DEVELOPING CULTURALLY COMPETENT ORGANIZATIONS

There is an increasing awareness of the role culture plays in the delivery of health and human services (10, 30, 32). One recent response in the area of children's mental health has been the emergence of the Child and Adolescent Service System Program's (CASSP's) cultural competence model. This concept emerged as a response to the goal of providing culturally-appropriate services to children with mental, emotional or behavioral disorders and their families (18). The emergence of the cultural competence construct recognizes: (a) the increasing cultural and racial diversity of consumer populations (28); (b) the role culture plays in help-seeking behaviors (10, 23, 25); (c) the differential service utilization rates of various cultural and racial groups (8, 22, 31); (d) diverse perspectives on the origins or etiology of behaviors, emotions or thoughts that the dominant culture describes as mental health problems (14, 32) and, (e) culturally relevant services may differ from services that ignore cultural differences (9, 27, 29, 34).

Identifying the Target Population

One important concern involves the target of the agency's interventions. It is of little use to identify an agency's target population as the minority community. The word "minority" has been so bandied about in recent years that it has lost some meaning. Is the reference to members of the *cultural groups of color*—African Americans? Asian Americans/Pacific Islanders? Native Americans? Hispanic- or Latino-Americans? Alternatively, Atkinson and Hackett (1) use the term *non-ethnic cultural groups* to refer to other minority populations such as lesbians and gays, elders, women, people with disabilities, religious minorities, and others.

While cultural groups of color and non-ethnic cultural groups share some common ground, the distinctions between the two in terms of respective vulnerabilities is little understood. However, what is critical is that systems and organizations should specify who is the target of a given multicultural or minority initiative. Mixing the two groups may result in an initiative that serves neither well and ultimately deflates the concern for cultural diversity. In any event, differences *between* and *within* cultural groups of color and non-ethnic cultural groups must be considered.

For example, ethnic groups of color have historically been at the bottom of the economic, social, and political order. They are represented in disproportionate numbers among the poor, the uneducated, the unemployed, the sick, and the homeless (14). The U.S. President's Commission on Mental Health observed that children and youth of color were particularly at risk because of low socioeconomic status, residence in stressful environments, and lack of access to mental health services. Arguably, these conditions have not abated, and these children and youth are still vulnerable by virtue of their ethnicity, poverty, and social isolation (6). Other factors worthy of both consideration and assessment include educational attainment, teenage pregnancy, suicide, substance abuse, and out-of-home placements including psychiatric and juvenile detention facilities.

It is projected that children of color will approximate 30% of the nation's youth by the year 2000 (28) which heralds many challenges. However, one must endeavor to find good information as to how to serve these populations. The motivation or value base to modify systems must also be developed. Ozawa (26) suggests the populations create an imperative that requires service system modification from the middle-class service orientation; Hodgkinson (15) ties the rationale for the changes to the professional's self-interest; and Cross, et al. (4) enumerate a list of systemic values that support such system changes.

Children and youth who are non-ethnic minorities *with* disabilities, *or* lesbian and gay, *or* poor, *or* female, of the dominant culture have different sets of issues to deal with than their peers who—respectively—to not have disabilities, are heterosexual, or are middle class, however, they *may* still derive the benefits of being

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"white" (12). Therefore, agency staff must attempt to discern how a given group is vulnerable in American society. By taking a broad-brush approach, agency efforts to improve services to culturally diverse groups (whether groups of color or non-ethnic groups) can be bogged down. Certainly some agency efforts will involve coalitions around overlapping issues, and culturally-specific approaches for problems facing a specific group.

As mentioned above, it is also important to pay attention to within-group diversity (27, 28, 32). The typical terms used to describe the four groups of color reveal very little in terms of important characteristics such as income, education, cultural identity, national origin, or social history. Agencies must avoid the propensity to re-stereotype the various groups based on new information that may reflect only upon a subset of a given group—for example—working class but not middle class Hispanics, urban and not reservation Native Americans, or refugee and not immigrant Asians. While the distinctions appear minor, they can be quite significant when providing services, advocating on behalf of a given systemic changes.

On an ongoing basis it is important for agencies to stay abreast of changing demographics (28), ecological perspectives of problems and solutions (14), and the corresponding quality of life indicators (e.g., infant mortality, educational attainment, employment rates) by each cultural group. This is particularly relevant where agencies pursue community education, program development, or class advocacy efforts. When agencies and systems advocate on behalf of a given community for the necessary changes that will empower diverse communities they must pay attention to the environmental or psychosocial stress that befall specific groups (17).

For example, the provision of mental health treatment is made difficult when children and their families are hungry, cold, besieged by urban crime, or are poorly portrayed in media accounts (6). Over-representation of children and youth of color in more restrictive settings is an issue (4, 18, 19). These circumstances highlight potential areas where agencies can play a viable role in community empowerment. Such efforts should be conducted in a spirit of collaboration and not well-intentioned yet inadvertent paternalism. A key goal is to develop leadership and self-determination as opposed to community dependence on external voices and leaders.

The Importance of Developing a Value Base

It is critical for the members of any given agency or system to know *why* they are embarking on the path towards cultural competence. The decision to move in this direction should not be solely a response to political correctness, or a marketing ploy to enhance utilization, or to comply with the requirements of an accrediting or funding body. The decision to proceed in this direction should be collaborative effort-involving group-specific natural helpers and leaders, parents and family members, and advocates-4o empower children, youth, families, and communities of color. Moreover, staff must recognize culture as a force in how problems are defined, including attribution of cause (10, 32), help-seeking (9, 23), how credible providers and services are defined (25, 34), and even how services are evaluated (29). As a beginning step, Woody (33) outlines the following self-assessment questions concerned with developing a rationale for cultural competence:

1. What is the organization's responsibility in meeting the service needs of minorities? This area of self-study is the organizational foundation that moves an organization towards cultural competence. It is here that the respective target groups are identified. Additional discussions will establish for agency staff why it is focusing on cultural diversity and will simultaneously send a message to the community. It is at this phase that mission or goal statements and hiring or outreach policies may be revised. Similarly, the organization's advocacy strategies may shift. It is also an appropriate time to involve, or at least update, board members, volunteers, and program advocates. To build such a framework, agency personnel (including board members and volunteers) may need to be made aware of: cultural differences as they concern changing demographics and demographic differentials between majority and non-majority cultures (28); culturally-specific perspectives of illness and health (10); culturally-specific program characteristics and components (17); and research concerning service delivery to culturally diverse communities (25, 29, 34).

2. How can the presence of minority and majority workers who are skilled in providing services to minority populations help an organization accomplish its mission? The benefits of culturally competent staff and agencies should be delineated in terms of their impact upon clients, professionals, the diverse communities and the community-at-large. This question invites sharing among staff in the form of brown bag discussions, sharing of cross-cultural insights, and generally using the often overlooked human resources of

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a given agency or system. Bear in mind that cultural competence is a developmental process based upon the belief that all individuals can make progress with proper instruction, support and rewards. Further, this area is very sensitive as many members of the dominant community are convinced that hiring diverse staff threatens their employment security. Moreover, existing staff may view new staff as less competent and hired to fill a quota requirement (7, 33). Win-win scenarios must be developed and widely disseminated. While workers' apprehension about being displaced must be addressed—from an organizational change perspective—administrators, staff, and others must see the mutual benefits that can be derived from a diverse work force and a work environment conducive to diversity.

3. How might services necessarily be different when provided in an appropriate context to the minority community? This question recognizes that different groups may have slightly different needs. It may be appropriate for some groups to provide services in satellite offices (25, 34) and, for other groups, services may be provided in other languages (10). It may be necessary with some groups to work to overcome a history of distrust (32), while others may require class- or system-advocacy efforts (6, 19). Generally, this is an opportune time to involve knowledgeable members of the various communities who can assist in developing a rationale for identifying group-specific needs and prospective interventions (16, 17). Once enlisted in the initial phases of activity, it is likely that these local key informants may be more willing to offer their support to the process. This is also a critical period to involve parents and family members who are often the most under-utilized resource (2).

4. What is the vision `of services to the minority community? This is an opportunity to design system or organizational refinements. It is particularly important to involve members of the diverse communities in creating the vision. This is the key opportunity to both envision the system as it should be and to identify ways of funding such a system. Moreover, by involving natural helpers and leaders, parents and family members, key informants, and others, community-based supports and resources may be brought to bear. This may also yield greater support for the program in various ways such as: assisting with staff and board recruitment, encouraging in-kind donations, identifying advocacy resources, and promoting parent or community education and support groups.

This is a time to consider the concept of "culture" quite broadly. Accordingly, the planning group should have as members representatives of the targeted groups. Cultural diversity within a given group should be strongly considered. For example, it is hard for one member of any group to represent the wide range of beliefs, practices, and customs within that group. Empowering members of a specific cultural group to help envision or otherwise design system improvements should result in greater relevance of services and service delivery approaches. Thus, if the target populations are groups of color, they may be a majority of the planning body. To use existing personnel with a few minorities sprinkled in may hint at tokenism. Similarly, simply identifying people of color may not be a guarantee that they represent or are aware of the cogent cultural issues. Hence, selecting cultural key informants for this process is a time-consuming yet critical step. Certainly parents, family members, and consumers need to be involved.

Attention to group processes such as problem-solving, decision-making, and conflict management is critical during this phase (35). A good group can be decimated by internal differences that remain unaddressed or by friction with other work groups that is ignored. Work with groups is often difficult. While diversity is a strength, untended, it can be a strain. Anti-bias and subsequently cultural competence training may be a primary activity that facilitates positive interaction among group members as well as ensures that interaction with other groups is respectful in nature.

5. How can one know if the goal of serving minority clients has been achieved? This remains the ultimate question for the cultural competence concept. As agency staff begin to develop plans, they must simultaneously identify measurable goals and objectives (24). Goals or milestones can be designed in measurable, incremental phases. While there are few standardized tools to measure cultural competency (5,14, 21), staff can review those that are available and adapt them as necessary to meet agency needs. Task forces or work groups can be convened to review emerging scales and measures that might be used or adapted for more quantitative analysis. Exit interviews, focus groups, and consumer satisfaction measures may be employed to generate an initial data set that can be reassessed overtime to discern where the program has grown and where additional growth is needed.

The Cultural Competence Model: Planning Issues and Implications

Several areas of knowledge have been developed with respect to the CASSP cultural competence model.

The theoretical foundation for the model is set forth in the monograph, *Towards a Culturally Competent System of Care* (4). A second monograph, *Towards a Culturally Competent System of Care: Programs Which Utilize Culturally Competent Principles* (17), identifies and describes several programs that exemplify various aspects of the model. As the latter publication demonstrates, there is no single approach to developing cultural competence. Even when the cultural group and service discipline are identical, programming may vary from site to site.

There are five basic principles that undergird the cultural competence model, namely: Valuing Diversity, Conducting a Self-Assessment, Understanding the Dynamics of Difference, and Adapting to Diversity. These principles undergird the model and its application. Contained within the Adapting to Diversity principles are the following four primary elements: (a) attitudes; (b) practices; (c) policies; and (d) structures (4).

Attitudes refers to the thoughts, beliefs, and biases people have as they regard culturally diverse groups. This area responds to the issue that many people have been negatively influenced by news media accounts, public education and social learning, and cultural conveyances (movies, books, jokes, folklore) about culturally diverse groups. As a result, deficit models with respect to ethnic groups of color have resulted in very negative biases about the respective realities faced by groups of color (10). Shedding these biases is very hard even for the most well intentioned individual. Often people are very unaware of their own cultural and racial biases, yet they must be acknowledged in order to be supplanted with cultural strengths perspectives. This element typically comes in the form of cultural sensitivity and awareness models, also some of the emerging anti-bias models can help set the foundation for learning more about cultural competence.

The **practices** element concerns clinical skills such as assessment, treatment planning, resource development, outreach, and advocacy for direct service staff; while for administrative personnel it will concern such things as recruitment and retention, networking with leaders from diverse communities, conflict management and mediation, program development, staff and board development, and program implementation and evaluation. The rapidly growing body of knowledge in the theoretical and research literature regarding service delivery practices for culturally diverse populations should prove helpful. With respect to this dimension, there exist two under-tapped resources that can be very helpful to consult: (a) research and theory describing programs that exemplify aspects of the cultural competence model (17), and (b) key informants such as consumers, family members, and parents of children with emotional or behavioral disabilities (20).

The **policy** element is an often overlooked-yet very important area. While many programs have culturally competent characteristics, these may not be supported by policy. Given the possibility of budget cutbacks, staff turnover, or other occurrences, it is important that good practice become routinized by virtue of policy. Examples include such things as mission statements, program goals, hiring practices, outreach and advocacy efforts. Culturally competent staff attitudes and program practices need to be upheld by policy lest they ebb and flow on the trends of the times.

The **structure** aspect of the model is twofold: (a) it refers to the diversity and cultural competence of the agency's governing structures (e.g., board advisors, directors, consultants, and policy- or decision-making bodies generally); and (b) considers the cultural appropriateness of the physical plant (i.e., in terms of access, artwork and office decor, program name, location, even what is available in the waiting room to read).

Hence, cultural competence is a set of congruent attitudes, practices, policies, and structures that come together in a system or agency and enable professionals to work more effectively in cross-cultural situations. The model is best viewed in the context of a continuum with a negative and a positive pole. Because the model is developmental in nature, organizations must continually strive to work towards the positive end of the continuum with respect to specific populations. Moreover, since culture is a dynamic phenomenon and subject to change, arriving at the most positive end of the continuum is an ideal state requiring a lifelong commitment. The caveat, however, is that an organization's staff may be proficient with one given cultural group but may need to work on enhancing their abilities to work with emerging or other existing groups within their catchment area. Similarly, agencies with demonstrated credibility with a given population may need to consider the varying contexts in which group members reside. For example, programs that effectively serve Latinos in Houston may not be appropriate for serving Latinos in Omaha or Miami. Other considerations include such factors as national origin, socioeconomic status, social history, rural/urban continuum, levels of assimilation and acculturation. Simply put, the racial categories currently used often lack the necessary details to comprehend and effectively meet the needs of children, youth, and their families.

Planning Implications

In efforts to move an organization towards the positive end of the spectrum, staff must: (a) identify the target of the change efforts (e.g., one specific cultural group, groups of color, non-ethnic cultural groups, or others); (b) assess their cross-cultural training needs; (c) identify barriers to serving the identified groups effectively; (d) develop goals and implementation steps for achieving them; and (e) develop approaches for measuring success. Diversity should be considered in all aspects of the organization-not just clinical practice. Certainly parents and family members of children and youth of color who have serious emotional disabilities are an underutilized resource. Additional resources include natural helpers, elders, clan and tribal leaders, and members of spiritual communities.

Timing is important. Since planning groups need to References have some sense of accomplishment to sustain momentum and interest, tasks should be: identified as short-, medium or long-term in duration; divided into manageable incremental steps; and, described in terms of whether personal or organizational resources are needed. The persons responsible for specific tasks should be identified and the methods for measuring progress should be carefully delineated. As much as possible, local communities should be involved and empowered to have influence into a process which is ultimately for their benefit.

Conclusion

There are many culturally-informed service delivery models emerging in various fields. Most contemporary models are concerned with more than worker cognition of differences. Therefore, any approach adopted should include a focus on organizational attitudes, policies, and structures. The target population needs to be identified and barriers to effective service delivery addressed (language, access, trust, lack of diverse staff); environmental stressors should also be explored and ways to mitigate against such factors considered (e.g. poverty (6), institutional bias or racism (16)) culminating in a sense of mutual benefit; and, a value base for why this is being developed should be disseminated. In particular, this information should be widely disseminated to staff, volunteers, board members, and relevant members of the targeted community. Planning should be conducted in a spirit of collaboration utilizing as many culturally- or community-based resources as possible. The possibility of subcontracting with indigenous people may be an initial way of creating a symbiotic relationship (27). Lastly, one should recognize the years of mis-education with respect to diversity and how many services delivered to groups of color are steeped in deficit models (10, 27, 32).

There is enough work to go around. While much of the work in cross-cultural service delivery has focused upon clinical interventions, additional work is heeded in such areas as: management information systems, recruitment and retention of diverse staff, community education and advocacy strategies, outreach techniques, and fund raising approaches. Ultimately, society will change and become darker in complexion. The challenges facing contemporary human service professionals are vast; however, so are the benefits to the children and youth with serious emotional disabilities, their families, and their communities.

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1. Atkinson, D.R. & Hackett, G. (Eds.) (1988). *Counseling non-ethnic minorities.* Springfield, IL: Charles C. Thomas.
2. Carrasquillo, A. (1986). The parent fade in reading language skills to English proficient learning disabled students Willig & H.F. Greenburg (Eds.), *Bilingualism and learning disabilities: Policy and practice for teachers and administrators*, (pp. 53-68). New York: American Library Publishing Co.
3. Chin, J.L. (1983). Diagnostic considerations in working with Asian Americans. *American Journal of Orthopsychiatry*, 53(1), I00-109.
4. Cross, T.L., Bazron, B., Isaacs, M.; Dennis, K. (1989). *Towards a culturally competent system of care. A monograph on effective service for minority children who are severely emotionally disturbed*. Vol. l. Washington, D.C.: Georgetown University Child Development Center, CASSP Technical Assistance Center.
5. D'Andrea, M. & Heck, R. (1991). Evaluating the impact of multicultural counseling training. *Journal of Counseling do Development*. 70, 143-150.
6. Edelman, M.W. (1987). *Families in peril: An agenda for social change*. Cambridge, MA: Harvard University Press.
7. Fernandez, J.P. (1991*). Managing a diverse workforce*. Lexington, MA: Lexington Books.
8. Flackerud, J.H. (1986). Diagnostic treatment differences among five ethnic groups. *Psychological Report*, 58(1), 219-235.

9. Guy, L.E. (1987). Attitudes of black adult- toward community mental health centers. *Hospital and Community Psychiatry*, 38(10), 1100-1 105
10. Green, J.W. (1982). *Cultural awareness in the human service*. Englewood Cliffs, NJ.: Prentice-Hill, Ins.
11. Grier, W., do Cobbs, D. (1968). *Black rage*. New York: Basics Books.
12. Hacker, A. (1992). *Two nations: Black and white, separate, hostile, unequal*. New York: Charles Scribner's Sons.
13. Ho, M.K. (1987). *Family therapy with ethnic minorities*. Newbury Park, CA: Sage Publications.
14. Ho, M.K. (1992*). Minority children and adolescents in therapy*. Newbury Park, CA: Sage Publications.
15. Hodgkinson, H. (1990, May). Non-white demographics. A speedy delivered at the Second Annual Conference on Racial and Ethnic Violence on Campus, Norman, Oklahoma. In M.K. Ho, *Minority children oral adolescents in therapy*. Newbury Park, CA: Sage Publications.
16. Isaacs, M. (1986). *Developing mental health programs for minority youth and their families*. Washington, D.C.: Georgetown University Child Development Center, CASSP Technical Assistance Center.
17. Isaacs, M.R. & Benjamin, M.P. (1991). *Towards a culturally competent system of care. Vol. II* Washington, D.C.: Georgetown University Child Development Center, CASSP Technical Assistance Center.
18. Katz-Leavy, J., Lourie, L, Kaufmann, R. (1987). Meeting the mental health needs of minority children and adolescents with severe emotional disabilities: A national perspective. *Children Today*, 16(5), 10-14.
19. Knitter, J. (1982). *Unclaimed children: The failure of public responsibility to children and adolescents in need of mental health services*. Washington, D.C.: Children's Defense Fund.
20. Lynch, E.W. & Stein, R.C. (1987). *Parent participation by ethnicity: A comparison of Hispanic, black, and anglo families*. Exceptional Children, 54(2), 105-111.
21. Mason J.L. (1988). Revisiting the ethnic dilemma. *Focal Point* 3(1). Portland, OR: Research and Training Center on Family Support and Children's Mental Health, pp. 4-5.
22. Meinirardt, K. & Vega, W. (1987). A method for estimating underutilization of mental health services by ethnic groups. *Hospital & Community Psychiatry*, 38(l 1), 1186-1190.
23. Neighbors, H.W. & Taylor, RJ. (1985). The use of social service agencies among black Americans. *Social Service Review*, 59, 258-268.
24. Orlandi, M. (Ed.) (1992). *Cultural competence for evaluators. A guide for alcohol and other drug abuse prevention practitioners working with ethnic/racial communities*. Rockville, MD: Office for Substance Abate Prevention, U.S. Department of Health and Human Services.
25. Owan, T.C. (1982). Neighborhood-based mental health: An approach to overcome inequities in mental health services delivery to racial and ethnic minorities. In D.E. Biegel & A.J. Naparstek. (Eds), *Community support systems and mental health: Practice, policy, and research*, (pp. 282-300). New York: Springer Publishing Co.
26. Ozawa, M. (1986). Non-whites and the demographic imperative in social welfare spending. *Social Work*, 31, 440-446.
27. Pinderhuges, E.B. (1989). *Understanding race, ethnicity, and power: The key to efficacy in clinical practice*. New York: Free Press.
28. Ponterotto, J.G. & Casas, J.M. (1991). *Handbook of racial/ethnic minority counseling research.* Illinois: Charles C. Thomas.
29. Slaughter, D.T. (1988). Programs for racially and ethnically diverse American families: Some critical issues. In H.B. Weiss & F.H. Jacobs (Eds.). *Evaluating family programs*, (pp.461-476). New York: Aldine De Gruyter.
30. Solomon, B.B. (1976). *Black empowerment*. New York: Columbia University Press.
31. Solomon, P. (1987). Racial factors in mental health service utilization*. Psychosocial Rehabilitation Journal*, 11(2), 3-12.
32. Sue, D.W. & Sue, D. (1990). *Counseling the culturally different: Theory and practice*. (2nd ed.). New York: John Wiley & Sons, Inc.
33. Woody, D.L. (1992). *Recruitment and retention of minority workers in mental health programs*. Washington, D.C., National Institute of Mental Health, Human Resource Development Program.
34. Zane, et al. (1982). Service system models for ethnic minorities. In D.E. Biegel & A.J. Naparstek (Eds.), *Community support systems and mental health: Practice policy, and research*, (pp.229-257). New York: Springer Publishing Co.
35. Zastrow, C. (1985). *Social work with groups*. Chicago, IL: Nelson-Hall Publishers.

Cultural Competence Self-Assessment Questionnaire

Minority Cultural Initiative Project staff at the Portland Research and Training Center developed the Cultural Competence Self-Assessment Questionnaire (CCSAQ) to assess cross-cultural training in human service agencies. The goal is to help social and human services agencies continue movement toward the positive end of the cultural competence continuum. A great deal of information has been learned since this document was first mentioned (Focal Point, Summer 1998, 2(4), p. 6) and, as a result, this tool has undergone several significant changes.

The tool involves an agency-based process of identifying training needs, and based on theses needs, developing site-specific training or other interventions that enhance cultural competence. The CCSAQ also contains a sheet to collect demographic data on a given work force. Once this information is collected and aggregated, agencies often discover hidden cross-cultural attribute or experience of their staff. For sample, agencies might take advantage of this in-house resource to learn more about diverse languages, communication styles, belief systems, religions and other cultural information.

The CCSAQ was designed for programs that serve children and youth who have serious emotional disabilities. The questionnaire has been field-tested at various levels and among different service disciplines in widely diverse sites across the country. Various sties have used the tool including: a western state mental health division management team, a mid-western state multi-service agency (containing mental health and child welfare programs), a county juvenile justice system in a western state, an eastern region child and adolescent mental health system, a southern state mental health bureaucracy, and a county mental health system in a northeastern state. In all instances, however, the assessment goal was to improve services to ethnic groups of color and other culturally diverse populations. The CCSAQ has also proven useful in workshops and consultation meeting in various states including: California, New York, North Carolina, Oregon, Pennsylvanian and Washington.

Preliminary assessment of the CCSAQ's psychometric properties has been very encouraging; the instrument will continue to be refined. Given the great demand for the CCSAQ from various systems, it will be published this fall complete with guidelines outlining its use. The tool allows an agency to measure its growth over time. Thus, by comparing pre-and post-measure, an agency can view how it has grown and in which areas continued growth is still nodded. This is particularly important because achieving cultural competence involves a developmental process designed around the belief that given proper instruction, support and motivation agencies and professionals can change.

There are two versions of the questionnaire: one version for administrative personnel and the other version for direct service staff. Project staff have field-tested a version for consumers and family member and one for non-paid staff (e.g., board members, volunteer, advocates). While the initial response are encouraging, these latter tools will not be published until further testing of psychometric properties is completed.

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