 10 years. The Director of the Office of Hispanic/Latino Affairs in the Office of the Governor, shared information on the legal protections for immigrants and refugees and the responsibility of service providers to meet the needs of these new citizens. People left the meeting informed and energized about the importance and purpose of our striving to be more culturally competent.

Our next step was to learn about examples around the country of service organizations that have incorporated policies and procedures that institutionalize cultural competency. We were searching for ways to increase the expectation of personnel that cultural competency was a core value of our human service organizations.



What organizations, with similar purposes, had incorporated this expectation into their organizational structure so that it was incorporated “without question”? How should this be addressed in hiring practices, staff evaluations, and continuous staff development and training? How can we incorporate cultural competency into the “soul” of our organizations so that barriers to services do not exist because of language or prejudice?

We identified the University of Chicago Medical System as an organization that has made much progress in this area. They have a process for all job applicants that includes a video that describes how the organization emphasizes the importance of respect for the culture of every person, both consumers and staff. Every applicant views this video before deciding to apply for a position, as buy-in to this perspective is expected for every employee. This is followed by an interview that includes questions that facilitate the candidate’s reflection on cultural sensitivity. Additionally, staff evaluations and reviews include this component, as every job description includes cultural competency.

We were so pleased to identify this organization as a resource and invited a representative to come to Guilford County and present their practices to human resource personnel in our various agencies. Opportunity was provided for in-depth exploration of the ways the University of Chicago Medical System had been successful in the implementation of policies and procedures that promote and support cultural competency.

This workshop led to the request that the internal diversity teams within each organization become linked in order to discuss further ideas that are applicable to our community. A series of networking meetings between community agencies encouraged the exchange of ideas, strategies, and training resources, and provided opportunities for peer support for leaders addressing cultural competency within agencies. Often, this work can be extremely difficult, as we

ask ourselves and our co-workers to make profound examinations of our behaviors and actions. The peer support, the opportunity to discuss these challenges candidly, and the opportunity to feel connected with others facing similar situations have helped a great deal as agency leaders confront these challenges.

It was determined that all agencies would benefit from workshops that addressed cultural practices of specific ethnic groups. Utilizing the Center for New North Carolinians and various ethnic organizations throughout the community, persons from East Asian, Central American, and Central African countries joined together to present a series of workshops on their specific ethnic and cultural traditions and shared how and why they had come to our community. These workshops deepened our understanding of their specific cultures and increased awareness.

With this increased awareness of individual cultures, every person was given the opportunity to examine his or her own cultural heritage. Human service providers reflected on why their family traditions had been adopted and marveled at the great diversity among themselves in holiday celebrations, traditional foods, and music preferences. Once people gained comfort in discussing their own cultural heritage, many began hosting a series of potluck lunches and “talk times” among staff to share their own cultural practices. Informal presentations of music and exchange of literature reflective of individual cultural heritages were encouraged. After work, staff visited ethnic grocery stores and restaurants and attended movies representative of particular cultures, such as *Monsoon Wedding*. Staff members were increasingly comfortable talking about cultural differences among themselves and consumers began to witness increased cultural awareness.

Throughout the task force’s work, family members have provided leadership to the human service providers in deepening understanding of the

importance of respecting the uniqueness of each family's individual culture. Although we had systematically addressed learning more about cultural groups, addressed language barriers inhibiting quality service delivery, and begun more self-examination of personal prejudice, family members continually reminded us that response to a family in a culturally sensitive

manner is more than a respectful response for a particular ethnic group's cultural practices. Being culturally competent is being respectful of each individual, her values and beliefs, and her traditions and practices, and then supporting these in all interactions with the family.

We are on the way toward cultural competence... a long way from achiev-

ing it, but traveling the road together to deepen understanding.

Dr. Margaret Bourdeaux Arbuckle is the Director of the Division of Children, Youth, Families and Community in the Center for the Study of Social Issues at the University of North Carolina at Greensboro. mbarbuck@uncg.edu.

**Research Update from the Research and Training Center
on Family Support and Children's Mental Health (RTC)**

INCLUSIVE CHILD CARE: CHALLENGES AND STRATEGIES

Families of children with emotional or behavioral challenges have labored for years to have their children included in neighborhood schools and classrooms, and they continue to struggle to have their children accepted by local child care facilities. Child care can provide a safe, enriching, supportive, and culturally appropriate context for the social and emotional well being and growth of all children. In a high quality child care arrangement, the worlds of children expand beyond the family and neighborhood. Children and youth develop cognitive skills, patterns of social interaction, and the ability to regulate their own behavior and feelings. Some of the most consistent findings in the social sciences are related to the effects child care has on children's school achievement and social, emotional, cognitive, and language development (Shonkoff & Phillips, 2000; NICHD, in press).

Child care arrangements that include children with emotional or behavioral challenges alongside typically developing children tend to collaborate more effectively with parents, and to use curricula that are more developmentally and culturally appropriate (Erwin, 1996). Such arrangements provide support for family members who may be overwhelmed by their

many responsibilities, as well as making it possible for parents to work and to lead lives with less stress and role overload (Harvey, 1998; Rosenzweig, Brennan, & Ogilvie, in press).

But one only has to ask a parent who has hunted for an arrangement to know that the quality of child care is grossly uneven, and many care providers are wary of including children who are not typically developing. In one study, Emlen (1997) found that children with emotional or behavioral challenges were 20 times more likely to be asked to leave child care arrangements than typically developing children. These children may display aggressive or other inappropriate behaviors or feelings in everyday situations, and may have great difficulty forming social relationships (Zigler & Hall, 2000).

The Models of Inclusion in Child Care Study

Responding to the need for research regarding models of inclusion in child care, the Research and Training Center on Family Support and Children's Mental Health is in the process of conducting a series of studies aimed at guiding the design and implementation of inclusive child care policies and programs. In the course of previous research studies, our research team found that there did exist qual-

ity programs and family care arrangements that successfully included children with emotional or behavioral challenges in child care settings (Brennan, Rosenzweig, Ogilvie, Wuest, & Ward, 2001). Our goal was to learn more about the provider and setting characteristics associated with these successful programs.

As a first step in the current research, state child care administrators, child care resource and referral agencies, and family organizations were sent a request to nominate programs that successfully included children with emotional or behavioral challenges in child care; this resulted in nominations of 104 programs across the United States. Personnel at thirty-four of the nominated programs participated in a survey designed to learn more about their challenges and strategies for inclusion. We were particularly interested in five key areas: (1) the types of services these programs offered, (2) the needs of the families they served, (3) the inclusion strategies they employed, (4) the barriers staff reported facing, and (5) their view of the role of families in their programs.

Results of the Survey

■ **Program Characteristics.** Data collected from the 34 nominated pro-

grams were given by 23 directors of child care centers, one family day care provider, and 10 heads of child care support programs. The support programs provided such services as resources and referrals, technical assistance, provider training, and mental health consultation. Several of the programs provided a blend of direct care of children and support services. In all but three of the center programs, families paid for child care. Only 3 of the 10 programs providing support services collected fees from families. Twenty-two of the programs were located in urban areas, 10 were in suburban communities, and 2 served rural locations.

Over half of the programs provided child care in traditional centers, only 11% provided in-home care, and 11% had family day care services. Some child care providers served families in uncommon time frames: summer (37%), vacation (11%), before/after school (30%), and drop-in (15%). All but two of the programs served children three years of age or younger; however, only six programs served children over the age of 12. Nine of the programs were targeted to serve families of children with emotional or behavioral disorders as their primary clients, while 16 of the programs had families of children with special needs as their primary clients. Only six of the respondents mentioned that they served ethnically diverse families, but nearly all programs rendered services to families with low income. In terms of family and child care supports, 10 programs indicated that they had specialized resource and referral services, 10 programs also gave technical assistance, nine engaged in inclusion or mental health consultation, and six considered themselves as providers of early intervention services.

From the brief qualitative answers provided in the survey, we saw that programs and providers began serving families of children with emotional or behavioral challenges in a variety of ways. Some started out providing services to a comprehensive

community, and began to see more and more children needing special supports in child care settings. These model programs reached out for assistance and training so that the children would have a successful child care experiences. Other programs were initially designed to meet the special needs of families having children with developmental or physical challenges and later developed expertise in serving children with emotional or behavioral problems. Finally, a few programs were designed just to serve families of children with emotional or behavioral challenges from the outset; among these, some included typically developing children in the same classroom settings.

■ **Family Needs.** The programs served families with needs for child care due to employment, training or educational commitments of the parents. Frequently, unusual and extended schedules made the provision of appropriate services a challenge. Finding sources of additional funding to help these families purchase appropriate care for their children has been problematic in some settings.

■ **Inclusion Strategies.** Some of the strategies care providers reported using to include children with emotional or behavioral challenges in their programs were: referring children for assessment or mental health intervention, using paid mental health consultants, working with the child's own therapist, engaging social workers to provide family support, intensive staff training on children's mental health, communication with parents about the child's medication, and the development of innovative and adaptive care strategies.

Individualized care and behavioral plans were emphasized by several programs, who also used such strategies as providing environments with reduced stimulation, concentrating on positive aspects of the child's behavior, and working with families to develop consistent strategies or techniques to be used both at home and at the care facility. Additionally, several programs emphasized the impor-

tance of improving the staff: child ratio so that there would be staff support for children experiencing problems; some centers have applied for and received special funding for these efforts.

The family support programs mentioned several other promising strategies for inclusion: providing centers and family day care with services of behavioral and educational consultants to help them deal with difficult behaviors, arranging for funding to increase personnel and improve staff: child ratios, providing home visits and coordination with parents, funding mental health services for children of families whose insurance would not cover them, and offering staff development around mental health issues.

■ **Challenges to Inclusion.** Numerous challenges accompanying the inclusion of children with emotional or behavioral challenges in care were identified by the respondents. Stigmatization was frequently mentioned as a problem for these children, with parents of typically developing children expressing concern for their children's safety. The children's behaviors were also identified as an issue due to the physical and emotional demands that they made on staff members, and the safety concerns that they raised for self, staff, and other children.

Several respondents listed as a critical issue staff members that were overwhelmed, inexperienced, underpaid, and undertrained. The lack of trained child clinical specialists was also recognized as a barrier to inclusion, as well as insufficient funding to support needed intervention services. Staff pointed out that caregivers are also increasingly overburdened, making it difficult for both caregivers and staff to find the time for collaboration and communication.

■ **Family Participation.** Although nearly all programs and providers reported that they were involved with families, a minority of the programs evidenced a high level of family participation. Those programs that had the most intense family engagement

carved out key roles for families as integral parts of intervention teams, as volunteers within the care program, as members of parent advisory boards, as participants in parent meetings, or as paraprofessional parent coaches.

Communication with parents was mentioned by respondents as critical for successful inclusion. Parents were counted on for information about the child's previous development and behavior, precipitating events or stresses, techniques or strategies that have been previously attempted and the success of such strategies. A few program directors discussed the need for parent training and registered concern about lack of parent engagement. The majority stated that they saw parent participation as paramount, although some reported that language and cultural barriers could be obstacles. In the words of one administrator, "It is especially important to form alliances with those families who have children with significant emotional/ behavioral issues so that we can work together to help these children succeed."

Current Research on Model Programs

The next step in discovering the key features of child care programs that successfully include families having children with emotional or behavioral challenges has been to conduct intensive studies of programs that represent a variety of services and settings. Interviews with directors, staff members, and family members of the programs, as well as direct observations of children, are currently being analyzed. The following centers have participated in the study: Broken Arrow Club House, in Broken Arrow, OK; Fraser School in Bloomington, MN; The Family Service Center of Morganton, NC; Little Angels Child Care Center in Milwaukie, OR; St. Benedict's Special Children's Center in Kansas City, KS; Kinder Haus Day Care Center/ Kinder Tots of Morgantown, WV; McCambridge Center Day Care in Columbia, MO; River Valley Child Development Ser-



vices in Huntington, WV; and Wayzata Home Base, in Wayzata, MN. Preliminary findings are available on the web: www.rtc.pdx.edu/pgProjInclusion.php.

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- Eileen Brennan, Ph.D., Elizabeth Haran Caplan, M.P.A./ H.A., B.S.N., Shane Ama, Olivia Warfield, and Jennifer Bradley, Ph.D.** prepared this article as members of the Models of Inclusion Child Care project at the RTC at Portland State University.

Reducing Minority Student Disproportionality in Special Education

SCHOOLS AND FAMILIES WORKING TOGETHER

Bobby, a six-year old African American boy, had several endearing qualities. He was quick to smile, very verbal, and loyal to his friends. However, for his teachers, Bobby was a handful. His attention span was short and he was gradually falling behind academically. In addition, he had a quick temper and often could not control his behavior. One day, he bit an aide who told him to wait in line for a drink of water. Another time, Bobby became upset at another student and began over-turning desks and throwing papers across the classroom. His school, lacking the capacity to identify underlying reasons or provide effective interventions for Bobby's behavior or academic difficulties, repeatedly passed him from classroom to classroom and school to school. After a few failed attempts to meet with Bobby's mother, Bobby was placed in a special classroom made up of several boys identified as having emotional and behavioral challenges.

The disproportionate and often inappropriate movement of culturally and linguistically diverse students from general to special education has long been an issue of significant concern. Bobby's story exemplifies this problem. By the time he finished kindergarten and first grade, Bobby had an unacceptable beginning to his educational career: six teachers in his first two years of school. What might have been done to better meet Bobby's social, emotional, and academic needs is the focus of this paper.

The research literature has for over 30 years documented the extent of minority student disproportionality in special education, citing broad inadequacies across a variety of educational fronts, including insufficient school, community, and family align-

ment; poor teacher preparation and support; a lack of early problem identification and effective intervention; and little attention to culturally competent instruction (Coutinho, Oswald, & Best, 2002; Harry, 1992; Kozol, 1992; National Research Council, 2002).

Overrepresentation in such disability classifications as emotional disturbance, mental retardation, and learning disabled is a particular concern for specific minority groups, including African Americans, Hispanics, and Native Americans. In addition, underreferral and placement of minority students for special and gifted education services, when warranted, is also an area of growing concern (Cummins, 1989; Ford, 1998). Minority disproportionality in special education is a significant problem largely due to its lasting negative impact, including

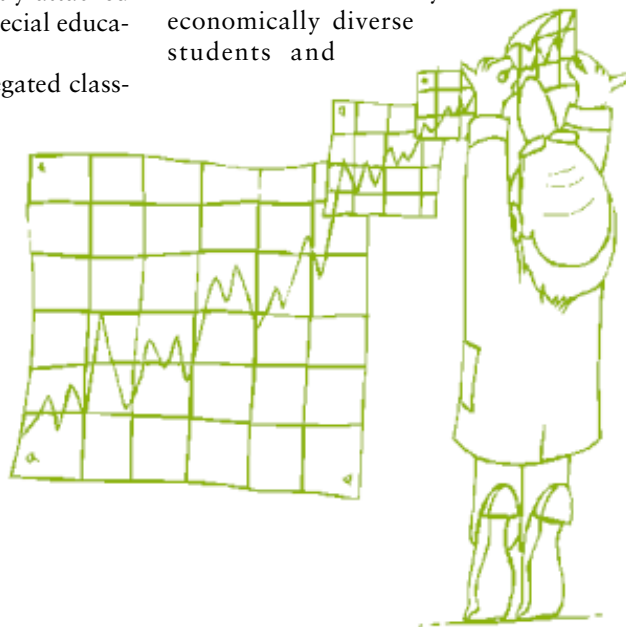
- the stigma and lowered expectations often associated with disability identification;
- deficit views frequently attached to families of minority special education students;
- higher levels of segregated classroom and alternative school placements; and
- poor academic outcomes and high rates of suspension, expulsion, and dropping out.

After exiting the special education system, many minority students move on to exposure to the criminal justice system and to unemployment at rates significantly higher than their White counterparts (Osher, Woodruff, & Sims, 2002; Oswald & Coutinho, 2002)

Students such as Bobby, often from low-income communities and challenging family backgrounds, are additionally handicapped by school settings with poor instructional quality, low expectations, lack of attention to culturally competent practices, and a lack of access to scientifically based practices and interventions for instruction and behavioral support. The following discussion provides an overview of suggested strategies for addressing minority disproportionality, including family involvement, support for effective instruction, and culturally competent practices in the classroom.

The Role of Family Involvement

One of the most difficult and unresolved problems in educational practice is the challenge of how to proactively involve culturally and economically diverse students and their families in the educational process. Limitations in aligning the typically mainstream/middle-class school culture to that of culturally and economically diverse students and



their families are a frequent roadblock to establishing a positive home-school relationship. This cultural disconnect contributes significantly to poor student behavior and academic outcomes. Cultural differences often lead to decreased levels of family comfort with the school and to negative judgments by teachers and other school staff. These negative judgments can lead directly to negative teaching behavior. Increased attention, awareness, and understanding by school staff of the cultural and environmental contexts in which minority students function can help to facilitate greater connection by students and their families to the school and improved teacher capacity for instructing and managing the behavior of diverse groups of students.

Suggested methods for increasing family involvement include

- recruiting parent liaisons to help establish an ongoing parent communication system;
- reporting student *accomplishments* to parents in addition to problems;
- including parents in activity planning, policy, and school improvement committees;
- recruiting school staff that reflect the diversity of the student population; and
- ensuring that school staff are welcoming, accessible, and respectful of the diversity of the student population.

Effective Interventions

A welcoming, culturally competent school setting is only the initial step in effectively addressing minority student disproportionality. The failure by schools to provide students showing early academic or behavioral challenges with effective interventions is directly related to eventual teacher referrals for special education placement. A comprehensive plan for providing academic and behavioral support and, when necessary, appropriate interventions should work across three levels: *school-wide support* for all students, *early interventions* for students found to be at risk, and *tar-*

geted interventions for students with intensive academic or behavioral needs.

Children's early school experiences are critical in helping to shape their self-concept, personal efficacy, and motivation for learning. Therefore, it is important to create school-wide learning and social environments that are supportive of children's total development, and that are responsive to their needs as individuals (Dwyer & Osher, 2000). One component of effective schoolwide support is the use of instructional strategies that have been demonstrated to work with diverse student populations. These strategies should be known to have positive benefits for children in developing both their academic and critical thinking skills. Examples of such strategies include *Success for All* (Slavin, et al., 1996) and *Class-Wide Peer Tutoring* (Greenberg, Kusche, Cook, & Quamma, 1995).

Another important component is instruction in social skills to increase appropriate behaviors and create a school-wide climate that is caring and supportive for all. For example, a curriculum utilized in East Baltimore (Woodruff et al., 1999) taught anger control, empathy, and appropriate ways to seek and receive help. When these social skills were taught to small groups of children by clinicians and trained teachers, teachers observed students' significant behavioral improvement in the classroom, and parents of participating students also reported improvements in their children's behavior at home.

While schoolwide supports can establish an environment that helps to prevent and respond to identified academic and behavior challenges, this support will not always be sufficient to address the difficulties of students with greater levels of risk. By identifying early signs of academic or behavioral challenges, schools can begin to address problems before they become more pronounced. These efforts should build on the schoolwide foundation of support. For example, in the East Baltimore Social Skills Pro-

gram, teachers received training to identify and assist students who exhibited early signs of aggressive behavior, thereby helping to prevent these children from developing more chronic and intractable patterns of antisocial behavior (Woodruff et al., 1999).

Students with severe learning or behavioral problems are frequently removed from the mainstream school environment through suspension, expulsion, and placement into segregated classes and alternative schools, where they end up spending even more time in environments marked by minimal academic expectations and punitive behavior management philosophies. Segregated placements can be reduced by providing individualized interventions and supports that build on student strengths and proactively address needs. In many cases these supports can be provided in mainstream classrooms. For example, student support centers, individualized learning, and behavioral services for students can utilize the skills of both regular and special educators; individualized services can also be provided in the mainstream classroom. In Westerly, Rhode Island, public schools established planning centers where students received individual counseling and assistance with homework, resolved conflicts, or had a quiet place to relax (Dodge, Keenan, & Lattanzi, 2002).

Conclusions

Without a greater school understanding of students, families, and their diverse cultures, and a coordinated implementation of support at the school-wide, classroom, and individual student levels, both negative misconceptions and ineffective teaching will continue to contribute to disproportionate minority special education identification and negative school outcomes. Regardless of educational context—school-wide, classroom or individual students in need—all students should be engaged in culturally responsive, student-centered opportunities to learn, marked by high expect-

tations and tailored to their individual needs. Schools must work to implement effective, evidence-based programs and interventions to increase family involvement and to provide positive social and academic experiences for all students.

All stakeholders in the success of our children—administrators, teachers, support staff, family members, and support agencies—have to be involved in creating an environment that is nurturing and supportive of positive student behavior, learning, and achievement. Everyone has a role to play in developing schools that are effective. Children need to be connected to structures that nurture the belief that they can be successful in mainstream society and let them know that they are supported in achieving their goals. Beyond looking at schools as a problem, the approach needed is a coordinated, proactive one—focusing on preventive, ongoing supports and behavioral and academic interventions that utilize the family, the child, and the school as critical sources of strength. High-quality teaching and learning results from a strong network of school supports, strong leadership, a clear focus, a positive climate, high expectations, and the participation and respect of everyone.

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ACHIEVING CULTURAL COMPETENCE THROUGH ORGANIZATIONAL SELF-ASSESSMENT

Editor's note: The following article is excerpted from *A Guide to Planning and Implementing Cultural Competence Organizational Self-Assessment* (Goode, Jones, & Mason, 2002), published by the National Center for Cultural Competence (NCCC) at Georgetown University. The full text for the guide is available on the internet at www.georgetown.edu/research/gucdc/nccc/.

Health and human service organizations are recognizing the need to enhance services for culturally and linguistically diverse populations. Assessing organizational policies and structures—as well as the attitudes and practices of administrators and service providers—is a necessary, effective, and systematic way to plan for and incorporate cultural competence within an organization. Determining the needs, preferences and satisfaction of family members is another essential aspect of this process.

The National Center for Cultural Competence (NCCC) at Georgetown University supports the concept that cultural competence is a developmental process that evolves over an extended period. The ability to engage in self-assessment is one attribute of a culturally competent organization (Cross, Bazron, Dennis, & Isaacs, 1989). Conducting periodic self-assessment promotes awareness, knowledge, and skill acquisition that leads individuals and organizations to higher levels along the cultural competence continuum (Cross, et al.). The self-assessment process can lead to the development of a strategic organizational plan with clearly defined short-term and long-term goals, measurable objectives, identified fiscal and personnel resources, and enhanced consumer and community partnerships.

Self-assessment can also serve as a vehicle to measure outcomes for personnel, organizations, population groups, and the community at large. The NCCC views self-assessment as an ongoing process, not a one-time occurrence. Various self-assessment measures can capture information at one point in time, providing the organization with a “snapshot” of how things currently stand. With repeated use of such measures, organizations and their personnel have the opportunity to assess individual and collective progress over time.

The NCCC uses a set of values and principles to guide all of its self-assessment activities including the development of knowledge and products, dissemination, and the provision of technical assistance and consultation. The principles are as follows (*greater detail for each of these values can be found in the full text version of this article*):

- Self-assessment is a strengths-based model.
- A safe and non-judgmental environment is essential to the self-assessment process.
- A fundamental aspect of self-assessment is the assurance of meaningful involvement of consumers, community stakeholders, and key constituency groups.
- The results of self-assessment are used to enhance and build capacity.
- Diverse dissemination strategies are essential to the self-assessment process.

Useful Steps for Planning and Implementing Self-Assessment

The process of self-assessment is as important as the outcome. The NCCC has found the following steps to be very beneficial to the self-assessment processes it has conducted.

Cultivating Leadership. Leadership

roles in the self-assessment process should be filled by people representing all strata of an organization. These leaders must then be empowered to have meaningful input into decision making relative to the self-assessment process.

Getting “Buy-In.” Establish a shared vision that conveys the importance of the self-assessment process to the overall organization, its personnel, and the families and communities served. Doing so provides an important benefit to the self-assessment process: the formation of a coalition of stakeholders who are informed, and who are prepared to effect and sustain the envisioned improvements.

Building Community Partnerships. A major principle of cultural competence involves working in conjunction with natural and informal support and helping networks within diverse communities (Cross et al., 1989). From the inception of the self-assessment process, include community partners and key stakeholders in meaningful ways. It is important to recognize that individuals and groups will choose different levels of involvement and ways to participate. Examples of this range include serving on task forces or workgroups, participating in focus groups, making in-kind or financial contributions, subcontracting for specific services, or providing meeting facilities and other accommodations. It is essential to demonstrate that the contributions of each community partner are valued and respected.

Structuring Support for the Process. Convene a committee, work group, or task force that will assume responsibility for the self-assessment process. The group should have representation from policy-making bodies, administration, service delivery providers, consumers and other community

Measuring Client Perspectives on Cultural Competence

In many ways, consumer and family perspectives are central to efforts to assess the cultural competence of services and supports provided to children and families. Assessment of family perspectives is valuable in helping service providers, organizations, and systems determine needs and priorities for efforts to move towards the positive end of the cultural competence continuum (Cross, 1988). Of course, in efforts to develop culturally competent organizations, attention is often focused on areas which are not directly experienced by children and families; for example, recruiting more administrators from underrepresented minority populations, or changing the type and amount of training available to service providers. Nevertheless, it stands to reason that efforts to increase the cultural competence at the service, organization, and system levels should produce results that will be perceived by the children and families who are being served. Furthermore, in contrast to assessments that rely primarily on data gathered from staff members, measures of family perspectives are less likely to be distorted by political, social, and internal pressures to view providers and organizations as being at and/or progressing successfully towards high levels of cultural competence.

Over the last few years, a research team at the University of Pittsburgh has been working on an instrument to measure cultural competence from consumer and family perspectives (Switzer, Scholle, Jonson, & Kelleher, 1998). Designed for use in mental health services, this instrument has recently been field tested among families receiving services from Community Connections for Families, a System of Care intervention in Allegheny County, PA (Bell & Scholle, 2002). The Client Cultural Competence Inventory (CCCI) was developed through a process that incorporated information from focus groups with providers and families, interviews, and a review of relevant research literature.

The CCCI is administered via a structured interview. In the field test with Community Connections for Families, family members were asked to rate service coordinators by responding to items grouped into four sub-scales: respect for cultural differences, community and family involvement, appropriateness of assessment and treatment options, and agency services and structure. Results gave evidence of the tool's usefulness both in assessing cultural competence directly and in providing valuable informational input into a larger process of planning for continuous quality improvement.

The research team continues gathering data and refining the CCCI. They are seeking collaborations with communities or organizations that are interested in using the instrument and that are willing to share data so psychometric properties of the scale can be further investigated. For more information, contact Sara Hudson Scholle, Ph.D., Assistant Professor of Psychiatry at the University of Pittsburgh at (412) 624-1703 or scholles@pitt.edu.

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stakeholders. It should also reflect the diversity of the organization and the community at large. This group is the primary entity for planning and implementing the self-assessment process, and should have ready access to decision makers or have the ability to make decisions.

Allocating Personnel and Fiscal Resources. Conducting a self-assessment process is resource intensive, and it requires a dedicated budget. The process also makes significant demands on organizational personnel. Their responsibilities and time commitment should be clearly delineated, and their workload or duties may need to be deferred or reassigned. Similarly, the organization can support community partners and key stakeholders during their participation in the process by providing stipends or honoraria and reimbursement for travel, child care, and/or other expenses.

Managing Logistics. The ability to effectively coordinate numerous logistical tasks is vital to the self-assessment process. The task force or workgroup needs to ensure sufficient time is available to plan and prepare. The workgroup must also focus on developing a calendar and schedule of activities, and must disseminate information to workgroup members and other stakeholders in a timely manner.

Analyzing and Disseminating Data. The self-assessment process values the active involvement of all stakeholders in the collection, analysis, interpretation, presentation, and dissemination of data. This approach is commensurate with culturally competent and participatory action designs in research and evaluation (Brandt, et al., 1999; Caldwell, Tucker, Jackson & Bowman, 1999; Goode & Harrison, 2000).

Taking the Next Steps. The self-assessment process can yield a wealth of information about organizational strengths and areas for growth. Careful consideration should be given to

- establishing organizational priorities,
- developing a strategic plan with goals and objectives to sustain

- strengths and address growth areas,
- allocating necessary resources to accomplish strategic plan goals,
- sustaining and maintaining partnerships with community stakeholders, and
- incorporating self-assessment results into the state block grant planning and development process.

The self-assessment process may lead to changes in organizational mission, policies, structures and procedures; staffing patterns; position descriptions and personnel performance measures; delivery of service and supports; outreach and dissemination approaches; composition of advisory boards and committees; professional development and in-service training activities; and management and information and telecommunication systems. Achieving cultural competence is a long-term commitment. Remember that it is accomplished one step at a time.

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The National Center for Cultural Competence (NCCC) is affiliated with the Georgetown University Center for Child and Human Development. The



mission of the NCCC is to increase the capacity of health care and mental health programs to design, implement and evaluate culturally and linguistically competent service delivery systems. The NCCC conducts an array of activities to fulfill its mission including: (1) training, technical assistance and consultation; (2) networking, linkages and information exchange; and (3) knowledge and product development and dissemination. Get further information via telephone, 800-788-2066; e-mail, cultural@georgetown.edu; or <http://gucdc.georgetown.edu/nccc>.

A Concept Mapping Alternative

CULTURAL COMPETENCE ASSESSMENT IN SYSTEMS OF CARE

At a time when this country has become a reflection of a very diverse world, human service organizations are striving to develop culturally competent services, programs, and employees. It is estimated that, by the year 2005, 40% of the population of children and adolescents in this country will be of color (“Embracing the

Dynamics of Difference,” 1997). Historically, mental health services have not effectively addressed the needs of children of color and their families (U. S. Department of Health and Human Services, 2001; Hernandez & Isaacs, 1998). However, by including cultural competence as a key philosophical value, systems of care for children with

serious emotional disturbance and their families are bringing it to the forefront of service delivery systems.

A growing body of literature supports the system of care philosophy in asserting that cultural competence can increase the effectiveness of mental health services delivered to children and families of color in such ways as

increased consumer satisfaction and decreased rates of treatment dropout (U. S. Department of Health and Human Services, 2001; Sue & Sue, 1999). This article describes the efforts of one system of care, The Children’s Partnership in Austin, Texas, to create a vision of cultural competence for its community and to determine what was needed to move toward realizing that vision. The purpose of the assessment was twofold: (1) to provide the community with a baseline assessment and process for monitoring its development of cultural competence over time, and (2) to provide the community with information necessary for developing technical assistance and training plans to address issues related to cultural competence.

Cultural Competence Assessment

A framework for developing effective, culturally competent services for children of color who have an emotional disturbance was pioneered and presented by Cross, Bazron, Dennis and Issacs (1989). The framework provides a widely accepted definition of cultural competence and outlines five elements deemed essential in the development of a culturally competent system, agency or institution. Since that time a number of culturally focused frameworks, performance standards, and benchmark measures have been developed and are being disseminated (U.S. Department of Health and Human Services, 2001). In addition, there are several excellent guidebooks available to help individuals or organizations assess and enhance their cultural competence (e.g., Roizner, 1996).

While a number of instruments are available for developing, implementing and enhancing individual and organizational cultural competence, only a few instruments are specifically relevant to systems of care (for example, Child Welfare League of America, 2000; Cross, 1993; Hernandez, Gomez & Worthington, 2001; Mason, 1995). The assessment process described here was guided by system of care values and offers an

Figure 1. Point Cluster Map

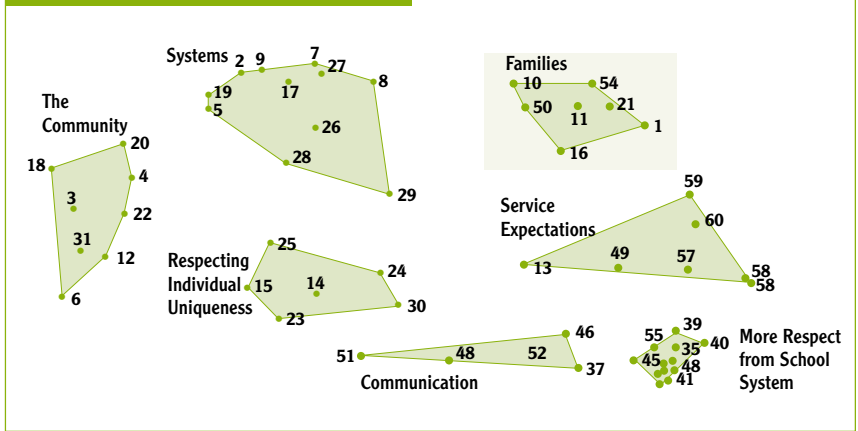


Table 1. Example of Cluster Statements

Focus Statement: Complete the following statement with an example: *I believe a level of cultural competence is achieved in a system of care when...*

Cluster 1: Families

53	Professionals are able to meet families’ unique needs.
54	Professionals take responsibility for addressing families’ needs.
1	The family team participates regardless of differences, is encouraged to participate, and participation is valued.
16	Families’ stories and space are respected and held in confidence.
21	Families feel the freedom to share information about cultural differences.
50	People are more careful and accurate about things that involve individual families.
11	Work with families raises the issue with families that cultural competence is an important value to embrace.
10	Families have access to opportunities to learn how to be culturally competent and value everybody.

innovative method for assessing cultural competence from multiple perspectives in a relatively short period of time. Findings from this study also suggest that Concept Mapping offers a means for systems of care to define, assess, and track cultural competence within a specific community’s context.

Method of Assessment

Families were involved in all facets of the assessment, including developing the focus statement, brainstorming responses to the focus statement, and sorting and prioritizing the responses. Their experiences with the

project varied based on their role with the Children’s Partnership system of care, yet all found the process beneficial in tailoring services to meet their unique needs.

The sample for this study included caregivers, youth, staff of various levels (direct service, administration, board members), and providers in one Center for Mental Health Services’ system of care grant community. A total of 24 people participated in the assessment. Of this number, 17 participant responses are included in the sorting results and 18 participant responses are included in the rating results.

The method of assessment chosen for the study was Concept Mapping as developed by Concept Systems, Inc. (Trochim, 1989). Concept Mapping uses a participatory and collaborative approach to gather input from many people. A total of 60 statements were gathered from participants through group and one-on-one discussions describing participants' ideas of a culturally competent system of care. Individual participants then sorted the statements into piles in a way that made conceptual sense to them and gave each pile a label. They then rated each statement on two criteria: importance of the statement and how often the statement was demonstrated in the community's system of care. In addition, staff and board participants rated each statement on its level of inclusion in the current written policies of organizations participating in the system of care. The sorting and rating information was used to generate conceptual maps and comparisons between groups. After initial analysis by the research team, an interpretation session was held with participants to discuss and interpret the results. Together, participants and the research team decided on the number of clusters and cluster label assignments for the final maps.

Results and Discussion

Figure 1 illustrates the 7-cluster map solution chosen by participants to represent the information gathered. The names of the clusters, chosen by participants, provide an indication of the area of cultural competence described by the cluster statements. The statements (indicated on the map by number) in each of the clusters offer concrete examples of what a culturally competent system of care would look like, as described by participants in this particular system of care community. Table 1 provides an example of the statements in one of the map's clusters, Families.

Overall, participant ratings indicate very high levels of importance (4.20-4.58 on a 1-5 scale) and lower levels of demonstration (2.52-3.33 on a 1-5

scale) for all statements in the clusters. On importance, statements in the Families cluster were rated the highest, and statements in the More Respect from the School System cluster were rated the lowest. On frequency of demonstration ratings, statements in the Service Expectations and Communication clusters were rated the highest, and statements in the Systems and Community clusters were rated the lowest.

A low level of consistency was found between how participants rank ordered clusters on importance and frequency of demonstration ($r = .16$ —the closer the r is to 1.0, the more consistency there is between two rankings of the clusters). Although statements in the Families cluster were ranked as most important, participants ranked the cluster third in frequency of demonstration. There were also differences between some of the participant subgroups in how they rated importance and demonstration of the statements. The family and staff groups demonstrated moderate agreement on importance rankings ($r = .47$) and strong agreement on demonstration rankings ($r = .79$). Comparisons between the people of color and White/European groups indicated a low level of agreement on the ranking of cluster importance ($r = .30$), but these two groups strongly agreed in rankings of demonstration ($r = .84$). There were other notable differences:

- Ratings by the family and people of color groups were identical for frequency of demonstration and opposite of the staff /non-family board group.
- The White/European group rated the Respecting Individual Uniqueness cluster as its top priority; that cluster ranked next to last in importance for the people of color group.
- The people of color group rated the Families cluster as its first priority, as did all other groups except the White/European group which ranked it second.
- The White/European group placed the Families cluster as second most demonstrated, while all other

groups ranked it third.

- The people of color group rated every cluster except Communication as less often reflected in policies than did the White/European group.
- Responses from staff and board members indicated a substantial lack of knowledge about organizations' policies related to cultural competence.

Recommendations for Technical Assistance and Training

Findings from the evaluation suggested a number of implications for technical assistance and training. The differences between group ratings offer helpful measures for determining cultural competence goals for the system of care and related training needed to reach those goals. Changes in cluster ratings can be tracked over time. An increase in the frequency of demonstration ratings would suggest that the level of cultural competence (as defined by participants) is improving. As gaps between cluster levels of demonstration and their respective levels of perceived importance begin to narrow, indications for improved competence in those specific areas are provided.

Following are some examples of how findings among the clusters were translated into identified training needs.

- **The Community:** Develop opportunities for the system of care to become more familiar with the community/neighborhood cultures of families targeted for services.
- **Families, Service Expectations, and Communication:** Develop training around individualizing services, confidentiality, provider skills for engaging families in discussions around cultural issues, and expectations regarding accessibility to families.
- **Systems:** Develop policies related to cultural competence and monitor how policies are put into practice (e.g., tying policies into performance measurement). Provide cross-agency training to all system of care stakeholders related to



agencies' policies, norms, and expectations.

Summary

Results from this evaluation suggest that Concept Mapping is a useful process for systems of care in developing community-specific visions for cultural competence. The findings further suggest that the method is useful for establishing a baseline for tracking cultural competence development over time. The statements generated by participants offer concrete information for developing technical assistance and training plans around issues of cultural competence.

The inherent nature of cultural competence demands individualization at the family, organizational, and community levels. The Concept Mapping methodology offers a unique way of gathering data from many individuals that can then be analyzed across multiple levels of a community's system of care. This study successfully integrated the participatory principles and values of systems of care philosophy in its planning, implementation, and reporting design.

Acknowledgments

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CAREGIVERS' PERSPECTIVES ON CULTURAL COMPETENCE

The Research and Training Center on Family Support and Children's Mental Health recently reported on research that focused on caregivers' perspectives on the cultural competence of services provided to their children, who were diagnosed with emotional or behavioral disorders (Walker, 2000; Walker, 2001). Our research study relied primarily on an analysis of caregivers' own descriptions of specific occasions when they experienced satisfaction or dissatisfaction with the extent to which respect for the family's beliefs and values was demonstrated. We asked specifically about the extent to which providers demonstrated respect during assessment, during the development of service plans, and during the course of services and activities provided to the child and family.

Results from our study highlight similarities and differences between and among members of different ethnic communities regarding satisfaction and dissatisfaction with the cultural competence of services. The study also provides specific information and examples about what goes wrong—and what goes right—when families and children interact with service providers and systems. Finally, our study also provides some insight into the major themes that are blended together in caregivers' own definitions of “culture.”

The Study

Data for the study were collected from 286 caregivers (90% female) whose children (6 to 18 years old, mean 11.9) had emotional or behavioral disorders. Children were primarily White (67%), with 22% being African American, 9% Native American, and 3% from other races. In addition to open-ended questions ask-

ing about specific occasions of satisfaction and dissatisfaction, the interview included questions asking caregivers to rate how important they thought it was for their culture to be considered in the service plan, and the extent to which their culture had been taken into account in the services and activities provided under the plan. Caregivers also provided information about their educational background, household income, and overall satisfaction with services.

Results revealed that 82% of respondents viewed culture to be of at least moderate importance in designing service plans. African American families were significantly more likely to rate this as an important issue as compared to Caucasian caregivers (100% as compared to 80%). Forty-seven percent of caregivers indicated that culture had indeed been taken into account in the design of their own child's service plan, with no differences between racial groups.

Responses to the open-ended questions were coded into five broad categories (community or ethnic values, religious values, parenting values, respect for child, and respect for caregiver), with several subcategories. Data were coded to reflect whether caregivers expressed satisfaction or dissatisfaction within each category. Analysis of satisfaction/dissatisfaction by race showed that African American and Native American caregivers offered significantly more examples of both satisfaction and dissatisfaction in the “community or ethnic values” category than did Caucasian caregivers. Although both African American and Native American caregivers reported a fairly high percentage of comments indicating satisfaction with cultural competence in the “community or ethnic values” cat-

egory (35% and approximately 25% respectively), more expressed dissatisfaction. Further analysis of subcategories within the community or ethnic values category revealed that African American and Native American caregivers were dissatisfied with the lack of ethnic-targeted programs, scarcity of therapists from their own racial group, and service providers' lack of understanding of cultural norms. Significant differences were found between Caucasian and African American caregivers in the “strict discipline” subcategory of parenting values. Specifically, African American caregivers more often expressed the specific dissatisfaction that service providers were too lenient in the discipline they prescribed or used, or that they unfairly condemned caregivers for using forms of discipline that were strict.

Interestingly, level of formal schooling, employment status, and single parenthood were not related to levels of satisfaction or dissatisfaction. However, caregivers with low household incomes were significantly more likely to report dissatisfaction with the extent to which they felt respected by service providers. In fact, our analyses showed that caregivers from low-income households were almost three times more likely than other caregivers (19% versus 7%) to talk about a specific incident during which they had felt personally disrespected.

An additional analysis examined whether being dissatisfied in the area of cultural competence would be associated with caregivers' overall satisfaction with services. Controlling for problem severity and family participation in planning, results revealed that overall satisfaction was not related to caregiver minority/majority status. However, an interaction effect

revealed that satisfaction with services was significantly lower for minority caregivers who had expressed dissatisfaction in the community or ethnic values category. Both minority and majority caregivers were significantly less satisfied with services if the caregiver was kin of the child (as opposed to a foster parent) and/or if the caregiver expressed any type of dissatisfaction related to cultural competence of services.

Conclusions: Caregivers say that...

...there is some success in the provision of culturally competent services.

Results from our study show that about half of caregivers—regardless of race, education, or other personal variables—felt that service providers had done at least a fairly good job in respecting their cultural values during treatment planning and service delivery. What is more, over one third of minority caregivers gave specific examples of ways that their community or ethnic values had been respected by service providers.

...more providers need to see caregivers as capably parenting unique children.

More than a quarter of all caregivers expressed concern that providers failed to see each child as a unique individual, not just a syndrome, a label, or a problem. About a quarter of caregivers also said that service providers failed to appreciate caregivers' knowledge of their children, and caregivers' ability to parent effectively. On the other hand, 28% of caregivers expressed satisfaction with the extent to which service providers did appreciate the children as individuals, while only 10% noted that providers saw caregivers as capable parents.

...there are many ways in which services are not respectful of the beliefs and values of children and caregivers from minority communities.

Close to half of minority family caregivers described specific ways that their community or ethnic values were disrespected by service providers. The

results reinforce the words of minority caregivers who emphasized:

[Providers] in general could be more sensitive and conscious of the struggles with racism in this culture. Don't say, "Just put it behind you." That does not validate the reality of what people of color experience with racial prejudice.

...providing culturally appropriate services is more difficult than just following a recipe.

Caregivers' voices emphasize that not all minority families want or need the same kinds of services. For example, some caregivers said that children from minority cultures needed therapists from the same background, or that they needed targeted programs to support their culture. At the same time, other minority caregivers insisted that the best services were those that were "color-blind" and treated all children the same.

This study indicates that service providers need to develop their understanding of the values, norms, and ways of life typical of different communities and cultures. At the same time, providers also need to be able to see people as individuals who reflect culture and community in unique ways. Promising research in cultural competence suggests that an important first step is for families and providers to work together to define their goals, how the goals can best be achieved, and how they can resolve disagreements when they arise (Sue, 1998).

... providers need to work with caregivers more flexibly around issues of discipline.

Caregivers—particularly African American caregivers—were also dissatisfied with providers' ideas about discipline. In particular, many caregivers felt that providers were too lenient with discipline in general, and also too rigid in their belief that physical punishment was never appropriate. Caregivers in this study pointed out that there is a difference between spanking (or other physical punishment) and abuse, and they voiced a

belief that there were times when physical punishment was necessary. There is clearly a need for providers to be more flexible in working with caregivers around issues of discipline.

...providers need to understand the additional burdens that come with having limited income.

Almost one in five low-income caregivers described ways in which service providers had disrespected them, viewing them, for example, as "lazy", or "losers" or "trash." Caregivers' words tell us that many service providers are not sensitive to the ways that having limited income places multiple additional burdens on caregivers as they interact with the mental health system. Caregivers indicate a serious need for more attention to this issue, not just by increasing provider sensitivity, but also by finding ways to offer services and supports in ways which do not end up actually increasing the stresses faced by families with limited economic resources.

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