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**Viability of Concept Mapping for Assessing Cultural Competence in  
Children's Mental Health Systems of Care:  
A Comparison of Theoretical and Community Conceptualizations**

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**Viability of Concept Mapping for Assessing Cultural Competence in  
Children's Mental Health Systems of Care:  
A Comparison of Theoretical and Community Conceptualizations**

by

**Tamara Sue Davis, B.S.G., M.S.S.W.**

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## **DEDICATION**

As each of us enters this complex world, those who shape our existence dream about the people we will become. When our uniquenesses evolve into convictions that contrast with those of our models, we are often bewildered by our differences. So it is to whom this dissertation is dedicated. I offer this work in memory of my father, Marvin Dale Davis, my surviving mother, Cora Sue Davis, and all peoples who seek to understand differences and yearn to be understood.

Though he hung in there as long as he could, my dad's passing during my doctoral journey ultimately provided the light I needed to see my own path clearly. He may never have understood the plight of his daughter, but because of *his* life she understands integrity and the value of standing by one's principles. This is how my father loved and how he lived. As I thank him for these blessings, I hope that in his peace he has found answers to many of his questions. Even as my life surely remains a mystery to my mom, she stands by me. Through her I have learned about unconditional love. She believes in me, no matter my choices in life. I thank her for her faith in God and her faith in me. May my choices always be worthy of her steadfast support.

I believe that each of us is offered life as a gift. How we choose to engage in life reflects the spirit with which we ourselves love and live. We fail ourselves, our gifts and the gift giver, when we do not consider the impact of our spirit on others. As we seek to be understood, we must also strive to understand. To all who grow tired but remain hopeful in humanity, may your patience prevail and transcend even the clumsiest of genuine efforts toward understanding.

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**Viability of Concept Mapping for Assessing Cultural Competence in  
Children's Mental Health Systems of Care:  
A Comparison of Theoretical and Community Conceptualizations**

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Tamara Sue Davis, Ph.D.  
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Supervisors: Dennis T. Haynes  
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Definitions of cultural competence, a dynamic and evolving concept, are based on the respective worldviews of social science theorists. In an increasingly diverse society, developing effective human services requires contextual responsiveness. Mental health systems in the United States have an unsatisfactory performance history in serving children and families with diverse backgrounds. Moreover, a lack of empirical research delineating the models and impact of culturally responsive practice on mental health inhibits knowledge-based progress. Cultural competence is essential at all levels of a service system. However, the lack of clarity around its meaning raises critical questions about the constructs underlying current practice models and measurement instruments developed from these models.

Concept Mapping, a structured participatory mixed-method research approach, was used to conceptualize and assess cultural competence in four children's mental health

systems of care communities. Conceptualizations generated from relational map structures and rating scales were compared for differences and similarities across communities. An adapted relational competence theoretical framework provided a useful structure for further comparing community conceptualizations for congruence with current models of culturally diverse practice. Analyses indicated that no one practice model accounted for all community concepts generated. The extent to which community conceptualizations included the practice models' elements varied across communities. Similarly, multiple elements of the practice models were absent from community conceptualizations but several of the models' elements were identified across communities. Thus, the study provides additional insight into the practice models' application to systems of care.

The study assisted multiple systems of care in identifying training needs and establishing baselines to monitor cultural competence development. As a function of this process, social work was positioned to effect change in state mental health policy. The findings suggest that current models of culturally diverse practice have questionable applicability across varied systems of care. Relational competence theory was a good fit with the models examined and offers a foundation for future development and empirical validation of a theoretically-based model of cultural competence. Additionally, Concept Mapping was found to offer a promising alternative research method for conceptualizing and assessing culturally responsive practice within specifically identified cultural contexts.

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## CHAPTER 1

### INTRODUCTION

In searching for ways to discuss and examine cultural competence, theorists across the social sciences offer a variety of definitions of the concept based on their respective worldviews. Social work is no exception. Not unlike concepts of culture, ethnicity, and race, the meaning of cultural competence continues to evolve. Indeed, one may say that even attempting to ascribe a static definition to cultural competence is antithetical to the fluid character fundamental to the concept. Yet social workers and mental health practitioners increasingly learn that effective practice requires integration of cultural references into their work with all people. Successful integration of cultural perspectives into practice depends on numerous personal and organizational factors, but the process begins with practitioners and organizations attaining an understanding about the cultures within the targeted communities of service.

Systems of care for children's mental health is a specific community of service designed to meet the needs of children with serious emotional disturbance and their families (Saxe, 1998; Stroul & Friedman, 1986). Given that children are already an exceptionally vulnerable group of society, it is important to consider the impact of culture in serving children suffering from mental health disorders. Census data indicate that the population growth of children and adolescents is extremely diverse. 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). The Surgeon General's Report on Mental Health (U.S. Department of Health and Human Services [USDHHS], 1999)

indicates that the “fundamental components of effective service delivery include integrated community-based services, continuity of providers and treatments, family support services (including psychoeducation), and *culturally sensitive services* [emphasis added]” (p. 455).

Cultural competence is a key philosophical value of the systems of care movement (Stroul & Friedman, 1986), and the federal branch of the United States government supporting this movement is challenging communities to implement and measure cultural competence at both practice and systems levels (USDHHS, 2001a). However, determining the best method for assessing cultural competence is a difficult task when the researcher is uncertain about what she/he is to observe. Terms used to describe culturally competent work, and models developed for implementing and assessing culturally competent practice, have proliferated across disciplines over the past two decades. Fong (2001) identified fourteen terms, some reflecting models for practice, used in social work alone. Ironically, as social work responds to demands for cultural competence through its curriculum requirements, the Social Work Dictionary includes no definition of the concept (Wells-Wilbon & McDowell, 2001). Social work’s professional journals have offered little guidance, as they have included minimal attention to issues of diversity and multiculturalism over the past twenty-five years (Lum, 2000). The recently published *NASW Standards for Cultural Competence in Social Work Practice* (NASW, 2001) was “the first attempt by the profession to delineate standards for culturally competent social work practice” (p. 7). The historical lack of clarity around the conceptual meaning of cultural competence leads one to question the constructs

underlying the models advanced and the measurement instruments developed based on those models.

This study explores the viability of a participatory mixed-method approach to assess cultural competence in four different communities implementing children's mental health systems of care across one southwestern state. The study attempts to compare conceptualizations of cultural competence from individual community perspectives with current theoretical conceptualizations of the construct and examine the results for theoretical and measurement implications.

### **Statement of the Problem**

This study's exploration of cultural competence in children's mental health systems of care was driven by three primary issues with potentially crosscutting effects on policy and program development, education and practice with children and families, and research efforts to determine the impact of services and best practices for mental health systems. One issue relates to the poor performance by United States' mental health systems in serving children and families with diverse backgrounds. Secondly, cultural competence is a key value for systems of care and social work, yet there is considerable lack of clarity around the meaning of cultural competence. Consequently, this ambiguity delays research progress, the third primary issue guiding this study, resulting in a lack empirical research validating the theoretical practice models, measures, and impact of culturally diverse practice in mental health services.

The need to develop more effective mental health systems for children with serious emotional disturbance and their families in the United States is well documented.

In 1961, the Joint Commission on Mental Illness and Health found that mental health needs of children and youth were going unmet. Noting a lack of community resources and uncoordinated mental health programs, the report cited specific recommendations to “shape community mental health programs around local needs” (p.122), and to engage states in providing consultation to communities for local community planning. In 1965, the Joint Commission on the Mental Health of Children began its work assessing the needs of the nation, culminating in 1969 with recommendations to build *systems of care* for children with serious emotional disturbance and their families (Lourie, Katz-Leavy, DeCarolis, & Quinlan, 1996). Findings of unmet needs were repeated when The Children’s Defense Fund (CDF) published *Unclaimed Children* (Knitzer, 1982), a landmark study indicating fragmented, uncoordinated, and sometimes inappropriate, services for children. In the mid eighties, a Congressional report sponsored by the Office of Technology Assessment examined the state of the children’s mental health knowledge base, substantiating the large number of children with serious mental health care needs and the respective lack of treatment available (Saxe, 1998).

Current national data indicate that one out of every five children will need mental health services at some point before reaching adulthood. The Surgeon General’s Report on Mental Health (USDHHS, 1999) indicates that approximately 21 percent of U.S. children ages 9-17 have a diagnosable mental or addictive disorder. Approximately 9 to 13 percent of all children suffer with serious emotional disturbances. While professional and academic disciplines and other interest groups vary on the specific definition of serious emotional disturbance (Friedman, Kutash, & Duchnowski, 1996), systems of care

often use a variation of the definition put forth by the Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Mental Health Services (CMHS). SAMHSA/CMHS (n.d.) define “children or adolescents” with “serious emotional disturbances” as those whom have “diagnosable emotional, behavioral, or mental disorders” that “severely disrupt daily functioning in home, school, or community” (p. 1).

The previously cited numbers of children with mental health needs are staggering, and this heightened awareness is accelerating movement toward addressing the needs of children and families struggling with mental illness. The challenges experienced by families with children who are seriously emotionally disturbed often result in their involvement with multiple public service systems. Indeed, research shows extremely high prevalence rates of various psychiatric disorders in youth served in public systems, including child welfare, juvenile justice, mental health, public school services, and alcohol and drug services (Garland, Hough, McCabe, Yeh, Wood, & Aarons, 2001). Given the multiple issues and systems impacting the child and family, their needs cannot be met through the mental health system alone. Rather, a broad array of comprehensive services and supports is necessary to meet the families’ needs (Stroul & Friedman, 1986).

Pulling these services together requires staff who can successfully navigate the multiple service systems, while individualizing work with youth and families. This specialized wraparound service delivery approach (Burchard & Clarke, 1990; VanDenBerg & Grealish, 1998) requires knowledge at many levels of service implementation. The wraparound model differs from "traditional" service delivery in several respects. Service planning involves a child and family team to work with the

family and focus on the family as a whole. The model focuses on the strengths of the child and family, including the "natural supports" of the family and the community in the plan of care. The model requires flexibility in providing the services needed for that individual family rather than fitting the family into a specific program (Goldman, 1999). To implement such a model successfully, practitioners must possess the ability to work with not only the family's culture, but also the culture of the family's identified community and the multiple organizational cultures within the children's service systems.

Perhaps one of the greatest challenges in this new paradigm of children's mental health services is the systems' partnerships with families (Stroul & Friedman, 1986). Families are increasingly seen as a vital resource for their children. It is widely acknowledged that families should be full partners in the planning and delivering of services for their own child (Burns, Hoagwood, & Mrazek, 1999; Worthington, Hernandez, Friedman, & Uzzell, 2001) and in planning and overseeing services at the system level (Friesen & Stephens, 1998; Koroloff, Friesen, Reilly, & Rinkin, 1996; U.S. Department of Health and Human Services, 1999). Yet, the involvement of families as full partners in the planning, development, and implementation of systems of care is still evolving and growing in acceptance (Friesen & Stephens, 1998). Simpson, Koroloff, Friesen, and Gac (1999) suggest three areas of family-provider partnership necessary for successful collaboration: a shared vision and shared goals, shared power in decision making at all levels, and a long-term commitment to collaborative development. The model implies numerous assumptions about the cultures of families and organizations that create enormous challenges not easily overcome. Communication between families

and professionals and among organizations is a particular challenge in systems of care development.

As our society becomes more structurally complex and ethnically diverse, organizations must be prepared to effectively communicate and provide services that meet the needs of a wide variety of ethnic and non-ethnic cultural groups. Addressing issues related to cultural competence in children's mental health is especially critical, as research indicates a history of unsatisfactory performance by mental health service systems in serving youth and adults with diverse backgrounds (Hernandez & Isaacs, 1998; Knitzer, 1982; Roizner, 1996; Smedley, Stith, & Nelson, 2002). Problems experienced by ethnic consumers of color in the mental health system include receipt of fewer and less intense services, fewer positive outcomes, prejudice from therapists, and a higher dropout rate from services (Davis, K., 1997; Lu, Lum, & Chen, 2001; Sue, S., 1992). Roizner points out, however, that research also shows services can be improved by developing culturally competent work with children and families. For example, consumer satisfaction increases, consumer dropout of services decreases, and service effectiveness increases when work with families demonstrates cultural competence.

In addition to cultural issues related to people of color, Hernandez, Isaacs, Nesman, and Burns (1998) discuss the relationship between poverty and youth with mental health needs going unmet. Children and youth of color are greatly impacted by the conditions of society, including poor economy, lack of health care provision, and discrimination, to name but a few. The range of youth affected by social conditions is compounded by the number of immigrants and refugees who live in poverty in the United

States. These societal conditions impact the emotional and psychological well being of children and families of color (Devore & Schlesinger, 1996; “Embracing the Dynamics of Difference,” 1997).

Yet another aspect of cultural difference is related to geography. Rural communities face a different set of challenges and barriers in providing needed mental health services than do inner city communities (Cutrona, Halvorson, & Russell, 1996). Residents of rural, urban, and suburban communities all address similar needs, but the solutions they develop must address the unique geographic characteristics of their communities.

With cultural competence playing such an integral role in systems of care designs, monitoring development of cultural competence within systems is a critical component of evaluation. Further investigation to identify the essential components of culturally competent care and their relationship to outcome is critical, as there is no empirical evidence currently available substantiating any such relationships (USDHHS, 2001a; U.S. Health Resources and Services Administration [USHRSA], 2001).

Although a number of cultural competence measurement instruments were developed across disciplines over the last decade (Hernandez & Gomez, 2000; Roizner, 1996), most of them are not compatible with the systems of care philosophy. Traditional scale development approaches (DeVellis, 1991; Springer, Abell, & Hudson, 2002), reflecting a top-down, expert-driven model of measurement development (Rogler, 1999) have guided the development of most measures currently available. In contrast, a participatory, professional/family partnership approach to developing services, policy,

and evaluation is fundamental to systems of care philosophy. Thus, the philosophy calls for a bottom-up approach to conceptualizing and assessing cultural competence. Current measures are not structured for flexible community conceptualizations of the construct. Indeed, researchers and theorists alike may discover that participatory approaches to conceptualization of any issue previously defined by “experts” results in contrasting perceptions of the issue between the experts and those to whom the issue is being applied. For example, issues of import to social work, such as social justice and self-determination, have been identified, defined, and incorporated into the core of social work theory and practice. Would a different understanding of these issues emerge if those served by social workers were asked to describe the meaning of these concepts for meeting the specific needs of the persons or communities being served?

Development of appropriate cultural competence measures in mental health is hampered by a lack of clarity around the meaning of cultural competence. Whether working within the traditions of social work or mental health, service systems and researchers alike must be able to conceptualize cultural competence in ways that can be measured and used for developing competent service delivery, systems, and outcomes research. The challenge for researchers is creating innovative methods for assessing a construct that is constantly evolving at multiple levels within a service community.

### **Purpose of the Study**

The purpose of this exploratory study was to implement and examine the viability of an innovative approach to examining cultural competence in children’s mental health systems of care. Concept Mapping (Trochim, 1989), as developed by Concept Systems

(2001), was used in four separate systems of care communities, two urban and two rural, for this cross-sectional exploration. Concept Mapping is a participatory structured conceptualization process that uses a mixed-method approach to understanding multiple ideas from multiple participants. The study generated community conceptualizations of cultural competence from the perspectives of individuals participating in the specified systems of care service communities. The conceptualizations generated through the comparison study were further examined for their congruence with the assumptions underlying current definitions, theories, models, and measures of cultural competence.

The study was grounded in a combination of intercultural/multicultural and communicative competence theories (Green, 1999; Spitzberg, 1989; Spitzberg & Cupach, 1984, 1987), which focus on the interaction and relational aspects of exchange of meanings. It was further grounded in the principles and values of systems of care and wraparound practices and the related model of cultural competence proffered by Cross, Bazron, Dennis and Isaacs (1989). To actualize the principles and values behind systems of care philosophy, the cultures of all participants must be recognized and integrated into the system's development. The primary mode of this recognition occurs through processes of communication. Previous research on the values of social work students indicated incongruence between student values and those of the social work profession, especially related to issues of poverty and welfare recipients (Haynes, 1993). Given the dominance of a Euro-White worldview in the structures of social service systems, such conflicts in value systems would certainly influence a social worker's capacity for engaging in culturally competent communicative and relational practice.

The Concept Mapping method was chosen in an effort to begin facilitating communication and meaning making around cultural competence across multiple communities implementing systems of care. In recent practice, social work has given more attention to individuals and families than to the communities in which they live (Green, 1999). This study attempts to look at cultural needs of families and providers, through their own lenses, at a system of care community level. Participants generated the qualitative information that was then used to construct and place value on conceptualizations of cultural competence.

On a practical level, the study sought to assist local communities in establishing a baseline from which their mental health systems can monitor the development of cultural competence. Participants quantitatively attributed values to their own conceptualizations of cultural competence as a means for assessing adherence to the community's system of care model at service delivery and policy levels. The study also assisted communities in gathering information necessary for developing technical assistance and training plans to address issues related to cultural competence. Experience from an earlier pilot study conducted by this author using the Concept Mapping approach indicated its utility in identifying concrete training needs across the system for application in systems development (Davis, Johnson, Barraza, & Rodriguez, 2002).

Finally, this research places social work in a position to effect change in mental health policy at a state level. Systems of care for children's mental health is largely about policy change in public systems serving children with serious mental health needs and their families. In effect, to realize child-centered and family-focused, community-based

and culturally competent systems of care (Stroul & Friedman, 1986), policy changes must support this philosophy. The study attempted to produce community-based information around cultural competence intended to assist a state-legislated consortium in guiding the policy development and legislative agenda around the state's children's mental health systems of care. Members of the state consortium, which include family member consumers and representatives from state public service agencies, are expected to implement changes in their respective agencies and efforts to support systems of care implementation. Results from the study produced concrete information for setting individual community and state goals and establishing baselines from which to measure the ongoing development of culturally competent practice and policy across public service systems.

### **Research Questions**

1. To what extent are there differences and similarities in conceptualizations of cultural competence among groups of participants across four systems of care communities?
2. Do systems of care community assessments (individually and collectively) support current assumptions and theoretical conceptualizations of cultural competence?
3. Do community conceptualizations of cultural competence support the usage of current generalized measures of cultural competence?
4. Is Concept Mapping methodology a viable approach to conceptualizing and assessing cultural competence in individual communities?

## **Significance for Social Work and Children's Mental Health**

In January 1999, a National Multicultural Conference and Summit was held by the American Psychological Association (APA), resulting in resolutions for action (Sue, D., Bingham, Porche-Burke, & Vasquez, 1999). Participants at this summit made a commitment to implementing cultural competence across the field of psychology and to advocate for endorsement of all recommendations by the APA. Sue et al. outlined five primary themes of consensus for action, summarized below.

1. The APA recognized that “traditional psychological concepts and theories were developed from a predominantly Euro-American context and may be limited in their applicability to the emerging racially and culturally diverse population in the United States” (p. 1063). The APA is making the promotion of multiculturalism and social justice top priorities.
2. The APA recognized that tendencies to focus on issues of race and ethnicity must be broadened to also include “gender, sexual orientation, ability and disability, religion, class, etc.” as these differences create barriers to “communication and understanding” (p. 1063).
3. The APA recognized the importance of spirituality as a “basic dimension to the human condition.” It was determined that Psychology needs to “break away from being a unidimensional science,” “recognize the multifaceted layers of existence,” and “balance its reductionistic tendencies with the knowledge that the whole is greater than the sum of its parts” (p. 1064-1065).

4. The APA recognized the far-reaching impact of its Euro-American worldview on the multicultural individuals it serves. Cultural competencies were called for across the profession, both at individual and organizational levels.
5. Lastly, the APA recognized needs for reform across psychology education programs. An overhaul of programs was recommended to develop policies, practices, and structures that will produce more culturally competent practitioners.

Why begin this section of significance to social work with an outline of what another discipline is doing to address issues of culture? Social work often lags behind the curve on issues and trends found important by its peer disciplines. Three specific examples are pertinent for this discussion. First, social work's efforts to establish its research knowledge base of evidence-based treatment, especially in the area of mental health, have been extremely belated (Austin, 1998; Task Force on Social Work Research, 1991; Zlotnik, Biegel, & Solt, 2002). Secondly, social work continues to experience slow recognition and incorporation of participatory research and evaluation approaches into its curriculum and research practices (Altpeter, Schopler, Galinsky, & Pennell, 1999; Davis, T., 2002). Finally, there is a recognized neglect by social work professional journals to include publications related to cultural diversity (Green, 1999; Lum, 2000). As previously noted, it was not until 2001 that standards for culturally competent practice were developed for social workers (NASW, 2001). The standards are briefly described beginning on page 27. The tendency of slow development around critical issues has tremendous influence on how professionals both inside and outside of social work view

the capacities of our profession. Since a majority of mental health services are conducted by social workers, these specific examples may lead one to question the preparation of its mental health practitioners for working with culturally diverse children and families.

While social work is involved in discussions around cultural diversity and even has curriculum requirements mandated by the Council on Social Work Education to include issues of diversity in coursework, there is no real consensus among educators about what the content should be or how it gets included. Additionally, social work's focus on diversity has largely been limited to people of color (cf. Devore & Schlesinger, 1996; Fong & Furuto, 2001; Lum, 2000) as opposed to including a broader multicultural perspective. This focus was further evidenced by a recently held task force meeting, *Cultural Competence in Child Welfare Practice: A Collaboration between Practitioners and Academics* (2001), which brought together many of social work's academic cultural competence experts to discuss issues related to families of the four largest groups of color in the United States: African American, Latino, Native American/First Nation, and Asian/Pacific Islander. Successful implementation of children's mental health systems of care requires a broader perspective for understanding issues of culture in service delivery processes. Social workers are partners in the development of these systems and in the direct wraparound care of children and families.

This study attempts to offer social work an alternative lens for viewing issues related to culture and cultural competence and contributes in three substantial ways. The study first attempts to provide some additional insight into current definitions and conceptualizations of the cultural competence construct. Secondly, the findings provide a

means for examining the content validity of current cultural competence measures. Finally, the study's method contributes to social work's knowledge base of research methodologies. Potocky-Tripodi and Tripodi (1999) called upon social work researchers to "develop their own [research] methods, or modify existing ones, to suit the profession's unique purposes" (p. 124) especially as they relate to the interface between the person and the environment. As this research examines the cultural interface between families and service systems, it has the further potential of adding a culturally appropriate alternative method for measuring cultural competence.

### **Limitations of the Study**

Several limitations to this study need to be acknowledged. Given the exploratory purposes of the study, the research does not include an in-depth review of the relationship between personal/cultural values and cultural competence, although the theories grounding the study do provide an interpersonal framework for conceptualizing cultural competence. The choice to include an interpersonal values-based theoretical framework was based on the epistemological fit with the researcher, the emphasis on values within systems of care and wraparound philosophies, and the integral relationship among social work values, ethics, and culturally competent practice. While an interpersonal framework underpins the research, the theory was expanded to illustrate its application on a macro systems level.

Another limitation of the study centers on the sample. The systems of care in this study were in early developmental stages, thus there were only a small number of families being served across communities. This early stage of the systems' development

limited the potential for a large number of families to be included in the research. Efforts were made to increase the number of families by broadening the definition of the system of care community to include families served in at least two of the partnering agencies but not enrolled in the wraparound service delivery. Because this was an exploratory study, the researcher did not want to expand participation beyond systems of care participants.

Additionally, due to the exploratory purposes of this research, the findings from the study are not generalizable to any specific population or community. The sample was limited to systems of care within one state. Although communities were encouraged to gather the greatest number of diverse participants to reflect the targeted populations of their systems of care, the community samples were not representative. The majority of systems of care samples were not large enough to examine differences between specific ethnic groups within each community. Making conceptual comparisons between groups is a goal and process of the Concept Mapping methodology, and comparisons among ethnic groups is a noted need in cultural competence research (Mason, Benjamin, & Lewis, 1996).

## CHAPTER 2

### REVIEW OF THE LITERATURE

#### **Cultural Competence: A Key Value for Children's Mental Health Services**

##### *Systems of Care Philosophical Development, Values, and Principles*

In 1982, the Children's Defense Fund (CDF) published a landmark study entitled *Unclaimed Children* (Knitzer, 1982) indicating fragmented, uncoordinated, and sometimes inappropriate, services for children with mental health needs. Following this study, the National Institute of Mental Health (NIMH) launched the Child and Adolescent Service System Program (CASSP) in 1984. The goals of CASSP were to develop funding and service delivery priorities and to assist states in developing coordinated systems of care for children and adolescents with serious emotional disturbances and their families by reorganizing child welfare, juvenile justice, education, and mental health agencies (Lourie, Katz-Leavy, DeCarolis, & Quinlan, 1996; Saxe, 1998). Recognizing the lack of defined structure for developing a coordinated system of care, CASSP sponsored an effort resulting in the seminal publication, *A System of Care for Severely Emotionally Disturbed Children and Youth* (Stroul & Friedman, 1986). This document continues to provide a conceptual framework for states and communities implementing systems of care.

Shortly thereafter, the Robert Wood Johnson Foundation initiated the Mental Health Services Program for Youth (MHSPY). In an effort to implement and broaden the guidelines for developing systems of care formulated by CASSP, the MHSPY design

included support for developing new services to assist families in maintaining their children in their own communities. The program also required the establishment of state-local partnerships in systems of care development, with specific attention to case management and financial reforms (Cross & Saxe, 1997). Based upon the success of the CASSP model and the MHSPY projects (Cross & Saxe), the SAMHSA appropriated money through the Community Mental Health Services for Children and Their Families Program for 22 demonstration grants to develop community-based systems of care. The success of these demonstrations has supported the expansion of federally funded systems of care development in 67 communities across the United States (Holden, Friedman, & Santiago, 2001) through the Center for Mental Health Services' (CMHS) Comprehensive Community Mental Health for Children and Their Families Program.

The CASSP, MHSPY and CMHS systems of care reform efforts are all based on similar core values and principles. The service delivery component of each of the efforts, i.e., wraparound, thus incorporates these values and principles into practice requirements. Stroul and Friedman (1986) define a system of care as:

...a comprehensive spectrum of mental health and other necessary services which are organized into a coordinated network to meet the multiple and changing needs of children and adolescents with severe emotional disturbances and their families. (p. xx)

The core values maintain that a system of care must be community-based, child-centered, family-focused, and culturally competent. These values and principles are to be operationalized at all levels of the system of care, i.e., the practice level, the community

level, and the policy level. Table 1 lists the principles and values for systems of care (Stroul & Friedman, 1986).

Table 1. Values and Principles for Systems of Care

<i>Three Core Values</i>	
1.	Child centered and family-focused → needs of the child and family determine services provided
2.	Community based → services, management and decision-making responsibility remain at community level
3.	Culturally competent → agencies, programs, and services responsive to cultural, racial, and ethnic differences of population served
<i>Ten Guiding Principles</i>	
1.	Access to a comprehensive array of services meeting child's physical, emotional, social, and educational needs
2.	Individualized service planning that meets unique needs and strengths of each child
3.	Least restrictive, most normative clinically appropriate environment
4.	Families are full participants in all aspects of planning and delivering services
5.	Services are integrated → planning, development, and coordination of services are linked among agencies and programs
6.	Case management process ensures the delivery of multiple services in a coordinated, therapeutic, and dynamic manner
7.	Early identification and intervention to increase potential for positive outcomes
8.	Smooth transitions of children to adult service system
9.	Protection of rights and promotion of advocacy for children with emotional disturbances
10.	Services delivered without regard to race, religion, national origin, gender, physical disability, or other characteristics; services are sensitive and responsive to cultural differences and special needs

Stroul and Friedman (1986) suggest that cultural competence, core value #3 and guiding principle #10, is inherent in a system of care that values child-centered, family-focused, and community-based care. Essentially, serving children and families in a system of care requires identifying the cultural context within which the family lives. This process includes developing an understanding of what the family considers its community, as well as the community of services. A comparison of systems of care and wraparound service delivery philosophies is helpful in understanding how cultural

competence is integrated into the framework. The next section discusses how the values and essential elements of wraparound fit within the values and guiding principles of systems of care.

### *Values and Essential Elements of Wraparound*

Wraparound service delivery defines a process (policies, practices, and steps) of providing individualized and culturally responsive services and supports for children and families (VanDenBerg & Grealish, 1996). An individualized process inherently requires cultural responsiveness. The youth and family are involved in planning services that are specific to the strengths and needs of the family (Burns & Goldman, 1999). While systems of care guiding principles reflect a requirement to respect everyone's individuality and plan services according to individual child and family needs, wraparound service delivery approaches depend on the system having policies in place to support these practices. Wraparound facilitators feel more supported in their promise to provide services based on individual strengths and needs of children and families when this value of cultural competence is also demonstrated at the administrative and policy levels. Wraparound is the primary mode of service delivery in systems of care, and research is underway to better understand its impact on functional outcomes (Burchard, Bruns, & Burchard, 2002; Burns, Goldman, Faw, & Burchard, 1999). Table 2 outlines the key values and essential elements of wraparound as identified by Burns and Goldman (1999) and VanDenBerg and Grealish (1996).

Table 2. Values and Essential Elements of Wraparound

<i>Values</i>
<ol style="list-style-type: none"> <li>1. Children and families have voice and choice in planned services</li> <li>2. Systems and workers demonstrate compassion for children and families</li> <li>3. Care to families is: unconditional, individualized, strengths-based, family-centered, culturally competent, community-based</li> <li>4. Emphases placed on safety, success, and permanency in home, school, and community</li> <li>5. Services and systems are integrated</li> <li>6. Service approaches and funding are flexible</li> </ol>
<i>Essential Elements</i>
<ol style="list-style-type: none"> <li>1. Individualized services and supports to families are built on strengths, meeting needs of children and families across life domains</li> <li>2. Wraparound efforts are based in the child's community</li> <li>3. Families are complete and active partners at every level of the service delivery process</li> <li>4. Service plan is developed and implemented based on an interagency, community collaborative process</li> <li>5. Service provision is a team-driven process involving family, child, natural supports, agencies, and community resources working together to develop, implement, and monitor an individualized service plan</li> <li>6. Wraparound teams use flexible approaches with adequate flexible funding to develop service plans</li> <li>7. A balance of formal services and informal community and family resources are used in wraparound plans</li> <li>8. Service delivery processes are culturally competent</li> <li>9. Community agencies and wraparound teams indicate an unconditional commitment to serve children and families</li> <li>10. Service plans indicate set outcomes and ways to measure each goal established</li> </ol>

Pulling multiple services together requires staff who can successfully navigate the multiple service systems, while individualizing work with youth and families. This case management function is critical to successful systems of care, as “case managers are the ‘glue’ which holds the system together, assuring continuity of services for the child and family” (Stroul & Friedman, 1986, p. 145). The Wraparound planning process differs from "traditional" service planning because it:

1. Requires an inter-disciplinary child and family team to partner with the family in planning services and setting outcome-oriented goals;

2. Focuses on the family as a whole rather than only the targeted child;
3. Focuses on the strengths, uniquenesses, and natural supports of the child and family;
4. Emphasizes maintaining the youth in the community, providing flexible service options rather than fitting the family into a specific program; and
5. recognizes cultural competence as central to effective practice (Goldman, 1999; Koroloff, Friesen, Reilly, & Rinkin, 1996; VanDenBerg & Grealish, 1996).

Partnering with families through a child and family team offers the wraparound service coordinator the process by which to ensure culturally competent services. The mental health field increasingly acknowledges the need to include families as full partners in the planning and delivering of services for their children (Burns, Hoagwood, & Mrazek, 1999; Worthington, Hernandez, Friedman, & Uzzell, 2001). Additionally, families are to be included as full partners in planning and overseeing services at the system level (Friesen & Stephens, 1998; Koroloff et al., 1996; U.S. Department of Health and Human Services, 1999).

In addition to the wraparound service coordinator and the family, the wraparound team also consists of other community members whom the family sees as critical to the child's success (VanDenBerg & Grealish, 1996). For example, this may include professionals from the systems in which the family is involved. It may also include a neighbor or friend of the youth or caregiver that provides an important support for the family. Key to the individualized wraparound process is assessing the child and family

team's strengths and then matching these strengths with the service plan developed. Wraparound trainers call this process of assessing and matching strengths a "Strengths Discovery" (VanDenBerg & Grealish, 1996). Short and long-term goals the family hopes to achieve are set and written into the service plan. As barriers emerge the team addresses the issues and the service plan is revised accordingly.

The availability of flexible resources for use with families is critical to successful wraparound. If existing resources in the community cannot meet the family's strengths and needs, then other resources are identified or developed. Flexible resources generally mean a pool of money that can be used by wraparound service coordinators for obtaining non-traditional services (Goldman, 1999; Lourie, Katz-Leavy, & Stroul, 1996). These non-traditional services are often those created or developed to support a culturally responsive plan of care. Building strong interagency collaborations that support the availability and creation of flexible resources for wraparound is important to systems of care development (Hodges, Nesman, & Hernandez, 1999; Koyanagi & Feres-Merchant, 2000). The flexible funds often mean the difference between providing individualized and culturally responsive care or traditional service provision.

#### *Congruence with Social Work*

The values, guiding principles and essential elements of systems of care and wraparound reflect a requirement for practitioners to tailor services to each child and family. This individualized service approach necessitates the practitioner to move beyond her or his own worldview and comfort zone in an effort to truly gain a cultural context within which services should be planned and delivered. In turn, the systems through

which services are delivered must be designed to support individualized care processes. These basic philosophies underlying systems of care and wraparound reflect tremendous congruence with current ethics and standards espoused in social work practice and education.

### *Social Work Practice*

Many systems of care and wraparound values and practices are supported in the NASW Code of Ethics (1996) and the NASW Standards for Cultural Competence in Social Work Practice (2001). The relevance of both is described below.

*NASW Code of Ethics.* A case could be made for how systems of care practices are a fit with all of the values, ethical principles, and ethical standards outlined in the National Association of Social Workers Code of Ethics (1996). Four of the values and principles directly relate to issues of culturally competent social work practice and the model implemented in systems of care: Social Justice, Dignity and Worth of the Person, Importance of Human Relationships, and Competence.

One goal of systems of care is to increase families' access to services (Stroul & Freidman, 1986). Systems of care research supports achievement of improved access to services, improved service coordination, improved consumer satisfaction, and reduced use of more restrictive placements (Bickman et al., 1995; Bickman, Noser, Summerfelt, 1999; USDHHS, 1999). As previously described, systems of care also require the inclusion of family members in planning and implementing culturally competent services. The social work principle of social justice promotes "sensitivity to and knowledge about oppression and cultural and ethnic diversity," encouraging social

workers to “strive to ensure access to needed information, services, and resources; equality of opportunity; and meaningful participation in decision making for all people” (NASW, 1996, p. 5).

The social work principles to “respect the inherent dignity and worth of the person” and “recognize the central importance of human relationships” (NASW, 1996, p. 5-6) encapsulate much of the essence of systems of care and wraparound processes. Individualized services, framed within the cultural context of the child and family, demonstrate respect to cultural differences. Partnering with families to plan and deliver services promotes client self-determination and demonstrates a level of trust and commitment to families. Using natural family supports and flexible community-based services is culturally responsive and reflects responsible use of community resources. Finally, the social work principle of competence admonishes social workers to “practice within their areas of competence and enhance their professional expertise” (NASW, 1996, p. 6). The term cultural competence implies that an individual possesses the necessary knowledge and skills to work effectively with people from a variety of cultures.

The ethical standards for social work written to operationalize the values and principles describe the responsibilities of social workers to people served, to colleagues, to practice settings, to their professional selves, to the profession as a whole, and to society in general (NASW, 1996). Each of these six areas of responsibility specifically address issues related to worker competence. Standards for responsibility to clients

include general references to competence within one's boundaries of credentials as well as competence based on knowledge of cultural diversity.

Issues of accountability found in systems of care and wraparound practices are also reflected in social work practice standards. The standards for responsibility of social workers to colleagues include respect of cultural differences, accountability for one's role on an interdisciplinary team, and social workers holding one another accountable for incompetent practice (NASW, 1996). Standards for social worker responsibility to individual professional development, as well as to that of the profession and settings within which they practice also include general and culturally related competence. For example, supervisors must be sensitive to cultural boundaries, social workers must practice within and continue to increase their scope of knowledge, social workers are to engage in research to assist in building the knowledge base, and social workers should advocate for and engage in nondiscriminatory practices (NASW). Standards for advocacy are extended to social and political action whereby social workers are to "advocate for programs and institutions that demonstrate cultural competence" (NASW, p. 27).

*NASW Standards for Cultural Competence.* Complementing the NASW Code of Ethics, the profession recently adopted the NASW Standards for Cultural Competence in Social Work Practice (NASW, 2001). In fact, three of the four ethical principles described above are used to support the cultural competence standards. The following ten standards were specified to guide practitioners: (1) practicing within the ethics and values of social work; (2) developing cultural self awareness; (3/4) developing cross-cultural knowledge and skills; (5) being knowledgeable about community resources; (6)

advocating with and on behalf of clients; (7) participating in building a diverse workforce; (8) engaging in efforts toward cultural competence education; (9) ensuring availability of diverse languages for clients; and (10) engaging in cross-cultural leadership across professions.

One way of increasing social worker cultural expertise is through obtaining information gathered from evaluation of cultural competence models. Standard 5 of the cultural competence standards mandates social workers to support evaluation activities and assist in setting related standards for practice (NASW, 2001). Effective systems of care and wraparound processes demand the continuous assessment and acquisition of new knowledge and skills necessary for working with culturally diverse children, families, and organizations. Staying abreast of the needs of families requires service providers to be aware of the changing cultural context of the communities in which families and systems reside. Actual adherence to social work's cultural competence standards requires the ability to assess and measure cultural competence at multiple levels. These issues must first be addressed at an academic level of the profession.

### *Social Work Education*

The extent to which social workers gain knowledge and skills for working with diverse people is largely determined by the educational content of the higher education program(s) they attend. The Council on Social Work Education (CSWE) recently released revised Educational Policy and Accreditation Standards (EPAS) that guide social work curriculum development (CSWE, 2001). Building upon the values of the profession, EPAS emphasizes continuous assessment and improvement of educational

program development to ensure basic preparation of social work practitioners. The EPAS preamble, policy, and standards all include specific references to preparing students for working in a diverse environment.

The purposes of social work education outlined in the EPAS policy include references to competent practice within the cultural context of persons served. The list of culturally distinct groupings cited in the policy achievement provisions and program objectives includes “clients’ age, class, color, culture, disability, ethnicity, family structure, gender, marital status, national origin, race, religion, sex, and sexual orientation” (CSWE, 2001, pp. 7, 9). This same list is repeated in EPAS Standard 6.0, Nondiscrimination and Human Diversity, whereby programs are required to use such references in describing the nondiscriminatory learning context of the educational program. The EPAS most clearly addresses issues related to cultural competence in Policy Section 4.0, whereby every social work program is required to provide foundation content to address issues of Diversity (Section 4.1), Populations-at-Risk and Social and Economic Justice (Section 4.2), and Human Behavior in the Social Environment (Section 4.3). The standards for accreditation ensure baccalaureate and master’s social work programs are developed around core content areas and the specific mission, goals, and objectives of individual programs.

Joining the NASW Code of Ethics (1996) with the newly established NASW Standards for Cultural Competence (2001) and the CSWE Educational Policy and Accreditation Standards (2001), particular implications emerge for individuals and institutions found to be culturally incompetent. The standards in both NASW practice

documents suggest that professionals are to hold one another accountable for participating in efforts to ensure culturally relevant interaction at both practice and service system levels. The ethics and standards require social workers to first address potential incompetence with one another, working their way up the supervisory chain potentially leading to intervention by the NASW.

The practice and educational ethics, policies, and standards clearly assert a significant and highly denoted level of responsibility for social work to ensure culturally competent practitioners, educators and institutions. Yet the profession's level of achievement in these areas is debatable at best. Will social work stand by its professed commitment to competent education and practice and hold itself accountable to its own standards? On what bases will sanctions be determined and carried out? Is the specified list of cultural groupings adequate for the multiple levels of social work? Does social work have adequate measures to assess the cultural competence of persons, programs and institutions? These kinds of critical questions must be considered and answered before social work can make any real progress or assume a related leadership role across disciplines.

### **Conceptualization of Cultural Competence in Social Work and Mental Health Services**

Definitions and conceptualizations of cultural competence abound across the literature and across fields of practice. The cultural competence concept is often characterized as “elusive” without any standard point of reference. Following are some examples of how cultural competence is defined by different professions. Additional

definitions and conceptualizations are included in the following sections describing specific models of practice.

- *Social Work*: “‘Ethnic competence’ is the mastery of relevant knowledge and skills, including insights and experiences, that can be used in any cross-cultural situation, regardless of the client’s or worker’s ethnic group” (Gallegos, 1982. p. 3);
- *Social Work*: Cross-cultural competence is “a working knowledge of symbolic/linguistic communication patterns; knowledge and skill of naturalistic/interactional processes; and underlying attitude, value, and belief systems of ethnic target groups” (Lum, 2000, p. 327);
- *Social Work/Child Welfare*: “Cultural competence denotes the ability to transform knowledge and cultural awareness into health and/or psychosocial interventions that support and sustain healthy client-system functioning within the appropriate cultural context” (McPhatter, 1997, p. 261);
- *Child Welfare*: “The ability of individuals and systems to respond respectfully and effectively to people of all cultures, classes, races, ethnic backgrounds, sexual orientations, and faiths or religions—in a manner that recognizes, affirms, and values the worth of individuals, families, tribes, and communities, and protects and preserves the dignity of each” (CWLA, 2001, as cited on-line, n.d.)
- *Psychology*: The cross-culturally competent counselor is one whose beliefs and attitudes, knowledge, and skills reflect (1) an awareness of one’s “own assumptions, values, and biases,” (2) an understanding of “the worldview of the

- culturally different client,” and (3) development of “appropriate intervention strategies and techniques” (Sue, Arredondo, & McDavis, 1992, p. 76);
- *Counseling Psychology*: Multicultural competence of counselors is based on their level of achievement along six dimensions: “(1) counselor self-awareness, (2) general knowledge about multicultural issues, (3) multicultural counseling self-efficacy, (4) understanding of unique client variables, (5) an effective counseling working alliance, and (6) multicultural counseling skills” (Constantine & Ladany, 2001);
  - *Psychology/Mental Health*: “Cultural competence is a prerequisite for a healthy society; it would embrace an ethnorelativistic citizenry who acknowledge, accept, honor, and understand differences as well as a responsive structure at federal, state, and local levels of government to provide health/mental health policy based on equity in services and service delivery mechanisms” (Dana, 1998, p. 61);
  - *Mental Health*: “The attribute of a behavioral health care organization that describes the set of congruent behaviors, attitudes and skills, policies and procedures that enable its caregivers to work effectively and efficiently in cross/multicultural situations at all of its organizational levels” (Siegel, Haugland, & Chambers, 2002, p. 5);
  - *Health and Social Care (United Kingdom)*:

Cultural competence is the ability to maximise sensitivity and minimise insensitivity in the service of culturally diverse communities. This requires knowledge, values and skills, but most of these are the basic knowledge

values and skills which underpin any competency training in numerous care professions. Their successful application in work with culturally diverse peoples and communities will depend a great deal upon cultural awareness, attitude and approach. The workers need not be (as is often claimed) highly knowledgeable about the cultures of the people they serve, but they must approach culturally different people with openness and respect – a willingness to learn. Self-awareness is the most important component in the knowledge base of culturally competent practice (O’Hagan, 2001, p. 235);

- *Health Care/Nursing:*

...a matter of evolving one’s thoughts, attitudes, and action through five stages,” including (1) “ethnocentricity...,” (2) “the awareness and sensitivity to cultural and language differences,” (3) refraining from “forming stereotypes and judgments that are based on one’s own cultural framework,” (4) acquiring “knowledge about the cultures...of the patients who the organization serves,” and (5) acquiring “skills and strategies to identify cultural differences and to know how to deal with them in a way that both meets the patient’s needs and expectations and satisfies the nurses and the institution’s standards of quality care (Salimbene, 1999, p. 31);

- *Managed Care:* “An acceptance and respect for difference, a continuing self-assessment regarding culture, a regard for and attention to the dynamics of

- difference, engagement in ongoing development of cultural knowledge, and resources and flexibility within service models to work towards better meeting the needs of minority populations” (USDHHS, 2000, p. 57); and
- *Special Education*: Cross-cultural competence is “the ability to think, feel, and act in ways that acknowledge, respect, and build upon ethnic, [socio]cultural, and linguistic diversity” (Lynch & Hanson, 1993, p. 50 as cited in Lynch, 1998).

While much has been written about the importance of culture in care, to date, espousal of culturally competent practice is based more on its advocacy as a more humanistic way of providing services than on research supporting its impact on outcomes (USDHHS, 2001a). Nonetheless, mandates for providing culturally competent services range from human service disciplines and programs to governmental agencies to managed care organizations.

A policy statement issued by the National Association of Social Workers in 2000 officially pronounced, “social workers have an ethical responsibility to be culturally competent practitioners” (NASW, 2000, p. 61). The policy statement adopts the following definition of cultural competence as put forth by Cross and colleagues, the same definition adopted by the children’s mental health systems of care movement. “Cultural competence is a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals and enable that system, agency, or those professionals to work effectively in cross-cultural situations” (Cross et al., 1989, p. 13; NASW, 2000, p. 61). This definition was later incorporated into the previously described social work standards for culturally competent practice (NASW, 2001). K.

Davis (2001) suggests expanding this definition, arguing that “culturally competent policy must integrate and transform attitudes, behaviors, knowledge, information, facts, patterns, history and data about individuals, groups, and communities of color into specific problem statements, policy direction, goals, strategies, desired outcomes, organizational structures, service locations, and service standards that match the individual’s culture” (p. 64).

A selected review of current approaches, models, conceptualizations, and underlying theories of culturally competent care related to social work and mental health is provided below. This review provides a context from which the design for this research study was developed.

#### *Models and Approaches of Cultural Competence in Social Work*

Social work has long recognized the importance of culture in its work with individuals and families, yet its development of practice models specifically designed to prepare practitioners for cross-cultural work began emerging only in the past two decades (Fong, 2001). Multiple models of multicultural social work are currently found in the literature, most of which are in early stages of development. The following discussion outlines three approaches to culturally competent practice that have sustained the longest histories and are the most often cited in social work practice literature: (1) Ethnic-Sensitive Social Work Practice (Devore & Schlesinger, 1996), (2) Cultural Awareness in the Human Services/Help-Seeking Behavior (Green, 1999), and the (3) Process-Stage Approach (Lum, 2000). The models by Devore and Schlesinger and Lum are written with a primary focus on working with people of color. While Green includes specific

applications of his model to groups of color, his model is somewhat more expansive in application. A matrix comparing four culturally focused models of social work and mental health practice is included in Table 3 presented later on page 66.

### *Ethnic-Sensitive Social Work Practice*

*Definitions.* The authors of *Ethnic-Sensitive Social Work Practice* (Devore & Schlesinger, 1996) are credited with writing the first social work book addressing ethnic practice, published in 1981 (Lum, 2000). The approach is focused on ethnic and social class groups, primarily working with people of color to the exclusion of other ethnic groups (Devore & Schlesinger). No specific definition of cultural competence is offered rather the authors use the Social Work Code of Ethics as the point of reference for grounding principles behind ethnic-sensitive practice.

The authors note that culture is a difficult concept to define. Each group is viewed as having its own behavioral structures, worldviews, perspectives on the “rhythms and patterns of life,” and in how they view humanity (Devore & Schlesinger, 1996, p. 43). The term “race” is considered to evoke negative connotations and offers a limiting range of categorizations from which people may choose to identify. In contrast, “ethnic group” is viewed as a more meaningful way of categorizing people. Ethnicity is defined as “the sense of peoplehood experienced by members of the same ethnic group” (p. 45). The model emphasizes the intersection of ethnicity and social class and its particular impact on people of color.

*Assumptions.* There are four basic assumptions espoused in this model:

1. Individual and collective history have a bearing on problem generation and solution.
2. The present is most important.
3. Nonconscious phenomena affect individual functioning.
4. Ethnicity is a source of cohesion, identity, and strength as well as a source of strain, discordance, and strife. (Devore & Schlesinger, 1996, p.169)

The model calls for an examination of how the collective histories of the ethnic group, such as issues of oppression and social class, the group's cultural traditions and values, affect the individuals. It is concerned with how this history is woven into each group member's sense of identity. While social workers are to focus on present issues of the individual, this history is important to understanding how the individual perceives the problem and potential solutions. The group's commitment to and value of family, ethnic traditions, participation in ethnic-based schools, and the group's primary language all engender both positive and negative implications for individual group members over the life course. The customs and habits of the ethnic group become an integral part of the individual's experience and impact the individual on an unconscious level. Although the authors cite ecological theory as a contributing framework for the model, they associate the model with an eclectic theoretical framework, positing, "no single theory or perspective is sufficient to serve as the basis for thought and action" (Devore & Schlesinger, 1996, p. 189).

*Practice process.* Ethnic-sensitive practice includes micro and macro issues related to the impact of racism, poverty, and discrimination on the individual. The process examines individual problems as well as the system's role in producing and solving the problems.

Knowledge, values, and skills of generalist social work practice are critical for understanding multiple layers of integrated influence upon the individual and system. Seven layers of understanding provide the lens through which professionals are to approach the presenting problems: (1) social work values specifically regarding persons and environment relationships, quality of life issues, and strengths-based treatment of people; (2) basic knowledge of human behavior; (3) knowledge and skill in agency policy and services and how they impact practice; (4) self-awareness and its impact on practice with members of different ethnic groups; (5) impact of the "ethnic reality" on the daily lives of the client; (6) recognizing the impact of the route the individual had to take to reach the social worker; and (7) adapting and modifying one's skills and techniques may be necessary to competently respond to the ethnic reality (Devore & Schlesinger, 1996). Some specific intervention procedures might include identifying problems within a minority framework; recognizing the client's difficulty in seeking help and how it impacts the perception of services; and assessment and intervention which focuses on ethnic identity and issues related to the minority experience, such as oppression and powerlessness.

Addressing macro issues requires a slightly different application of the seven layers of understanding. Responding to social work values in a community context

involves responding to ethics which "seek to restore responsibility to clients as well as those calling for ethical responsibility to society" (Devore & Schlesinger, 1996, p. 229). The knowledge base must include an understanding of the community, its resources, its problems, and sources of power. The worker must have knowledge and skills in dealing with agency policies and available services. Self-awareness includes understanding how addressing your client's issues will affect your relationships with others and the community. Specific regard must be given to the ethnic reality of the client and the related barriers and challenges resulting from racism and discrimination. Understanding whether the client came for services voluntarily or through coercive means provides necessary information for how one must work with the systems. Finally, the target for change shifts to the power structures. Macro strategies to address the issues might include the use of a planning model, an administrative model, an evaluation model or a community organization model.

#### *Cultural Awareness in the Human Services*

*Definitions.* The Cultural Awareness model also termed "Help-Seeking Behavior" (Green, 1999), initially published in 1982, was developed through an anthropological lens and is based on an ethnographic understanding of cross-cultural relationships. Echoing the lack of a standard definition of culture, Green explains culture as "not something the other 'has,' such as a specific value or a physical appearance; it is rather the 'perspective' that guides our behavior, however brief the encounter. Culture and ethnicity are not essential or innate properties of persons; they are the meanings that two people act on in a

specific relationship” (p. 14). Where race is dismissed as a concept without any scientific value, ethnicity is viewed as a more useful concept for understanding cultural differences.

In the Help-Seeking Behavior model, practice emphasis is placed on recognizing and appropriately responding to differences. Differences are understood through either categorical or transactional explanations. Categorical explanations originate from concepts of pluralism and assimilation, whereby lists of ethnic traits and related assumptions and expectations (often related to issues of power) are imposed upon relationships. Transactional explanations emphasize expected differences between groups, with specific regard to boundaries and issues of power, and seek to understand the complexities of groups within a cultural context. A primary goal of the model is to add to service practice “the *comparative* basis for learning and for action in cross-cultural relationships” (Green, 1999, p. 35).

*Assumptions.* In this model, care is viewed as part of an individual’s daily life occurring within a larger cultural system. Personal and collective group experiences impact the care process. There is no specific overall social work theory discussed as a foundation for the model. Three basic assumptions guide the model:

1. Language is especially important; it is “the symbolic device by which the flow of experience is categorized, labeled, evaluated, and acted on”;
2. “Any need or problem is both a personal and a social event”; and
3. The model “rests on a fundamental dichotomy between illness” (the experience of suffering) “and disease” (a diagnostic category) (Green, 1999, p. 52).

The model aims to bridge differences among professionals, their organizations, and the cultures of the persons seeking help through service relationships. The basic model of Cultural Awareness requires the practitioner to first consider differences in how “problems” are conceptualized. The client enters the counseling situation with a “cognitive map” reflecting a combined individual/community perspective of the problem. The counselor’s interpretation of the problem must be reconciled with that of the client. Through the client’s narrative descriptions, the counselor gains a sense of the “client’s semantic evaluation of a problem” (Green, 1999, p. 59). The counselor learns the meanings behind the client’s language to really understand how the client perceives the situation. That is, by moving beyond a referential (dictionary) understanding of language to a social (contextual) understanding, the counselor’s “communicative competence” with the client is increased.

A conceptual understanding of the client is combined with an understanding of the client’s cultural community. This combined understanding is also significant to perceptions of illness, their causes, symptoms, and cures. The model postulates that individual illness experiences are culturally formed; therefore, interventions for relieving suffering must be contextualized to the client’s culture. The social worker must explore the client’s indigenous cultural strategies for resolving problems and determine the culturally based criteria for knowing when a satisfactory resolution is achieved. This requires building knowledge of resources and alternative sources of care in the client’s community, and understanding when it is appropriate to access those resources. The

definition of a successful outcome must be formed within the client's cultural conceptual framework.

*Practice process.* The practice process outlined below is described as a model for effective cross-cultural social work. Given the contemporary use of the term "cultural competence," Green (1999) offers a definition of the construct in the third edition of his book:

*The service provider who is culturally competent can deliver professional services in a way that is congruent with behavior and expectations normative for a given community and that are adapted to suit the specific needs of individuals and families from that community. (p. 87)*

Using the Help-Seeking Behavior framework described above, Green (1999) builds five components into a culturally competent model of care. The components are listed and defined:

1. Awareness of self-limitations: To understand the perceptions of the client, the social worker must understand one's own perceptions and how they differ from those of the client. The worker needs to engage oneself in a comparative analysis to determine these differences and recognize one's limitations in working with the client.
2. Interest and openness to cultural differences: This requires "a genuine and open appreciation of ethnic differences, without condescension and without patronizing gestures" (p. 90). The worker must determine what the client expects from the worker-client relationship.

3. A client-oriented, systematic learning style: The social worker must place oneself in the role of student with the client to gain the contextual knowledge necessary for developing the intervention plan. Three steps for systematic learning are offered: background preparation, use of cultural guides, and participant observation.
4. Appropriate utilization of cultural resources: This component involves learning how to help the client locate and use resources available, with a specific focus on using the strengths and natural resources of the cultural community. “The capacity for individualizing the client within a specific cultural matrix is the genius and the challenge of effective cross-cultural social work” (p. 92).
5. Engagement with diversity: To truly learn about the cultures of clients, the social workers must be willing to engage on a different level. This means moving out of the office and beyond the job description to spend time in the cultural communities of the clients. It requires direct observation and participation in “naturalistic” settings.

While the Cultural Awareness model of cultural competence is focused on direct practice, Green (1999) includes organizational competence and its ongoing evaluation as critical elements towards the delivery of culturally responsive services. Sources of conflict come from issues around race and gender, legal mandates, policies, funding limitations, internal hierarchies, inadequate training, and agency needs for accountability. Qualitative process evaluations using empowerment evaluation models are recommended

to understand how the conflicts relate to the cultural context of the organization and its ability to provide culturally responsive care.

### *Process-Stage Approach*

*Definition and assumptions.* The process-stage approach developed and currently advanced by Lum (2000) focuses on generalist social work practice with people of color. While admittedly drawing criticism for his view, Lum generalizes themes of the model as universal to all people of color in the United States in an effort to establish a “metacultural” perspective of practice. Culturally diverse practice is defined as that which:

...recognizes and respects the importance of difference and variety in people and the crucial role of culture in the helping relationship. Its primary focus is on people of color—particularly African Americans, Latino Americans, Asian Americans, and Native Americans—who have suffered historical oppression and continue to endure subtle forms of racism, prejudice, and discrimination...practitioners draw on the positive strengths of diverse cultural beliefs and practices and are concerned about discriminatory experiences that require approaches sensitive to ethnic and cultural environments. (Lum, p. 11)

Lum summarizes multiple definitions of culture by other authors as “the lifestyle practices of particular groups of people who are influenced by a learned pattern of values, beliefs, and behavioral modalities” (p. 89).

The model uses social work’s application of systems theory and psychosocial theory as a foundational basis, asserting that knowledge of these theories is “essential to

understanding the underlying themes that motivate people of color in their relationships to others and to society” (Lum, 2000, p. 111). To ensure that a culturally diverse practice framework is applicable to people of color in general and to particular subgroups requires both “etic” and “emic” views of cultural patterns. Social workers must be able to recognize patterns common across cultures (etic) and those patterns specific to a particular culture (emic).

*Practice process.* The primary goal of the Process-Stage Approach is to “improve the quality of psychosocial functioning” (Lum, 2000, p. 11) of people of color as they interact with society. Practice draws on the cultural strengths of clients and “relies on a person-to-person human relationship based on warmth, genuineness, and empathy” (p. 11). Reflecting the name of the model, the approach is presented within a framework that includes beginning, middle and end stages. Key process stages are included in each stage. The beginning stages include Contact and Problem Identification; the middle stages include Assessment and Intervention; and the end stage includes Termination. Three primary practice issues are considered within each of these five process stages: Client-System practice issues, Worker-System practice issues, and Worker-Client tasks. Client-System and Worker-System issues refer to practice issues of the client and worker as individual systems and in relationship with one another. The client deals with individual issues in collaboration with the worker, and the worker deals with the individual and system issues necessary for moving the client forward. The Worker-Client tasks reflect an obligation of the social worker to “nurture, understand, learn, and focus” (p. 132).

Following is a summary of the five process stages along with their respective practice processes:

1. **Contact:** The primary goal in this stage is the establishment of relationship and trust between the client and the worker. Client issues relate to resistance, ethnic history, and identity. Communication barriers between the client and worker must be resolved. Other worker issues involve knowing how the service system can respond in this particular cultural context, learning about the client's ethnic community, and development of relationship with the client. Worker-Client tasks involve nurturing, a willingness to be mutually involved, and demonstrating understanding.
2. **Problem Identification:** In this stage identification of the client's problem emerges through client-worker dialogue. Client issues involve informing the worker of the perceived problem, and through trust, more fully disclosing information. Worker issues involve examining the problem at multiple levels (micro, meso, macro) and understanding the client's orientations to the problem. Worker-Client tasks involve learning more in-depth information about the issues and focusing on one mutually agreeable problem.
3. **Assessment:** This stage involves an in-depth examination of the psychosocial problem being experienced by the client. The goals for this stage are to identify cultural strengths and available cultural community supports. Client issues involve examining the impact of the social environment on the individual client. Worker issues involve the assessment and evaluation of the

interaction of the client and environment, the impact of history and related group mindset on persons of color, and the affective and behavioral dynamics resulting from the ethnic group's experience. Worker-Client tasks include interacting with the client and evaluating the individual and environmental factors critical for developing a service strategy.

4. Intervention: In this stage a strategy is determined to address the problem, meeting the needs through client systems. Client and worker issues involve teaming with one another in setting goals and developing strategies to address the problem at all levels. Strategies for intervention include liberating the client from an oppressive situation, client empowerment, working toward achieving parity for the client, and maintaining the client's ethnic identity. Worker-Client tasks involve creating new ways to assist the client in dealing with the problem and changing the situation. Task-centered and behavioral strategies are often used in developing a specific course of action.
5. Termination: The final stage involves the closure of the relationship. The client and worker issues center on measuring the growth of the client from beginning to end of the relationship. The client recounts the changes that have occurred as a result of the work, and the worker develops a plan to maintain follow-up contact with the client to evaluate ongoing progress over time. The Worker-Client tasks include evaluating the outcomes and processes of the relationship and determining what was achieved and coming to terms with the

decisions that were made along the way. Focus is placed on the positive changes that occurred.

In keeping with the current discourse around cultural competence, Lum (2000) discusses culturally competent social work practice within the context of the Process-Stage approach. The general themes involve issues around multicultural service delivery and service delivery processes based on client needs, considering the collective values of an ethnic community in service practices, acquiring a culturally diverse theoretical knowledge base that can be used with clients as an individual, family, or community level, and using the Process-Stage approach as a culturally diverse practice framework. Four components of culturally competent practice are identified. The first component is Cultural Awareness, as similarly described in Green's (1999) model. The second component is Knowledge Acquisition, centering on an understanding of the basic ethnic and cultural group's language and concepts impacting people of color, including information on demographics, group's history of oppression, cultural values, and practice theory applications. The third component is Skill Development, focusing on strategies and techniques to be used in all five of the process stages, skills in conceptualization of issues, and personal interaction skills in working with multicultural clients. The final component is Inductive Learning, which involves worker self-assessment and continuous growth and learning in multicultural practice.

#### *A Comparison and Contrasting Summary of Social Work Models*

The three social work models presented have many overlapping characteristics. The Ethnic-Sensitive Practice and Process-Stage Approach models both specifically

target application with people of color to the basic exclusion of others who might currently be considered members of minority groups. While the Cultural Awareness model appears the most inclusive, emphasizing application across multicultural contexts, specific references to racial and ethnic groups of color remain the focus.

The models all tend to view ethnicity as a more meaningful construct than race, reserving race to reference issues of discrimination and prejudice. The models emphasize practitioners attending to historical issues of power and dominance for groups of color, but each model approaches the issues with a distinct consideration. Ethnic-Sensitive Practice specifically examines the intersection of ethnicity and social class and its impact or consequences on the individual lives of ethnic persons of color. In the Process-Stage Approach, understanding the common experiences across people of color with regard to the interaction of racism, prejudice, and discrimination is important for improving the psychosocial functioning of minority persons in society. The Cultural Awareness model implores social workers to explore their own conceptual construction of racism and prejudice and to examine the meanings of these issues for working with ethnically different persons. Issues of power are specifically discussed with regard to the worker-client relationship.

Other elements common among all three models include: basic knowledge building of the cultural and ethnic groups served, the need for practitioners to engage in some form of self-awareness process, skill building for work with ethnic persons of color, and incorporating indigenous supports and strategies into the intervention plan. Two models, Ethnic-Sensitive Practice and Process-Stage Approach, specifically discuss the

importance of a strengths-perspective in practice. These references to strengths include both the worker's approach to the engagement process and the identification of client strengths for inclusion in the intervention. The Cultural Awareness model and Process-Stage Approach both emphasize the importance of language in its broadest sense and its impact on worker-client communication.

Issues of values are approached differently in each model. Ethnic-Sensitive Practice emphasizes the significance of cultural values, and the Process-Stage approach emphasizes potential conflicts between social work and client values. The Cultural Awareness model includes values as one area of cultural knowledge to obtain, but suggests that a values approach does not capture important dimensions of culture.

Each of the three models presents a practice process for implementing its respective concepts and elements. Ethnic-Sensitive practice takes practitioners through seven layers of understanding as they develop relationships and respond to the client's ethnic reality. The Cultural Awareness Help-Seeking Behavior model includes five components necessary for competently working within a cultural differences context with the client. Neither of these approaches suggests any particular directional relationship among the model components. In contrast, the Process-Stage approach offers a step-wise process that walks the social worker through five stages, conceptualized from beginning to end of the client-worker engagement, implying a directional relationship among the model components. None of the authors discussed any empirical support for the components or application of their models.

While each of the three social work models presented offers varying degrees of the models' application to macro practice, all of them focus primarily on direct practice with clients. This is not to suggest that the models are not expandable to include a model specific for macro practice. However, as the models are currently presented their specific applications to macro practice are sketchy. Ethnic-Sensitive practice (Devore & Schlesinger, 1996) offers the most detailed discussion of the model's implementation within a macro framework. Table 3 (located on page 66) provides a matrix comparison of these three social work models and the model of cultural competence generally advocated in systems of care (described beginning on page 60). As previously noted, the systems of care model largely provided the framework for development of the NASW Standards for Cultural Competence in Social Work Practice (2001).

### **Social Work Theoretical Underpinnings of Culturally Responsive Practice Models**

The models of cultural competence in social work presented above draw upon multiple theories forming the current foundations of social work practice. None of the approaches uses a single theoretical framework as its base. Indeed, in the Cultural Awareness model no specific ties to social work theories were noted. The following discussion includes a brief overview of four theories noted in the models and the support they lend to cultural competence. The theoretical perspectives reviewed include Systems theory, Psychosocial theory, Ecological theory, and Strengths-based theories. The theories' application to the proposed research are described with regard to how principles and values of culturally competent systems of care and wraparound models are manifested in the theoretical models.

## *Systems Theory*

Systems theory examines how individuals, families, groups, organizations, and communities interrelate with one another. Von Bertalanffy ([1975] as cited in Whitchurch & Constantine, 1993) generally defines a system as a “set[s] of elements standing in interrelation among themselves and with the environment” [p. 159], p. 332). In their discussion of general systems theory and family systems, Whitchurch and Constantine (1993) describe family members each as components of a larger family system. This same application can be extended to individual members of an organization. Whitchurch and Constantine (1993) further explain that, “because components in a system are *interdependent*, or held together in a system, behaviors of the components exhibit *mutual influence*, meaning that what happens with one component generally affects every other component” (p. 332). This understanding of systems theory has particular relevance to relational competence theory (described later in this chapter), the primary theory on which this study is based.

Systems theory is used in multicultural social work practice to determine how individuals and systems interact (Lum, 2000). For example, concerns may include how the individual interacts with the family system or how the family system interacts with the community system. More emphasis is given to targeting the system for change than the individual. Devore and Schlesinger (1996) point out that systems theory offers support to ethnic-sensitive practice through its recognition of the gaps in institutional care related to discrimination and cultural differences.

In systems of care, multiple systems are interacting on behalf of children and families, including public and private human service agencies, individual family systems, and informal support systems surrounding the family. A huge impetus for the development of systems of care was the fragmentation of services and the large number of children and families falling through the gaps. The primary focus of change in systems of care is placed on how the systems can work together to ensure linkage of services that ultimately effect individual and family improvement.

### *Psychosocial Theory*

Psychosocial theory has a long history of application both inside and outside of social work. It is based on a dual perspective that psychological and environmental experiences contribute to an individual's development. Two basic premises of the approach are that our feelings and functioning are changed by our interactions with people and that by helping people understand themselves they can change their life and feelings (Cohen, 1998).

Psychosocial theory's contribution to models of cultural competence is the focus it places on the role of the social environment. Specifically, the theory examines the impact of the environment on people of color and what individual and community resources are available to assist in the change process (Lum, 2000). Additionally, the theory offers a way of examining the coping strengths of an ethnic group, along with the negative impact the majority culture has had on the ethnic group (Devore & Schlesinger, 1996). In psychosocial theory, the client remains the primary target for change.

While systems of care are focused on changes at the systems level, the wraparound service delivery component targets the child, family and community. The psychosocial approach has some application within wraparound service delivery plans of care in that a clinical worker is generally included as part of the service plan. In this regard, the clinician needs to understand how the child or youth may be impacted by psychological and environmental experiences. The clinician would especially work with the youth in connecting with any positive experiences and drawing on the youth's family and community to build connections with the cultural group that will facilitate healthy development.

### *Ecological Perspective*

The ecological perspective as adopted in social work finds its roots in the work of Urie Bronfenbrenner (Bretherton, 1993). This perspective suggests that human development must be understood through a contextual lens, whereby individual meaning making is developed from the interaction of a person within and across different environments. Bretherton credits Bronfenbrenner with a unique approach to understanding development by emphasizing this interrelationship among subsystems: "He [Bronfenbrenner] hypothesized that the developmental potential of a specific setting is enhanced when there are many supportive links (shared goals, mutual trust, positive orientation, and consensus) between settings, so that both can function as a harmonious network" (p. 286). Similar to systems theory, the ecological perspective's emphasis on the impact of relational interactions has particular relevance to the theory undergirding this research.

According to Browne and Mills (2001), the ecological perspective has become the prevailing general framework for social work practice. These authors assert that it is from the ecological model's person-in-environment view of a client's situation that social workers strive to understand the power dynamics and oppression experienced by an individual and try to improve the client's "fit" in the environment. To understand the client's fit in an environment, an assessment of the community in which the client lives is necessary (Browne & Mills, 2001). While the focus of the ecological perspective is on the transaction of people with their environments, the primary locus for change remains with the client. Systems of care are focused more on fitting the system to the needs of the child and family. In either case, an assessment of the community is necessary to understanding the dynamics between the child and family and the environment.

Devore and Schlesinger (1996) give much credit to ecological theory's contribution to the development of culturally responsive practice models. The theory's focus on the complex and reciprocal interactions of persons and their environments is central to the conceptualization of ethnic sensitive social work practice. Specifically, the authors note that the theory supports issues around how ethnicity, minority status, social class and resource availability all impact an individual's existence in society.

### *Strengths-Based Perspectives*

Strengths-based social work practice with people and communities has gained increased prominence over the last decade (Saleebey, 1997, 2002). The Strengths perspective focuses on the potential of persons rather than on problems or pathology. While problems are not ignored, services to deal with the problems are built on the

strengths and capacities of the individual. Kisthardt (1997) describes the strengths-based case management model, in which the primary helping functions are very similar to those described within the essential elements of wraparound. Six primary principles are incorporated into strengths-based practice, all of which are embedded within the philosophy and practice of wraparound service delivery:

1. Focus on the strengths, interest, abilities, knowledge, and capabilities of persons rather than on diagnoses, deficits, symptoms, and weaknesses;
2. The helping relationship is one of collaboration, mutuality, and partnership. Rather than power over one another, there is power with one another;
3. Every individual is responsible for her/his own recovery, and the service recipient directs the helping effort;
4. All human beings possess the capacity to learn, grow, and change;
5. Using a strengths-based, person-centered approach encourages services in naturally occurring community settings; and
6. The community has an untapped and rich supply of potential natural resources, which are considered for service recipients first before any formal services (Kisthardt, 1997, 2002).

The Strengths perspective offers enormous contributions to a culturally responsive framework for practice. Such an approach helps people to recognize that they possess individual and community resources that can help them break down barriers and develop creative solutions (Browne & Mills, 2001). Such empowerment is a central tenet of wraparound service delivery practices. Although the Strengths-based approach is

gaining in acceptance, a deficit-based approach remains the primary modality of practice in social work (Browne & Mills, 2001).

Another widely cited strengths-based approach gaining recognition in social work was offered by Kretzman & McKnight (1993). Their community development model provides guidelines on how to build a community around its assets rather than its deficits. Youth are a specific group considered to have multiple assets to contribute to the community. The model was highlighted in the Surgeon General's Report on Mental Health (USDHHS, 1999) in its recommendation for the development of culturally appropriate mental health programs in local communities.

### **Alternate Models and Approaches in Behavioral and Mental Health and Health Care**

Development of culturally competent practice models for human services reaches beyond the discipline of social work. A tremendous amount of effort has been made by the psychology and health care professions to advance models appropriate for their work with people and systems. Lending support to these efforts, the need for culturally competent care was a notable concern in the Surgeon General's Report on Mental Health (USDHHS, 1999). This concern resulted in a recent supplement to the report that focused specifically on issues of culture, race and ethnicity in mental health (USDHHS, 2001a). The models cited in the supplement were primarily developed in the mental health and health care fields. This is not surprising since "to date the discussion on cultural competency has been mainly conducted in terms of multicultural counseling and therapy by professionals other than social workers" (Lu, Lum & Chen, 2001, p. 2).

### *Models for Behavioral and Mental Health*

In 1990, the American Psychological Association (APA) adopted Guidelines for Providers of Psychological Services to Ethnic, Linguistic, and Culturally Diverse Populations (APA, 1990). As noted in chapter one, the APA has since made a commitment, in 1999, to implement cultural competence across the field of psychology (Sue, D. et al., 1999). In 1991, the Association for Multicultural Counseling and Development documented recognition of the importance of including a multicultural perspective in counseling, followed by proposed competencies and standards for inclusion in accreditation criteria (Sue, D., Arredondo, & McDavis, 1992). The model was developed with a specific focus on four groups including African Americans, American Indians, Asian Americans, and Hispanics and Latinos. Shortly thereafter, the Association for Assessment in Counseling (AAC), a division of the American Counseling Association, adopted 34 multicultural assessment standards by which all counselors were expected to practice (Prediger, 1994), also focusing on the four groups listed above. The standards were subsequently grouped by assessment-related tasks as follows:

1. Selection of assessment instruments: Content considerations;
2. Selection of assessment instruments: Norming, reliability, and validity considerations;
3. Administration and scoring of assessment instruments; and
4. Use/Interpretation of assessment results.

Under each task standards were further grouped by Code of Fair Testing Practices in Education; Responsibilities of Users of Standardized Tests; Standards for Educational

and Psychological Testing; Multicultural Counseling Competencies and Standards (only 3 standards were placed in this category); and Ethical Standards of ACA.

Professional literature and textbooks related to multi-cultural counseling and therapy have proliferated in the mental health care field over the past decade (cf., Brislin, 1990; Cuellar & Paniagua, 2000; Dana, 1998; Ponterotto, Casas, Suzuki & Alexander, 2001; Sue, D., Arredondo, & McDavis, 1992; and Sue, S. 1992, 1999). Models for application, psychological theories behind the models, field examples, measurement instruments, discussion of ethical issues and much more are examined specifically for use in an individual counseling situation. The models are too numerous to detail here, and they do not have specific relevance to this study's focus on cultural competence assessment at the service system level. Contrasting the counseling and psychology models' specific focus on the therapist-client encounter, the social work direct practice models previously described include a more holistic approach by attempting to address the role of service systems within the context of worker-client relationships. The service interaction occurring within the systems under study are broader than one-on-one therapeutic endeavors.

In contrast to the individual counseling paradigms that have shaped the work of professionals in the mental health field to date, newer models of cultural competence place the greatest responsibility of individual outcomes on the systems and practitioners providing services rather than those receiving services (USDHHS, 2001a). The model of cultural competence generally espoused in systems of care for children's mental health, developed by Cross, Bazron, Dennis and Isaacs (1989), follows a similar macro approach

to cultural competence. The work of Cross and colleagues was grounded in the goals of the Child and Adolescent Service System Program and broke new ground by offering a comprehensive model of care that extended from the practitioner to the agency to the systems providing the services. Their model of culturally competent practice is currently the most often cited model across literature and disciplines. Given its significance to systems of care and wraparound service delivery, the model is reviewed in detail.

### *Cultural Competence Model*

Like all of the other cultural competence models reviewed earlier, Cross and colleagues' (1989) work also focuses on "ethnic minorities of color," who have historically been subjected to the values and goals of the dominant groups constructing the service systems. Specifically, the model focuses on improving services to children of color who are experiencing serious emotional disturbances. It is primarily an agency-based model targeting service providers, policymakers, and administrators.

*Definitions.* Although stated earlier, the Cultural Competence model's definition of cultural competence is repeated here for clarity:

Cultural competence is a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals and enable that system, agency, or those professionals to work effectively in cross-cultural situations. (Cross et al., 1989, p. 13)

Culture is defined as "the integrated pattern of human behavior that includes thoughts, communications, actions, customs, beliefs, values, and institutions of a racial, ethnic, religious, or social group," and competence is defined as "the capacity to function within

the context of culturally-integrated patterns of human behavior as defined by the group” (Cross et al., p. 3).

*Issues of concern.* Cross and colleagues (1989) outline five primary issues relating to provision of culturally competent care, including system policies, professional training, accessible resources, traditional intervention practices, and a lack of research. Their model of care is in response to these issues, which primarily reflect needs for service systems to include definitions of family and community appropriate to the cultural communities served and to recognize the importance of these conceptualizations in working with the child. A brief description of each issue is provided:

1. Policy: There is a large number of children of color served, but little representation of people of color in policymaking positions. The trends of service types offered children of color often differ from those offered to their white counterparts and do not meet the needs of many minority children;
2. Training: With the shortage of minority mental health workers, the higher education curricula needs to do a better job of addressing the needs of minority communities. The institutionalization of cross-cultural practice needs to be a priority;
3. Resources: Adequate resources are often inaccessible to persons of color due to factors such as geographic location, language, distrust of provider systems, and cultural differences;

4. Practice: Practice with children does not adequately recognize or support the informal, cultural mental health system for children and their families and does not adequately address cross-cultural issues; and
5. Research: There is a lack of research with regard to cultural impacts on services and service outcomes. Culture is not often considered a variable, and research planning efforts often lack involvement of minority persons, leading to unethical research practices.

*Assumptions.* “Attitudes, policy and practice must all come together in a congruent whole called cultural competence” (Cross et al., 1989, p. 25). The original model includes 20 assumptions that offer a value base for culturally competent systems of care. The assumptions are summarized here. A culturally competent system of care recognizes, respects, and validates the uniqueness within and between minority and dominant cultures with regard to values, conceptualized needs, definitions of family and community, and worldviews. It prioritizes family and natural cultural system involvement in the service process according to cultural preferences. It understands that dignity of the individual requires preservation of the entire culture and advocates for universal movement toward competent service delivery. A culturally competent service system accepts the existence of cultural differences and works within a cultural context to address issues resulting from these differences. Service systems understand that process is at least as important as outcome for many minority cultures.

*Practice process.* The Cultural Competence model is considered a developmental model whereby attainment of cultural competence is achieved in varying degrees along a

continuum (Cross et al., 1989). Six levels of achievement are outlined: cultural destructiveness, cultural incapacity, cultural blindness, cultural pre-competence (implies movement), cultural competence (system meets the minimum definition of cultural competence), and finally cultural proficiency. At the highest level of competency the system has institutionalized cultural competence to the degree that it is recognized as holding culture in high esteem and demonstrates commitment to increasing the knowledge base through participation in research activities.

Five essential elements need to function at every level of the system to produce movement along this continuum (Cross et al., 1989). These elements are based on the assumptions described above and include:

1. Valuing diversity, whereby the system recognizes and respects the worth of diversity, accepts and responds appropriately to differences in meeting the needs of children and families;
2. Cultural self-assessment, whereby the system assesses itself for cultural competence and gains an understanding of its own culture;
3. Dynamics of difference, which examine the process of cross-cultural system interactions and what each interactant brings to the relationship based on individual experience;
4. Institutionalization of cultural knowledge: “The system of care must sanction...mandate the incorporation of cultural knowledge into the service delivery framework” (p. 20), thereby increasing its ability to effectively interact across systems and within the cultural community; and

5. Adaptation to diversity, whereby the system recognizes and adapts the system to fit the needs of children and families of color.

Four levels of the system are targeted for change in developing a culturally competent system of care: policymaking, administrative, practice, and consumer levels (Cross et al., 1989). At the policymaking level, community involvement is prioritized. The system must connect with minority communities, bring them into the system's planning processes, determine standards for working with persons from the communities, and support these standards through policy development and training across all levels of personnel. Empowerment models of decision-making structures should be implemented with cultural competence integrated into the system's mission statement and strategic plan. Policymakers should use research to guide their decision-making processes and advocacy at a legislative level.

Changes at the administrative level "sets the tone" for the organization's commitment to cultural competence (Cross et al., 1989). Support for cultural competence must be reflected in the organization's goals and objectives, personnel practices, intensity levels of training, and program evaluation efforts. Services must be accessible, located within the communities, and welcoming to persons of color. Services must be flexible and responsive to the needs of families. Information gathered through evaluation should be used for improving services and disseminated to community members.

Change at the practitioner level requires an individual commitment of staff to work through the five essential elements listed above (Cross et al., 1989). The practitioner must develop an awareness of cultural differences and similarities, recognize

the influence of one's own culture on one's own thoughts and behavior, understand power-related issues, develop a contextual perspective of the client's behavior, and develop knowledge about the client's culture and how to use it appropriately. The ability of the practitioner to communicate with the family is critical – “only through the development of cross-cultural communications skills can the worker become more effective” (Cross et al., p. 49).

The final level of change occurs at the consumer level. In this regard, families learn to become more effective in advocating for their children (Cross et al., 1989). This is accomplished by gaining skills in communicating the importance of the family's culture for successfully working with the youth. Movement along the cultural competence continuum requires change at all levels within the system of care.

As illustrated in Table 3, the Cultural Competence model incorporates many components common to the social work models previously compared. Elements similar across all four models include a need for self-awareness assessment; building appropriate knowledge, skills, and behavior; use of a strengths-approach with children and families; attention to issues of political dominance; and a strong emphasis on the importance of language and communication. In greatest contrast to the social work models, the Cultural Competence model was primarily developed to target competence of multiple levels of provider systems. Its authors (Cross et al., 1989) include a limited discussion of the model's application to direct practice.

Table 3: Models of Culturally Responsive Practice

<i>Model of Practice</i>	<i>Emphasis of Model</i>	<i>Theoretical Framework</i>	<i>Assumptions</i>
<p><i>Ethnic-Sensitive Social Work Practice</i></p> <p>Authors: W. Devore &amp; E. G. Schlesinger (1996)</p>	<p>Ethnic and social class groups, primarily persons of color; collective histories of ethnic group; sense of identity; intersection of ethnicity &amp; social class; focus on direct practice</p>	<p>Eclectic integration of theories used in social work</p>	<p>Individual &amp; collective history impact problem generation/ solution; Present is most important; Non-conscious phenomena affect individual functioning; Ethnicity is a source of cohesion, identity, strength, and strain, discordance, strife</p>
<p><i>Cultural Awareness in the Human Services: Help-Seeking Behavior</i></p> <p>Author: J. W. Green (1999)</p>	<p>Recognize/appropriately respond to differences; uses comparative process for learning &amp; action; bridge differences among professionals, organizations &amp; cultures of persons seeking help</p>	<p>Anthropological framework based on an ethnographic understanding of cross-cultural relationships; no specific theoretical framework noted</p>	<p>Language is critical to understanding how one categorizes, labels, evaluates, and acts on experience; Problems are both personal and social; Fundamental dichotomy between illness (experience of suffering) and disease (diagnostic category)</p>
<p><i>Process-Stage Approach</i></p> <p>Author: D. Lum (2000)</p>	<p>Generalist social work practice universal to all people of color; Primary goal is to improve quality of psychosocial functioning of people of color as they interact with society</p>	<p>Systems theory; Psychosocial theory</p>	<p>All people of color in the U.S. share common experiences of racism, prejudice and discrimination; Practice must consider "etic" (universal) and "emic" (culturally unique) cultural patterns</p>
<p><i>Cultural Competence</i></p> <p>Authors: T. L. Cross, B. J. Bazron, K. W. Dennis, &amp; M. R. Isaacs (1989)</p>	<p>Ethnic minority (children) of color with serious emotional disturbances served in systems of care; targets providers, policymakers, and administrators by addressing policies, training (knowledge, skills, communication/ language), resources, traditional practice &amp; lack of research; emphasizes strengths and roles for families</p>	<p>Child and Adolescent Service System Program/Systems of Care for Children's Mental Health philosophical framework</p>	<p>Systems: recognize, respect, validate unique values, needs, definitions of family &amp; community, and worldviews within/between minority and dominant cultures; prioritize family/natural cultural system in service process; recognize that dignity of individual requires preservation of entire culture; accept differences &amp; work within cultural context; understand process is as important as outcome for minority cultures</p>

Table 3 Continued

<i>Model of Practice</i>	<i>Model Elements</i>	<i>Practice Processes</i>
<i>Ethnic-Sensitive Social Work Practice</i>	Knowledge; Values; Skills--application of these three elements to micro & macro issues related to impact of racism, poverty, discrimination, oppression; primarily focuses on direct practice, but discusses application to macro practice.	<p><b>Micro:</b> 7 layers of understanding: Social work values of persons &amp; environment relationships, quality of life issues, strengths-based practice; Knowledge of human behavior; Knowledge, skill of agency policy &amp; impact on practice; Self-awareness &amp; impact on practice with ethnic groups; Impact of “ethnic reality” on clients; Impact of client route to services; Adapting/modifying skills to competently respond to ethnic reality</p> <hr/> <p><b>Macro:</b> Application of 7 layers: Social work values of restoring responsibility to client, and ethical responsibility to society; Knowledge of community's resources, problems, sources of power; Knowledge/skills in agency policies/services; Impact of client issues on worker relationships; Ethnic reality &amp; challenges due to racism/discrimination; Issues of voluntarily vs. coercive referrals; Target for change is power structures, with corresponding system change strategies</p>
<i>Cultural Awareness in the Human Services: Help-Seeking Behavior</i>	Ethnographic knowledge base (narratives; use of language); Professional preparedness (meaning of racial/cultural differences for self); Comparative analysis of problems; Culturally appropriate interventions; focuses on direct practice, but includes application to macro practice	<p><b>Micro:</b> 5 components: Awareness of self-limitations (comparative analysis to understand difference between self and client perceptions); Interest and openness to cultural differences in expectations of relationship; Worker assumes a client-oriented, systematic student learning style to gain contextual knowledge; Locating and using indigenous resources; Deeper level of engagement with diversity</p> <hr/> <p><b>Macro:</b> Organizational competence &amp; ongoing evaluation; Focus on sources of conflict: race, gender, legal mandates, policies, funding limitations, internal hierarchies, inadequate training, agency needs for accountability; Use of qualitative process evaluations using empowerment models to examine relationship between conflicts, cultural context of organization, and ability to provide culturally responsive care</p>
<i>Process-Stage Approach</i>	Sensitivity to ethnic & cultural environments; discrimination; oppression; culturally diverse strengths; self-awareness; knowledge acquisition (including language); skill development; inductive learning	<p><b>Micro:</b> Framework includes key process stages: Beginning: <i>Contact and Problem Identification</i>; Middle: <i>Assessment and Intervention</i>; End: <i>Termination</i>. Three primary practice issues considered at each process stage: Client-System issues, Worker-System issues, &amp; Worker-Client tasks. Client-System and Worker-System issues address participants as individual systems and in relationship with one another; Worker-Client tasks reflect obligation of worker to nurture, understand, learn &amp; focus</p> <hr/> <p><b>Macro:</b> Model primarily focuses on direct practice; macro issues to be addressed by direct workers are built into practice stages</p>
<i>Cultural Competence</i>	Developmental continuum model addressing attitudes (biases), policy (impartiality), and practice (perceptions of behaviors) across all levels of system	<p><b>Micro:</b> Change at the practitioner level requires individual staff commitment to work through the 5 essential elements required at macro level; change at consumer level involves families learning to become more effective in advocating for their children</p> <hr/> <p><b>Macro:</b> A system level model: 6 levels of achievement: cultural destructiveness, cultural incapacity, cultural blindness, cultural pre-competence, cultural competence, &amp; cultural proficiency; 5 essential elements needed at every level of system: valuing diversity, cultural self-assessment, dynamics of difference (including political dominance), institutionalization of cultural knowledge, adaptation to diversity</p>

### *Models for Health Care*

The U.S. Health Resources and Services Administration (USHRSA) Office of Minority Health (2001) conducted a study looking at how cultural competence was being conceptualized and measured in health care delivery systems. That study identified the following five models of cultural competence most often reflected in the health care literature:

1. Continuum of Cultural Competence (Cross et al., 1989), previously described in detail in section *Models for Behavioral and Mental Health*;
2. Five Components of Cultural Competence (Campinha-Bacote, 1999, as cited in USHRSA-OMB, 2001): This model is noted as similar to the model developed by Cross and colleagues. Cultural competence is viewed as a process for learning to work in the patient's cultural context. Five components of cultural competence are included: cultural awareness, cultural knowledge, cultural skill, cultural encounters, and cultural desire. The intersection of these five components reflects cultural competence. Both internalization of the processes and quality of care increase as the intersection becomes larger.
3. LIVE & LEARN (Carballeira, 1997, as cited in USHRSA-OMB, 2001): The study describes this model as one viewing cultural competence as an attainable goal given the development of certain skills. Cross-cultural interaction involves an exchange of attitudes, whereby the provider's attitude can range from superiority to competence, and the patient's response ranges from resistance to adaptation. A stage-type approach is used for gaining

cultural competence. LIVE stands for Like, Inquire, Visit, and Experience; LEARN stands for Listen, Evaluate, Acknowledge, Recommend, and Negotiate.

4. Sunrise Model (Leininger, 1993, as cited in USHRSA-OMB, 2001): This model is also described as a methodical approach to achieving cultural competence. Health care practitioners develop skills, knowledge, and patience to conduct patient assessments that explore their cultural patterns of illness in order to respond with the appropriate medical treatment. Seven dimensions are included in the assessment: cultural values and lifeways; religious, philosophical, and spiritual beliefs; economic factors; education factors; technological factors; kinship and social ties; and political and legal factors.
5. Transcultural Assessment (Davidhizar, Bechtel & Giger, 1998, as cited in USHRSA, 2001): This last model included in the HRSA study is also viewed as having a phase-like approach to developing cultural competence. An assessment is conducted with patients focusing on six factors: communication, space, time, social organization, environmental control, and biological variations. The goal is to determine the health beliefs and practices of the patient that might impact treatment. The assessment is a tool to assist in providing sensitive and tailored care to culturally diverse patients.

Of these five models, the conceptual definition of cultural competence outlined by Cross et al. (1989) (previously noted as the model used for systems of care) was adopted to frame the discussion of the USHRSA report.

### *Managed Care Models*

The last group of models to be mentioned has evolved from the managed health care and managed mental health care arenas. As the federal government of the United States continues to wrestle with its role in setting policy and governing health care practices in this country, recognition of disparities in health and mental health care for ethnic persons of color continues to increase (Abe-Kim & Takeuchi, 1996; Davis, K., 2001; Smedley, Stith, & Nelson, 2002; USDHHS, 1999). Along with this recognition come demands to address and reconcile these differences. Abe-Kim and Takeuchi suggest that the limitation of service options available to consumers through managed care systems places more responsibility on these systems to respond with more culturally appropriate care. While response to the demands is largely driven by managed care principles of cost containment through effective and quality service delivery (USDHHS, 2000), K. Davis suggests an hypothesis “that the greater the degree a health care policy is based on cultural competence, the greater the probability the goals of cost efficiency, quality services, and equity of health status will be achieved” (p. 65).

Multiple efforts to determine the specific cultural elements and processes directly related to quality care are underway. Managed care models of cultural competence focus on the development of core competencies for direct care providers that can be measured and linked to consumer outcomes. Several recent publications listed below have emerged reporting on studies designed to identify the core competencies of cultural competence with a goal of developing performance measures. Key reports, along with their definition of cultural competence, include:

- *Cultural Competence Performance Measures for Managed Behavioral Healthcare Programs* (New York State Office of Mental Health and The Research Foundation for Mental Hygiene, 1998). Cultural competence: “the set of congruent behaviors, attitudes and skills, policies and procedures that come together in a system, agency, or individuals, to enable mental health caregivers to work effectively and efficiently in cross/multicultural situations” (p. 4).
- *Cultural Competence Standards in Managed Care Mental Health Services: Four Underserved/Underrepresented Racial/Ethnic Groups* (USDHHS, 2000). Cultural competency: “An acceptance and respect for difference, a continuing self-assessment regarding culture, a regard for and attention to the dynamics of difference, engagement in ongoing development of cultural knowledge, and resources and flexibility within service models to work towards better meeting the needs of minority populations” (p. 57).
- *National Standards for Culturally and Linguistically Appropriate Services in Health Care* (USDHHS, 2001b). Cultural and linguistic competence: “a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations. ‘Culture’ refers to integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups. ‘Competence’ implies having the capacity to function effectively as an individual and an organization

- within the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities” (pp. 4-5, based on Cross et al., 1989).
- *Health Resources and Services Administration Study on Measuring Cultural Competence in Health Care Delivery Settings: A Review of the Literature* (USHRSA, 2001). No specific definition of cultural competence was developed for this study, rather a review of conceptualizations found across the literature were included.
  - *Cultural Competency Methodological and Data Strategies to Assess the Quality of Services in Mental Health Systems of Care: A Project to Select and Benchmark Performance Measures of Cultural Competency* (Siegel, Haugland, & Chambers, 2002). Cultural competence: “The attribute of a behavioral health care organization that describes the set of congruent behaviors, attitudes and skills, policies and procedures that enable its caregivers to work effectively and efficiently in cross/multicultural situations at all of its organizational levels” (p. 5).

Multiple methods were used to determine the managed care models’ identified domains and performance indicators for measurement, such as reviews of the literature, expert panels, and focus groups. The indicators were not derived through empirical methods and have not yet been tested for their contributions to outcomes. In response to a request by Congress, the Institute of Medicine conducted a study to specifically examine issues of healthcare disparities between minorities and non-minorities and provide recommendations for eliminating disparities. While not specific to managed care systems,

the recommendations in the resulting report, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* (Smedley, Stith, & Nelson, 2002), further emphasize research needs to “provide a better understanding of the contribution of patient, provider, and institutional characteristics on the quality of care for minorities” (p. 17).

In way of summary, many models of cultural competence currently espoused across disciplines are concerned with mental health. Psychology and counseling models attempt to delineate specific attitudes, beliefs, knowledge, and skills of the therapist that contribute to a culturally competent one-on-one counseling endeavor. Health care models include a broader lens than the psychology models, offering insight into cultural patterns and response strategies specifically related to illness and healing. The managed care models are attempting to produce lists of standard indicators against which providers and systems can be measured for culturally competent care. The social work and systems of care models offer what appear to be more holistic perspectives that include greater focus on persons within their cultural communities, issues of power and oppression, and the impact of both on the persons presenting for services. The systems of care model contributes the greatest focus on cultural competence at an organizational level.

While a number of elements are shared across models, there is no clear or agreed upon conceptualization of the meaning of the construct. The concepts underlying current models were primarily based on expert-driven processes rather than being developed from perspectives of persons receiving mental health services, and have not been substantiated through empirical studies. Furthermore, the models do not offer any empirical understanding of the relationships between concepts. This issue alone has

enormous implications for direct providers of mental health care, those developing the systems in which the care is provided, and the educational systems preparing practitioners for working in social service systems. If there is no clear understanding of which elements are critical to culturally competent care in systems serving children with mental health needs and their families, or how the elements are related to one another, then on what bases do we formulate our educational curricula, methods of practice and interventions, system structures, and methods of research?

### **Theoretical Conceptualization for Study**

As noted in chapter one, this study's exploration of cultural competence in children's mental health systems of care was driven by several issues potentially effecting policy, mental health programs, professional education and practice, and research on mental health systems. The inadequacy of mental health services for children and families with diverse backgrounds in the United States has prompted efforts to develop more culturally responsive systems and practices. However, while cultural competence is a key value for systems of care and social work, there is no consensus around its meaning, resulting in a lack empirical research that validates the theoretical practice models, measures, and impact of culturally diverse practice in mental health services.

This research study incorporates multiple perspectives on culturally competent care for children and families. As reported throughout this review, there are no specifically agreed upon definitions or conceptualizations of cultural competence. The one area of agreement for the majority of models presented is that the focus of cultural competence should be primarily placed on ethnic groups of color. Yet this focus is

somewhat contradictory to the values and principles of systems of care and wraparound, which require individualization and tailor-made plans of care for all children and families served. A term often used to direct this focus is “family culture.” Discussions with adult caregivers of children with serious emotional disturbance often reveal that families living this experience consider themselves part of another group culture that is separate from what they perceive as the dominant culture of families without such complexities.

The foundation for the study’s design was grounded in the principles and values of systems of care and wraparound practices. The Cross et al. (1989) model of cultural competence developed for systems of care provided further support for the philosophy underlying the research process. As a part of their model, Cross and colleagues call for an assessment of the environment that focuses on the attitudes, policies and practices of the organizations providing services, specifically targeting those not part of the dominant culture. This environmental assessment should help the organization clarify its values related to culturally competent care and include other members of the community in the process.

To establish a culturally competent system of care, common, unique, and dynamic constructs of cultural competence need to be considered for reliable conceptualization and assessment. For purposes of this study, common constructs are identified as ideas about culturally competent care that are shared among constituent groups within and/or across systems of care. Unique constructs are those that are identified with a specific group(s) within or across systems of care. Constructs must also be dynamic in that as systems change, the capacities and needs of the system will vary. Measurement of

constructs must provide a means for capturing these transformations. Conceptualizations will likely always differ from one system of care community to another. Thus, determining a way to identify the common, unique, and dynamic aspects of cultural competence across and within groups and systems of care communities becomes a formidable challenge.

The idea of bridging groups through commonalities is not new. In his discussion of functional interrelations among cultures, Gillin (1948) suggested that, “when comparing one culture with another we must compare not only the separate customs of each (the content of the cultures) but also the wholes as total organizations of custom” (p. 185). He goes on to state that, “if no similarities in culture could be found and no regularity could be discovered, we would be helpless in our attempts to explain and predict cultural phenomena” (p. 198). Fifty years later social work was asked to remember that it is by strengthening its common bonds that it will act to promote justice, equal opportunity, acceptance, and community for the larger society (Haynes & White, 1999). In exploring methods for conceptualizing and assessing cultural competence, we must sacrifice neither the differences that make us unique nor the common strands that hold us together as a humane society.

How to achieve such balance remains one of the critical unanswered questions. The complexity of this question increases when the balance sought links people and the institutions created by people. This research study adopted the perspective that communication competence is an integral element to any successful intercultural exchange or relationship. Green (1999) and Leigh (1998) provide in-depth discussions of

the role of language in people's perceptions of the world. Both authors assert that in order to achieve communicative competence with others we must extend beyond our own frame of reference and learn the "language" of those with whom we are communicating. Hammer, Gudykunst and Wiseman (1978) provided early evidence that the ability to communicate effectively is a key component to intercultural effectiveness. Saldaña (2001) additionally emphasizes the key function of communication for culturally competent therapeutic encounters. As well, the Surgeon General (USDHHS, 2001a) recognized the importance of communication in the mental health field as it relates to culturally competent care.

Our individual realities are constructed and made meaningful through the words we put to our experiences. The language we choose to use in intercultural encounters serves as a guide for the direction of the interaction (Leigh, 1998). "To learn someone's language is to enter into his or her world. Social workers must be able to look *into*, not at, the culture of the other. The culturally sensitive social worker must have a strong sense of what meanings are suggested by the language of the client" (Leigh, p. 90).

### *Relational Competence*

Substantial support for using communication in relationship as a central theoretical construct for this research is based on the early work of Spitzberg and Cupach (1984, 1987), both trained in communication sciences. Their Relational Competence model was developed within a framework of interpersonal communication competence. Spitzberg (1989) further developed their ideas and discussed the framework as a "pre-theoretical" model of Interpersonal Competence in the Intercultural Context. Given the

absence of an empirically validated theoretical framework for culturally competent care in social work and mental health services, the model offered by Spitzberg and Cupach (1984, 1987) seemingly provides a basic theoretical framework for conceptualizing and assessing cultural competence. As will become evident, concepts embedded within the four previously reviewed practice models of cultural competence used in social work and systems of care (previously compared in Table 3) can be found within the individual components of the Relational Competence model.

The relational competence model is first discussed as conceived by Spitzberg and Cupach (1984, 1987) and Spitzberg (1989). Based on this discussion a diagram was developed by this author to depict a visual representation of her interpretation of the relationships among the theoretical constructs. Following this representation an algorithm is offered by this author to illustrate how the theoretical model of interpersonal relational competence could be applied to a theoretical model of competence at a system level.

A comprehensive theory of competence ultimately will need to deal with the diverse processes of information acquisition and processing, behavioral performance, learning, and impression formation. Further, such a theory must come to terms with the complexities of interactional systems rather than individuals (Harris, 1979). (Spitzberg & Cupach, 1987, p. 1)

Relational competence is defined as “the extent to which objectives functionally related to communication are perceived to be fulfilled through interaction appropriate to the interpersonal context” (Spitzberg & Cupach, 1987, p. 3). The term *relational* qualifies the context in which *competence* is being evaluated, i.e., a unique relationship.

*Competence* “is an evaluative judgment of the quality of a performance” (p. 3). As conceptualized in this theory, “competence is not ‘located’ in the behaviors themselves, or the abilities or traits enabling those behaviors, but in the inferences regarding those behaviors” (p. 4). *Objectives* are the conscious or unconscious desired outcomes of the interaction. *Functionally related to communication* refers to the communicative interaction as the act of achieving some effect, i.e., the effectiveness of the interaction. *Appropriate to the interpersonal context* means that the valued standards, rules or expectations of the interaction/relationship in a particular context are not perceived as violated. Thus, relational competence is the quality (appropriateness and effectiveness) of an interaction as perceived by the interactants.

*Assumptions.* There are eight basic assumptions of the relational competence model (Spitzberg, 1989; Spitzberg & Cupach, 1984, 1987). The assumptions are grouped into conceptual and methodological categories (Spitzberg & Cupach, 1987). Each assumption is described separately to clearly delineate the critical concepts of the model.

*Conceptual Assumption 1 - Competence is an interpersonal judgment:*

Competence is an impression one has of oneself or of another during interaction based on current and historical contexts. Competence continuously changes and is based on individual perceptions, as different people perceive particular behaviors as appropriate and effective in different contexts. Judgments made about competence include the quality of person(s) or performance.

*Conceptual Assumption 2 -Competence inferences evolve from an interdependent process:* All participants in the interaction should be recognized, as “an individual is

competent only in the context of relationship” (Spitzberg & Cupach, 1984, p. 114). The interactants in each relational encounter may assess differing levels of importance to multiple relational components, such as previous relational history, personal values and beliefs, and social context. The interaction of these components and their assessed importance form each interactant’s conceptions of perceived competence of that encounter.

*Conceptual Assumption 3 - Competence inferences are continuous judgments:*

Judgments of relational competence are complex and multidimensional. Impressions of appropriateness and effectiveness are evaluated along a continuum based on an interplay of behaviors, affective responses, and cognitions. Judgments of competence are dynamic in that they can change from one encounter to another, or even within a given encounter.

*Conceptual Assumption 4 - Certain personal attributes increase the likelihood of being perceived as competent:* The authors maintain that there is generally a great deal of agreement between one’s behavior and another’s perception of behavior, although this is not always the case. Given this belief they assert that,

Across numerous episodes and across society’s collective interactions, it seems reasonable to conjecture that certain behaviors generally are seen as competent...[thus, they] posit a probabilistic model of relational competence, in which the research objective is to identify those behaviors with the highest probability of being viewed as competent. (Spitzberg & Cupach, 1987, p. 9)

*Methodological Assumption 1 - Measures of competence should reference behavioral (molecular) and evaluative (molar) impressions:* Molecular behavior

impressions are the concrete observable indicators of competence. Molar evaluation impressions are the abstract cognitive evaluations of the interaction. In evaluative terms, molecular behaviors could be described as the measurable indicators of success (e.g., someone is always available in times of crisis), and molar impressions would be the overall targeted outcome being measured by the indicators (e.g., the program is dependable). The authors suggest that the molecular and molar impressions can be related to one another “within and across contexts to assess the behaviors that most consistently relate to competence impressions” (Spitzberg & Cupach, 1987, p. 10).

*Methodological Assumption 2 - Measures of competence should be related to functional outcomes:* The process of communication relates to and produces functional outcomes. These outcomes should be satisfying to the interactants, resulting in relationship satisfaction and perceptual congruence. In order for the interaction to be perceived as effective, the outcomes of the interaction must be relevant to the interactants’ desired expectations.

*Methodological Assumption 3 - Measures of competence should be event-specific:* Competence is contextual, and appropriate and effective communication varies with the situation. Traits or characteristics of a person considered competent in one situation may not be perceived as competent in other situations. Behavioral traits are performed differently based on one’s knowledge, motivation, skills, and outcomes of the specific situation. The authors contend that if judgments of competence are truly dynamic then measures of competence must be sensitive to the impact of context on the interaction.

*Methodological Assumption 4 - Measures of competence should permit self and other assessment:* As previously noted, competence is concerned with quality of performance. Both appropriateness and effectiveness are necessary components of relational competence. Assessments of appropriateness and effectiveness made by both participants involved in the interaction are viewed as critical in order to identify the disparities and consistencies between the interactants' perceptions. Examination of any perceived discrepancies is integral to understanding the conclusions drawn from competence assessments.

*Components.* The Relational Competence theory is built upon four personal relational components, motivation, knowledge, skills, and outcomes, and a complex contextual component (Spitzberg & Cupach, 1984, 1987). In short, the theory suggests, “that as person A’s motivation to communicate, knowledge of communication, and skill in communicating within a given context with person C increase, the more competent A is likely to be perceived by self and by C, and the more positive *outcomes* [emphasis added] will accrue to A” (Spitzberg & Cupach, 1987, p. 11). The authors further suggest that extremes in motivation, knowledge and skill could also have a negative impact on perceptions of competence. The concepts embedded into the theory are defined below.

*Motivation:* “Motivation is the confluence of affective and cognitive psychological factors that lead an actor to desire and pursue a specific interactional objective or set of objectives in a given encounter” (Spitzberg & Cupach, 1987, p. 12). As conceived by the theory’s authors, motivation can be viewed through a social learning theoretical perspective. The interactants’ level of motivation depends on things such as

interest in the interaction (value placed on potential goals), anxiety about the interaction (how much confidence one has that the goals will be obtained), and how much reinforcement of self the interaction appears to offer (examining the potential negative consequences) (Spitzberg & Cupach, 1984, 1987).

*Knowledge:* Knowledge “is the comprehension of, and the capability to generate comprehension of, the characteristics of a given encounter relevant to a competent performance” (Spitzberg & Cupach, 1987, p. 13). The knowledge component includes a self-monitoring process to identify needs for continued learning. The authors identify four specific areas of knowledge critical to perceptions of relational competence: (1) possessing information on the topics discussed in the interaction, (2) knowledge of the other person (relationship-specific knowledge), (3) understanding the rules of the interaction (language, socially or culturally normative, relational), and (4) performance procedures (knowledge of the range of appropriate behaviors in the given context) (Spitzberg, 1989; Spitzberg & Cupach, 1984, 1987).

*Skills:* In the relational competence model, skills refer to the actual behaviors performed in an interaction and one’s ability to repeatedly perform specific behaviors necessary for obtaining the desired goals. Spitzberg (1989) refers to these skills as “mastered behaviors.” The authors cite research to substantiate the inclusion of four specific types of skills that contribute to competent interaction: (1) expressiveness (verbal and non-verbal), (2) interaction management (how one structures and manages the interaction processes, such as awkwardness or synchrony in turn taking, topic discussions, etc.), (3) altercentrism (a sense of otherness, such as listening skills,

empathy, attentiveness, adaptive to other in interaction role, and immediacy), and (4) social composure (behaviors related to social competence, such as assertiveness, level of anxiety or relaxation, level of confidence, etc.) (Spitzberg, 1989; Spitzberg & Cupach, 1984, 1987).

*Context:* The authors describe context as a subjective experience involving cultural, social, environmental, relational, and functional features, each of which can be characterized along a given set of dimensions. The context of a relationship implies specific expectations for each person engaged in interaction. The more or less congruent one's performance is with expectations, the more or less competent one will be perceived (Spitzberg & Cupach, 1987). Spitzberg (1989) further explicates context along four specific dimensions: Valence (one's perceived affiliation and evaluation of affective climate in relationship), Potency (issues of power in the relationship), Surgency (one's level of intensity or activity in the interaction), and Socialization (one's awareness and interpretation of the cultural context and expected rules of conduct).

*Outcomes:* Outcomes are the functional effects of the interaction evaluated in terms of its perceived appropriateness and effectiveness. The authors have identified several outcomes of relational competence (Spitzberg & Cupach, 1987). An outcome highly related to relational competence is communication satisfaction, as rated by self and other. Linked to satisfaction is the construct of "feeling good" in the interaction. Affirmation of "self-identity" is another noted outcome of competent interaction. The theory purports that there is a positive relationship between the levels of perceived relational competence and the extent of outcomes achieved.

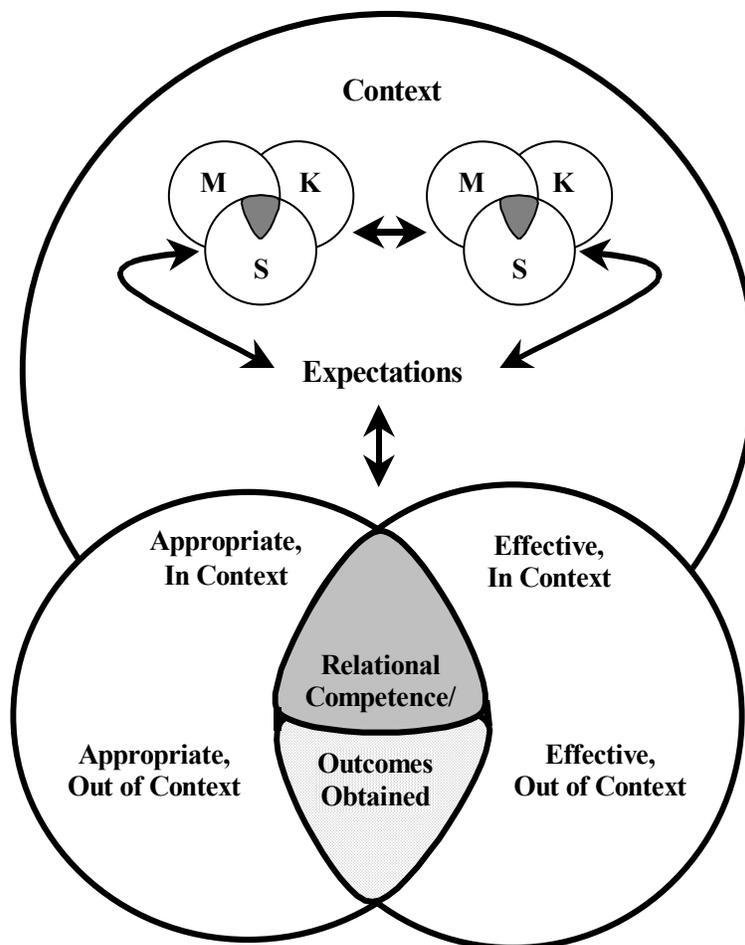
*Interpretation of theory for current study.* The following diagram (Figure 1) presents a summary of this author's interpretation of how the integrative theory of relational competence can help in understanding the dynamics at play in culturally competent care. While many of the elements included in the relational competence theory are embedded in the models of culturally competent practice in social work and children's mental health systems of care, the models do not offer a particular sense of how the different elements might be directly related to one another. The relational competence model is viewed as a way of conceptualizing and making meaning of the data that were anticipated from this study.

In short, Figure 1 illustrates that every interaction initiates within some context. The interaction of each individual's motivation (M), knowledge (K), and skills (S) produces individual expectations of the encounter. Simultaneously, each person's MKS are interacting with one another, dynamically changing the expectations of the encounter. The shaded centers of each individual MKS represents what this author would conceive as a genuine or ideal connection between interactants and congruence of contextual expectations. As the relationship ensues, outcomes are obtained to a greater or lesser degree based on the interaction of the individual and combined MKS and contextual expectations. Different degrees of outcome obtainment and relational competence are illustrated by a second set of concentric circles. Again, the darkest shaded area reflects what might be considered the highest levels of relational, or cultural, competence.

Models of cultural competence often include elements of knowledge, skills, abilities, behaviors, and attitudes. In the relational competence theory (Spitzberg &

Cupach, 1984, 1987) attitudes and one's perceived abilities are embedded in the element termed motivation. In effect, using the referential definition of attitude (a mental position, feeling, or emotion with regard to a state [Mish et al., 1988]), motivation can be linked to the root of attitude. Following the ideas behind relational competence theory, motivation facilitates performance (i.e., behavior within a context), stimulates or influences perceptions of the interaction, and engages the cognitive functions in an interactive experience. The degree of one's motivation, then, influences one's consideration about whether and how much to engage in any particular interaction. According to Spitzberg

Figure 1. Interpersonal Relational Competence

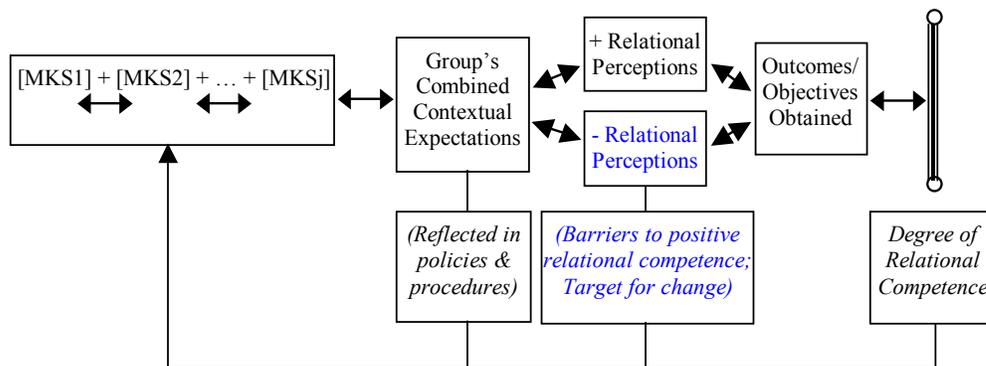


and Cupach (1984), if someone is motivated to engage, then the knowledge stored in cognitive schemas based on past experiences is retrieved in order to determine the appropriate response. Thus, we could surmise, it is reasonable to follow that the level of engagement chosen may be related to the individual's self-perception of abilities to effectively interact. Relational competence theory asserts that although a person may have the motivation and the knowledge of how to communicate in a situation, the person may not possess the actual skill necessary to respond appropriately. In effect, motivation, knowledge and skills can work in isolation or in tandem with one another (Spitzberg & Cupach, 1984). The concentric circles of individual participants reflect these possible interactions.

Following the illustration, just as individuals' MKS impact one another, so do they relate to individual and combined contextual expectations. These expectations, in turn, provide the evaluative criteria for the resulting behavior. If relational competence is indeed a dynamic process (Spitzberg & Cupach, 1984, 1987), and behaviors are different from what was expected, the new information is reconfigured through continuous MKS interaction, and expectations are revised accordingly. Ultimately, the experience of the interaction leaves the interactants with individual positive or negative perceptions or impressions of the encounter. The fluidity of the model suggests that these outcomes can be different with each interaction and can change over time. As such, each outcome ultimately impacts all future interactions for each interactant.

The conceptual structure of the interpersonal relational competence theory can also be moved to a conceptualization at a group level. Given that systems are comprised of people who, in turn, give structure to those systems, applying the relational competence model to a group becomes a matter of additive processes. Figure 2 presents a potential algorithm for broadening the interpersonal relational competence theory to one of group relational competence.

Figure 2. Group Relational Competence – Changing Patterns of Perceptions



The expansion to group relational competence is essentially a way of thinking about changing patterns of perceptions. Service systems are comprised of people who are responsible for ensuring service provision, and people who are receiving services. These different groups of people engage in relationships with one another, built on individual and collective perceived experiences. The additive interaction of individual and combined motivations, knowledge and skills form the groups' expectations of relational experiences. In other words, collective or group perceptions are created by the cumulative experiences of the individuals making up the collective.

These group expectations lay a critical foundation for determining how positively or negatively the interactions will be perceived internally and externally to the group, in turn, affecting the ability of the group to effect positive outcomes and perceptions of relational (i.e., cultural) competence. As the group's internal perceptions of relational competence increases, instances of negative behavior (barriers to perceived group relational competence) become more recognizable. Thus, a reasonable next link would be to conjecture that as barriers are recognized they become associated with individual group member behavior or with structural factors related to the behavior (such as policies). To then transform the structures or members perpetuating negative or incompetent behavior, the patterns of perceptions of the individual group members (or structures governing group member behavior) must be altered in order to generate more positive interactions of motivations, knowledge and skills that lead to achieving outcomes reflective of relational competence.

Expanding relational competence theory from an interpersonal to a group application in human service organizations (particularly systems of care) can be supported by political economy theory. The political economy perspective analyzes human services in interrelationship with the larger society (Austin, 1988). Specifically, this perspective focuses on the interaction between political forces and economic resources, both internal and external to the human service network, in the shaping of human services (Austin, 2002). Externally, political economy refers to the social context and negotiation of network legitimation through distribution of resources to the human service network. Internally, political economy examines legitimation through the flow of

resources to individual organizations or programs within the network. The legitimation process is largely controlled through the perceived effectiveness of the network and individual organizations.

Two assumptions of political economy theory are of particular relevance. First, economic self-interest and status are what motivate collective or societal processes and marketplace exchanges (Austin, 1988). Secondly, communal relationships, mutual interdependencies among individuals, are the motivations behind collective action. Conflict occasionally emerges between these two motivations, as communal relationships prioritize personal involvement in group interests, and economic self-interest is inherently individualistic. Human service organizations are essentially collectives that value and depend on communal relationships for their existence, yet are dependent upon marketplace exchanges for their survival.

Following political economy theory, behavior change or social control objectives of programs are established first by the legitimators, then the consumers, and finally the providers (Austin, 1988). As a core value of systems of care philosophy and as a key interest of federal and private funders of mental health services, provision of culturally competent care becomes a factor in the legitimization of the system. Legitimators' expectations and perceptions of a culturally competent system of care are supported through evaluations of the system. Since consumers play integral roles with providers in the planning, implementation, and evaluation of systems of care, the perceptions of consumers and providers are critical to internal and external collective impressions.

Ultimately, perceived relational group competence will help ensure sustenance of the system of care and consumer receipt of appropriate and effective services.

Similar ideas are proposed by Gutierrez, Alvarez, Nemon and Lewis (1996) in their discussion of multicultural community organizing. These authors suggest that the devolution of federal resources results in increased power for local communities in legitimizing social welfare services. Building on methods from community practice multicultural organizing uses relationships among individuals, families, groups, and organizations to “eliminate social injustice and oppression based on specific group membership” (Gutierrez et al., 1996, p. 502). System structures are viewed as contributing to inequalities that must be eliminated in order for cultural competence to “build bridges across cultural barriers” (Gutierrez et al., p. 503). Building relationships across culturally diverse groups increases the level of influence the groups will have on system reform.

Families and children involved in systems of care have generally experienced numerous interactions in multiple service agencies providing them with a rich data bank of material from which to store up expectations and perceptions of relational encounters. Unfortunately, by the time children with serious emotional disturbances and their families come in contact with systems of care their expectations may be jaded by past experiences, which often resulted in poor outcomes and/or poor impressions of relational experiences. Indeed, these experiences largely contribute to the call for culturally responsive mental health service systems. Recalling that relational competence theory views outcomes and competence as directly related to one another, consumers in systems

of care likely enter the system with lower expectations of successful outcomes and of the system's performance than the workers assigned to coordinate their services. While people working in individual agencies have their own cognitive data bank of experiences with consumers, systems of care and wraparound philosophies often generate a new level of excitement and expectations for successfully working with families.

The differing expectations of consumers and professionals alone requires each participant to come to some consensual understanding of what might be expected from this new way of engaging in the care process. A sort of re-constructing one's motivations, knowledge and skills will likely need to be a part of the relationship forming process. Understanding what is important to consumers, providers, and the systems governing and legitimizing children's mental health services, along with gaining a sense of the state of perceived competence at each participant level, will help in the interpretation of outcomes obtained.

While this study did not endeavor to empirically test the relational competence theory, it did intend to use its structural constructs to assist in understanding the information gathered from systems of care communities related to culturally competent care. A relational competence way of thinking about cultural competence differs from general approaches to teaching cultural diversity and culturally competent social work practice. Practitioners often believe that if they possess the skills and perform behaviors that they have been taught are culturally appropriate, then they are responding in a culturally competent manner. This theory, however, conceptualizes competence as perceived appropriateness and effectiveness viewed through the lenses of the interactants.

## **Cultural Competence Assessment**

Cultural competence assessment methods have not kept pace with the developing approaches to culturally competent practice (Lu, Lum, & Chen, 2001; Pope-Davis & Dings, 1994). The Surgeon General's supplemental report (USDHHS, 2001a) suggests that developing a refined understanding of cultural competence is needed in order to conduct research on the impact of culturally competent care. The dynamic and fluid nature of cultural competence is a likely contributor to the difficulty in arriving at a static conceptualization of the construct. Even if an agreed-upon conceptualization of the construct were developed, one would have to question its utility across all groups, in all communities. In turn, how much confidence could be placed in an assessment conducted with a measurement instrument that was based on a conceptualization of the construct that does not fit the system under evaluation.

A common method of conceptualizing and assessing cultural competence is referred to as the list technique (Spitzberg, 1989). Adaptations of this technique are widely used in the rapidly developing managed care assessment models. The list technique is a process whereby researchers identify skills or characteristics through literature or "expert" reviews and then use those items to measure cultural competence. Spitzberg argues that while items on the list may well contribute to competent interaction, the ideas are often based on the conceptions of the authors rather than having been empirically derived from the interactants themselves and tested for validity. He further suggests that lists present an "illusion of validity" when in fact the techniques used for data reduction are generally unreliable and come from small samples. The illusion is

magnified when characteristics appear to be consistent across lists, but where the constructs (or characteristics) were actually conceptualized within a different context by each author. Moreover, the lists do not generally reflect any type of relational model among the components.

Clearly, efforts need to direct attention toward conceptual integration *across* such lists, ultimately seeking the underlying abilities and constructs, and their mutual interrelationships, that facilitate intercultural competence. This kind of effort obviously produces a list as well, but one that is conceptually integrated rather than simply collectively accumulated. Unfortunately, such a goal will likely continue to evade researchers as long as measurement efforts continue to be of questionable validity and coherence. (Spitzberg, 1989, p. 246)

Current models of cultural competence assessment in mental health are primarily hierarchically driven (Rogler, 1999). They are largely developed based on key expert consensus around a particular concept and then assumed to be transferable across cultures. Rogler asserts that “the procedural norm that unwittingly promotes the easy transferring of concepts can be a source of cultural insensitivity, depending on the degree of such cultural differences or similarities” (1999, p. 430). He advocates for adapting research designs to engage the group under study from planning the research to interpretation of the findings. In essence, Rogler supports using participatory research methods in the assessment of cultural competence.

The lag in cultural competence research may be due in part to the quest for controlled quantitative studies that suggest cause and effect. S. Sue (1999) questions the

mental health field's choice to emphasize internal validity over external validity, and advocates for expanded research approaches that include qualitative and ethnographic methods. Additional support for qualitative research methods was offered by Ponterotto, Gretchen, Utsey, Rieger, and Austin (2002). However, the majority of cultural competence assessment measures developed in mental health to date are rooted in traditional scale development processes.

### *Current Mental Health Assessment Measures*

The following review highlights a selected number of measures currently used in assessing cultural competence in mental health. The first four measures described are those most often cited in the literature and those with the most empirical validation. These measures were developed specifically to assess the one-to-one interaction between a counselor/therapist and a client based in large part on the model of cultural competence outlined by D. Sue, Arredondo and McDavis (1992). They were not developed for use in broader-based practice models such as those espoused in social work.

1. *Multicultural Counseling Knowledge and Awareness Scale* (MCKAS; Ponterotto, 1997; Ponterotto et al., 2002; Ponterotto et al., 1996): a counselor self-assessment scale developed to measure multicultural awareness and knowledge. This 32-item, 7-point Likert-type scale is a revised version of the Multicultural Counseling Awareness Scale (MCAS). Reported to have two subscales (knowledge and awareness), content and face validity, and an adequate level of construct validity (Constantine & Ladany, 2000).

2. *Cross-Cultural Counseling Inventory-Revised* (CCCI-R; LaFromboise, Coleman, & Hernandez, 1991): an assessment for supervisors to assess trainees' cross-cultural counseling competence. This is a 20-item, 6-point Likert-type scale that measures cross-cultural counseling skill, sociopolitical awareness, and cultural sensitivity with a unidimensional structure. Reported to have content validity, internal consistency, and construct validity (LaFromboise, Coleman, & Hernandez).
3. *Multicultural Counseling Inventory* (MCI; Sadowsky, Taffe, Gutkin, & Wise, 1994 as cited in Pope-Davis & Dings, 1994): a self-report assessment of cultural counseling competence. This is a 40-item, 4-point Likert-type scale focusing on behavioral measures of multicultural counseling skills, knowledge, awareness and relationship. Reported to have content validity, criterion-related validity, and adequate construct validity (Constantine & Ladany, 2000).
4. *Multicultural Awareness/Knowledge/Skills Survey* (MAKSS; D'Andrea, Daniels, & Heck, n.d.): a self-report assessment of multicultural counseling training developed in 1991. This is a 60-item, 4-point Likert-type scale that assesses awareness and knowledge about people of color and cross-cultural communication skills. Reported to have questionable content validity, criterion-related validity, and construct validity (Constantine & Ladany, 2000).

The next three selected measures were developed specifically for cultural competence assessment at the organizational level. This review does not include the extensive lists of performance measures developed through managed care models. Two models of assessment presented below were developed specifically within the children's mental health systems of care framework. The third measure discussed was developed for primary use in child welfare organizations.

1. *Cultural Competence Self-Assessment Questionnaire (CCSAQ; Mason, 1995, 2000)*. This measure offers two versions of a tool for organizations to assess the cultural competence of their direct service workers (79 items) and administrative staff (60 items) with people of color. Six sub-scales (primarily using 4-point Likert-type scales) measure knowledge of community, personal involvement, resources and linkages, staffing, organizational policies and procedures, and reaching out to communities. Good internal consistency reliability is established on all but one subscale, personal involvement. It is reported to have content validity, but no other validation was reported (Mason, personal communication, February 14, 2000).
2. *Systems of Care Practice Review (SOCPR; Hernandez & Gomez, 2000; Hernandez et al., 2001)*. This measure offers a case study approach for assessing culturally competent practice within organizational and familial cultural contexts. Three primary domains of systems of care philosophy are measured: child centered and family focused; community based; and culturally competent; impact was added as a fourth domain. Each domain

includes a number of sub-domains. The assessment process includes researching record-keeping documents; case record document reviews; interviews of the caregiver, youth, provider and informal provider; and 34 7-point Likert-type scale summative questions for rating the information gathered. The instrument's authors initially reported adequate interrater reliability. Some concern for response consistency among interviewers was noted in one study (Hernandez et al.). An abbreviated version of the measure was recently released for performance measurement purposes.

3. *Cultural Competence Agency Self-Assessment Instrument* (CCASAI; Child Welfare League of America, 2002). This measure was designed as an educative tool for staff along with identifying agency strengths and challenges in serving diverse children and families. It was not intended for use as an empirically validated measure. There are 96 items measured on a 5-point Likert-type scale that cover seven domains: valuing culture and diversity; documents checklist; governance; administration; policy development and program; service delivery; and children, youth, and families served. No data on reliability or validity are reported.

An additional and more detailed review of instruments specifically related to cultural competence assessment can be found in Roizner (1996). While these organizational assessment methods provide valuable options, they do have some limitations. For example, the CCSAQ does not gather input from family members and focuses primarily on people of color. With regard to the SOCPR, the intensive amount of

training necessary for data collectors combined with the lengthy data gathering process limits its ongoing use by community systems of care. Additionally, each of the measures outlined in this section were developed with a priori conceptualizations of cultural competence. In most instances, the conceptualizations of the construct were developed from an expert-based approach as opposed to seeking ideas of cultural competence specific to individual systems of care communities. Thus, the models do not permit examination of the particular commonalities and uniquenesses across communities.

#### *Model of Assessment*

In some ways the managed care models described earlier provide somewhat of a bridge between the practice and research efforts of cultural competence, as they often promote a participatory, community-based approach to assessment (USHRSA, 2001; USDHHS, 2001b). The assessment process used for this study was guided by systems of care values that place children, families, and communities at the center of all work. Concept Mapping (Trochim, 1989) offers a mixed-method approach that can be used for assessing cultural competence from multiple perspectives in a relatively short period of time. Mixed method approaches for cultural competence assessment were recently suggested for use in helping to describe the cultural context of a community (Hernandez et al., 1998). A brief review of the method's prior use will set the framework for discussing its fit for this research.

*Prior Use of Concept Mapping in Mental Health Research and Cultural Competence Assessment*

Mental health evaluators have used Concept Mapping for a variety of purposes, such as program planning and needs assessment (Johnsen, Biegel, Shafran, 2000). For example, Shern, Trochim, and LaComb (1995) used Concept Mapping to assess the fidelity of a psychiatric rehabilitation program model for psychiatrically disabled homeless persons, where the model tested was compared to the theoretical model upon which the practice model was based to detect differences between theory and practice. Another application was used to get staff views of a program serving persons with severe mental illness (Trochim, Cook, & Setze, 1994).

Concept Mapping is also noted for its utility in instrument development (e.g., van Nieuwenhuizen, Schene, Koeter, & Huxley, 2001). In a study to assess the construct validity of a program evaluation measurement instrument, Marquart (1989) linked correlations from evaluation data with conceptual clusters obtained through Concept Mapping to compare theoretical and observed patterns of measurement. A high degree of agreement between the theory and observed evaluation results was found, suggesting the attainment of instrument construct validity. Marquart further suggested distinct advantages of the approach over more common methods of instrument development. For example, the flexibility of the multidimensional scaling procedure used in Concept Mapping offers fewer constraints on the level of measurement than are imposed by factor analysis. Consistent with systems of care principles, the approach is especially useful for involving participant constituents in a way where their input is evident throughout the

entire instrument development process. This advantage is of particular interest for development of community-based instruments.

With regard to culturally related research, one study was identified that assessed barriers and identified solutions for involving African American families in planning services for family members suffering from severe mental illness (Biegel, Johnsen, & Shafran, 1997). Researchers made modifications to the Concept Systems process and noted that the flexibility did not impact the reliability of the method.

Most recently, Trotter and colleagues (2001) used variations of Concept Mapping within a large international study to examine whether the International Classification of Impairments, Disabilities and Handicaps met standards for cross-cultural application. The researchers used variations of methodological processes embedded within Concept Mapping (Concept Systems, 2001) to conduct two separate analyses on the existing classification list in use at that time. The method was used to determine item difficulty, item appropriateness for different groups based on demographic and ethnic characteristics, item cultural sensitivity, item placement within the classification scheme, and item importance to the classification scheme. The method was found useful for comparing cross-cultural classification conceptualizations and for identifying issues that appeared to be applicable across cultures (Trotter et al.). No other applications of Concept Mapping were identified related to assessment of cultural competence.

#### *Fit of Concept Mapping with Research Study and Related Implications*

As discussed in detail in a previous section, there is no one generally agreed upon conceptualization of cultural competence in social work or mental health. Moreover, one

must even question the appropriateness of conceptualizing cultural competence in one specifically defined manner. There are no doubt common elements of the construct that weave across systems of care communities; however, it is more culturally responsive to allow communities an opportunity to identify those commonalities for themselves. At the same time, the use of a proscribed conceptualization of the construct for assessment might limit the opportunity for people to talk about the unique cultural characteristics that strengthen their communities. Identification of common and unique cultural elements is important to understanding the cultures of the community (Guerra & Jagers, 1998).

Concept Mapping brings a group of people together in dialogue around an identified issue and provides a structured way of gathering information while retaining the context of the group throughout the process. The process is participatory in that community members are included from the beginning planning stages through interpretation of the data. This level of community participation is critical to the fidelity of the systems of care paradigm. Indeed, Cross et al. (1989) called for the need to develop and implement new research methods that involve the community throughout the entire assessment process. Not only is it important to systems of care, but as previously discussed, participatory approaches are congruent with social work ethics and are gaining ground in social work's peer disciplines.

Beyond allowing communities to conceptualize their vision of cultural competence, the Concept Mapping approach provides an opportunity for participants to place varying degrees of value on the many elements of their conceptualization. Guerra and Jagers (1998) suggest that, "in order to evaluate the influence of culture on the

assessment process, we must begin by specifying those aspects that are most important” (p. 169). It is not in the purview of the researcher to make such value-based decisions rather only those within the culture being assessed can responsibly make those determinations for themselves. Furthermore, as a dynamic and ever-changing construct, the values assigned to indicators of cultural competence will likely change over time. The Concept Mapping process provides a means for tracking these changes over time.

Concept Mapping also has the potential of increasing our understanding of how the conceptual components of culturally competent interaction are related to one another. The statistical techniques behind the method provide a way of structuring the ideas and examining how participants perceive their interrelatedness, both within and across individual systems of care communities. Spitzberg (1989) articulates the need to explore a method with such cross-cutting potential:

There is a disturbing lack of grounded or inductive item generation based at the interactant’s level of understanding and meaning....The instruments being used in current research are not necessarily invalid. The problem is that their validity is simply unknown, given their developmental histories and construct validity evidence to date. The search for new conceptual and measurement directions appears justified. (p. 249)

Social work is seeking new and innovative ways for conducting research in all its endeavors. The process used in this study explored the use of an innovative methodology in a way not previously applied to culturally related research. There are only a minimal number of sound measurement tools developed for assessing cultural competence beyond

the individual counseling interaction. It is clear that any study of cultural competence must be able to generate common and unique conceptualizations of what is appropriate and effective within the context of each system of care community.

A primary objective of this study was making a contribution to social work's understanding of conceptualizations and indicators of culturally competent practice. It is possible that different conceptualizations of cultural competence will emerge from this research for those working in children's mental health systems of care. What consumers and systems perceive as important may differ from one system of care to another, or from one set of demographic characteristics to another. Specifically, participants in this study may perceive the conceptual relationships among elements differently than our current practice models might suggest. While the conceptualizations identified are limited to the perceptions of participants in this study, they may still provide critical insights into the cross-cultural applicability of current models. Thus, current understandings of elements considered critical to effective culturally competent care and service structures may need to be revisited.

### **Hypotheses**

In an attempt to generate an increased understanding of how current models and measures of culturally responsive practice might apply across multiple mental health systems of care for children and families, four hypotheses were adopted for this study:

1. Comparisons between groups of participants will indicate relational differences on cultural competence ratings of importance, frequency of demonstration, and agency policy.

2. Individual community assessments will produce common and unique conceptualizations of cultural competence that are not wholly accounted for in current definitions (assumptions and theoretical conceptualizations) of the construct.
3. Individual community assessments will produce common and unique conceptualizations of cultural competence that are not fully supported by current measures of the construct.
4. Findings from the proposed mixed-method, participatory research methodology will indicate the viability of Concept Mapping as a reliable and valid approach to community-based conceptualization and assessment of cultural competence.

*Groups of participants* refers to groupings that can be made based on numbers of participants and demographic characteristics. *Relational differences* will be determined by comparing average ratings by participant groups. *Common conceptualizations* are defined as those that are shared among participant groups within and/or across systems of care. *Unique conceptualizations* are those that are identified with a specific group(s) within or across systems of care. *Community-based conceptualizations* are identified as the items generated by participants in systems of care communities to reflect (1) their perceptions of cultural competence, (2) how their ideas are structured, and (3) the value they assign to the structural elements.

The relational differences referred to in the first hypothesis are primarily based on conceptual relationships among the ratings assigned by participants. While a statistical

correlation is produced to examine patterns of participant perceptions, the analyses do not include tests of statistical significance. Rather gaining a greater understanding of the substantive significance of relationships as perceived by participants was the objective for this exploratory study.

## CHAPTER 3

### METHODOLOGY

This study was exploratory in that it sought to implement and examine the viability of an innovative approach to examining the construct of cultural competence in children's mental health systems of care and comparing data gathered through the method to current practice models of cultural competence. Although the study was exploratory, it was grounded in theory and attempts to begin a dialogue about the validity of current conceptualizations and assumptions of cultural competence as a construct. While there are many different approaches to Concept Mapping (Jackson & Trochim, 2002), its application used in this study is a structured process developed by Concept Systems (Concept Systems, 2001; Trochim, 1989).

Concept Mapping was used in two phases of this study. The first phase was a cross-sectional study of four separate systems of care communities, two urban and two rural. The second phase was an aggregated study across all four communities. For purposes of this study, urban and rural classifications are descriptors the four systems of care communities assigned to themselves. Descriptions of the four communities are described in the "Participant Sample" section later in this chapter. However, for purposes of clarification, community descriptions primarily refer to *rural* as country or agricultural life, and *urban* reflects areas characteristic of a city (a more detailed description of each community is provided later in this chapter beginning on page 115).

As used in this study, Concept Mapping generated conceptualizations of cultural competence from the perspectives of adult individuals participating in the specified

service communities. The data generated from individual communities were then aggregated, reduced to a combined set of data, and used in a second Concept Mapping application to examine participant conceptualizations of data generated in multiple systems of care communities. The individual and aggregated community conceptualizations were further examined impressionistically (Shern, Trochim, & LaComb, 1995) within the relational competence theoretical framework for their congruence with assumptions and elements underlying current practice models of cultural competence. Concept Mapping is viewed by the researcher as a potentially culturally appropriate method for understanding the cultures of individuals and systems within the communities' systems of care.

Four specific questions guided the research study:

1. To what extent are there differences and similarities in conceptualizations of cultural competence among groups of participants across four systems of care communities?
2. Do systems of care community assessments (individually and collectively) support current assumptions and theoretical conceptualizations of cultural competence?
3. Do community conceptualizations of cultural competence support the usage of generalized measures of cultural competence?
4. Is Concept Mapping methodology a viable approach to conceptualizing and assessing cultural competence in individual communities?

Four hypotheses were developed based on these four research questions:

1. Comparisons between groups of participants will indicate relational differences on cultural competence ratings of importance, frequency of demonstration, and agency policy.
2. Individual community assessments will produce common and unique conceptualizations of cultural competence that are not wholly accounted for in current definitions (assumptions and theoretical conceptualizations) of the construct.
3. Individual community assessments will produce common and unique conceptualizations of cultural competence that are not fully supported by current measures of the construct.
4. Findings from the proposed mixed-method, participatory research methodology will indicate the viability of Concept Mapping as a reliable and valid approach to community-based conceptualization and assessment of cultural competence.

### **Research Design**

Concept Mapping, as implemented using the Concept Systems approach, is a structured method for developing a conceptual framework using a group process (Concept Systems, 2001; Trochim, 1989). The method applies a participatory process that uses a mixed-method approach to understanding multiple ideas from multiple participants. A qualitative research design is used in combination with quantitative analytic techniques. The method is flexible in that it can incorporate a mix of data

collection processes. This methods section is written following the general stages of the Concept Mapping methodology (Concept Systems, 2001).

In an effort to model implementation of systems of care philosophy, increase the chances for gathering valid and reliable data, and to increase the capacity for culturally appropriate processes, a specialized team was assembled for the specific purpose of conducting the systems of care cultural competence assessments. The core team consisted of a Family Evaluator who is a caregiver of a child with serious emotional disturbance. The two contracted Facilitators are experienced teachers and trainers of cultural diversity. The Research Associate is the principal investigator who brought personal multicultural experience, knowledge of systems of care processes, and knowledge of the research method. All four team members are trained master's level social workers. The team was culturally and ethnically diverse, reflecting the differing cultures served in the local communities. Two of the team members were Mexican American and fully bilingual in English and Spanish. One team member was African American, and one member was Caucasian. All four team members were female.

The principal investigator was trained in the methodology by its developer, Dr. Bill Trochim, and others from Concept Systems, Inc. in Ithaca, New York. The training consisted of two separate levels. The first level involved two and one-half days of intensive hands-on training learning the Concept Mapping facilitation process, Concept Systems software application, and data analysis techniques. The second level included one and one-half days of advanced training primarily focusing on the method's statistical analyses and use of the method for theory and scale development. Following the first

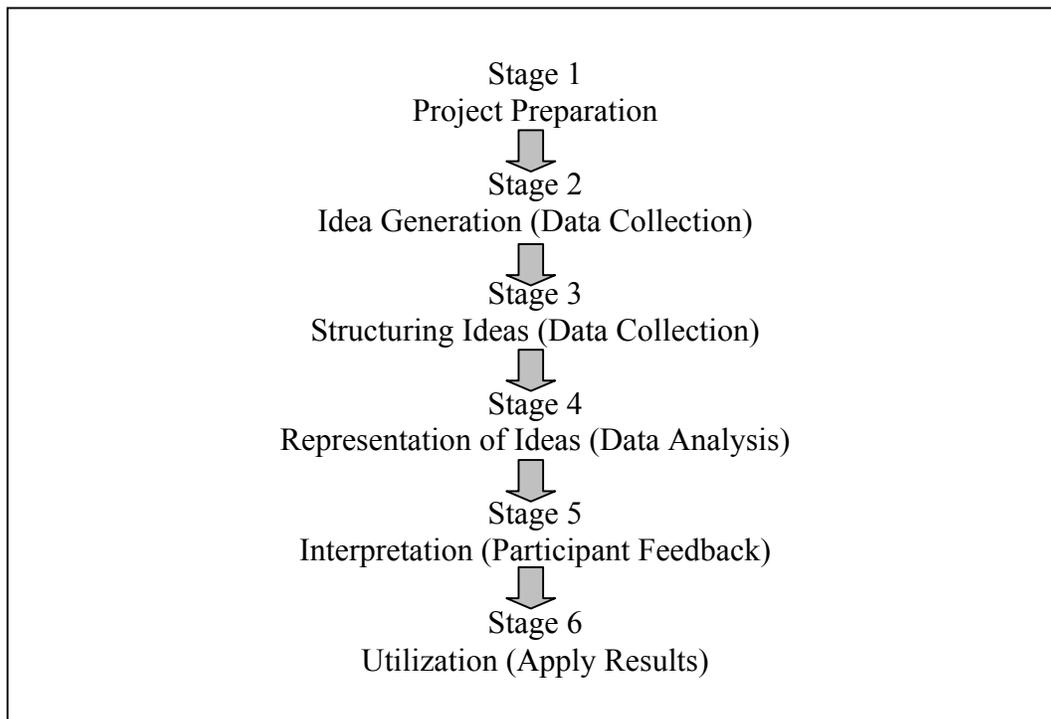
training, the principal investigator provided one and one-half days of training to the other three research team members. Their training focused primarily on the facilitation process and an introduction to the software application. The author of this study retained primary responsibility for the database, its management, and statistical analyses.

### *Concept Mapping Overview*

Figure 3 illustrates the six general stages of the Concept Mapping process (Concept Systems, 2001). Stage one of the methodology involves the Preparation of the study design. With the exception of its participatory approach, this process is similar to any other research planning effort, including development of the specific questions for the practical application of the study. Stage two, Idea Generation, uses *brainstorming* to facilitate the gathering of descriptive statements that then serve as the data for the study. The brainstorming can be done in a group setting or individually. In stage three, Structuring Ideas, participants are asked to individually *sort* the statements and group them into conceptual piles in whatever way makes the most sense to them. The sorting process is used to structure the information and assess meaning to the data. The individual sorts are entered into the computer to produce a conceptual map showing how the participants as a whole think all the different statements are related to one another. Participants then use Likert-type scales (points as determined by the researcher) to *rate* each of the descriptive statements based on pre-determined criteria to give interpretive value to each statement. This process facilitates the creation of correlational results. In stage four, Representation of Ideas, statistical analyses are conducted to produce graphical maps of the ideas generated and group comparisons based on the ratings

assigned by participants. Stage five, Interpretation, involves sharing the results of the analysis with the participants and obtaining feedback and clarification of the concept maps. Participants are asked to provide input into the *interpretation* of the data. In the final stage, Utilization, findings from the study are used for *action planning*.

Figure 3. Concept Mapping Using Concept Systems Process



*Note.* Concept mapping analysis and results conducted using The Concept System® software: Copyright 1989-2001; all rights reserved. Concept Systems Inc.

Prior to this research a pilot study was conducted in a local system of care using a variation of the proposed study method. The principal investigator of the current study was also the lead investigator for the pilot study. Results of the pilot study indicated that the process may be very valuable in conceptualizing the complex construct of cultural competence (Davis, Rodriguez, Barraza & Johnson, 2002). The findings produced the

intended information for the community. That is, a community conceptualization of cultural competence was generated with enough participants to allow group comparisons of the conceptualizations. Both commonalities and differences were found among the groups, with specific indications for training needs.

The process also provided the researcher an opportunity to test out the method before implementing it in this more comprehensive study. Based on the experience from the pilot study, several modifications were made to this research design. The remainder of the methods chapter is structured around the design originally implemented in the pilot study and the subsequent revisions applied to this study. The pilot and revised designs are described for each stage of the Concept Mapping process. The methodology used for the aggregate phase of the study is described in a separate section after the description of the process used for individual community assessments.

### *Project Preparation*

This statewide study was initiated with the creation of a committee of representatives from five systems of care communities in Texas who volunteered to participate in the preliminary tasks of designing the study. The planning committee met via teleconference during the months of October, November and December 2001.

### *Participant Sample*

*Pilot study.* Participants for the pilot study included family caregivers, youth with serious emotional disturbance, agency staff and administrators, and members of the project's board. Participants were primarily recruited through research team efforts. Flyers (in both English and Spanish) were sent as part of a Federation of Families mailing

to families actively being served in the project. In addition, the research team telephoned families before each of the scheduled meetings. Some families also received telephone reminders from their case management staff. Professional participants were recruited through Board meeting announcements and visits, emails sent out by project staff, and word of mouth by various members of the research team and project staff. The greatest efforts were given to recruiting family members for the study. Though extensive efforts were made by the research team to recruit participants, the sample size was limited.

*Revisions for current study.* Experience from the pilot study suggested a couple of key revisions were needed to the participant sample. First it was determined that members (professional and family members) of the system of care needed to take primary responsibility for recruiting participants. It was believed that low turnout for the pilot study was in large part due to a lack of investment by the system of care professional members. To increase participation from a broad spectrum of systems of care participants, staff and families from the four systems of care communities in this study were asked to recruit members of their respective systems of care to participate in the assessment. Planning committee members were provided with flyers in both English and Spanish (see Appendix A), similar to those used in the pilot study, and other written materials describing the effort for use in recruiting participants.

The second key revision pertained to youth participation. Based on the pilot study experience and the objectives of the research study, the decision was made to focus the Concept Mapping process on adult participants. The pilot experience indicated that the scope of the study, along with the sorting and rating processes as designed for use in this

study, were potentially too complex and not conducive to maximizing involvement of youth with serious emotional disturbance. However, it was still important for purposes of practical application to retain youth involvement in the individual community assessments. Thus, while the objectives for gathering information from youth and adult participants were similar, the processes used with each were different. The methods used with youth are described throughout the methodology section to enable the reader to gain a fuller sense of the context in which the study was implemented. However, given the specific focus of this research on the contribution of Concept Mapping, results from the youth participation are included in the appendices rather than in the Findings chapter.

The study included participants from four systems of care communities in Texas, two urban and two rural. At the time of the assessment, all four systems of care received monetary state support, but none of the systems of care were federally funded initiatives. All four were in their second year of development. Following are summaries of general descriptions of the communities as provided by the communities.

The first community, hereinafter called URB-N, covers diverse geographic boundaries that include both rural and urban communities but is primarily urban. It estimates that 31,700 of its youth population suffer with serious emotional disturbance, about 14,400 of whom are extremely functionally impaired. Families with children ages 5-17 are eligible for participation in the system of care based on varying geographical residences and levels of impairment. Primary objectives of URB-N include the development of a cohesive community-wide decision- making entity that adopts a

common approach to assessment, planning and service delivery across all participating child serving agencies.

The second community, hereinafter called RUR-W, covers ten rural counties in its geographical catchment area. The counties cover more than 9,000 square miles, with a combined population of approximately 100,000. The economy is agricultural-based, and approximately 23% of families live below the poverty level. The community estimates that 50% of its ethnically diverse youth live in homes receiving some form of public assistance. Systems of care target children and youth ages 10-17 who are at risk of incarceration or other out-of-home placement. Primary objectives of RUR-W include increasing family involvement at the local practice, program, and system levels, while maximizing and coordinating funds to provide individualized and cost efficient services.

The third community, hereinafter called URB-E, is the most populated urban county in Texas. Its population includes over 3.2 million residents, with estimates of over one million children ages 0-18. Primary objectives of this school-based system of care include establishing a cohesive community-wide decision-making entity whereby families are true partners in developing and implementing a culturally competent, child-centered and family-focused system of care that utilizes a wraparound approach in working with families.

The fourth community, hereinafter called RUR-E, consists of two rural areas and one urban-like area covering three counties. Families selected for participation in the system of care reside in any one of the three counties and include youth who are at risk for out-of-home placement or who are currently placed outside the home. Primary

objectives for RUR-E are to move the system of care from its current level of operation to a more integrative system of care for children and their families in all three counties.

Participants eligible for recruitment included family caregivers, youth with serious emotional disturbance (primarily 11 years or older), agency staff and administrators, members of the local community advisory boards, and any other community members involved or targeted for the system of care effort. Members of the community who were not eligible for referral to the system of care or who would not be considered as participating in a professional capacity in the system of care were not recruited for the study.

#### *Developing a Framework*

*Pilot study.* The first task of the committee was to develop a working definition of cultural competence best suited for systems of care in Texas. The committee developed the following definition:

Cultural competence is knowledge, skills, abilities, attitudes, and behaviors that demonstrate respect of differences in people of all ages and organizations in all aspects of a community.

In the pilot study, the facilitators presented this definition to participants and engaged them in a minimal amount of discussion before generation of the qualitative statements began. The definition was posted on the wall for participants to review during the brainstorming data collection process.

*Revisions for current study.* While it had initially been thought that presenting a pre-determined definition of cultural competence to the community would facilitate

understanding of the concept, this process ultimately seemed contradictory to the intent of the study. Using a preconceived definition narrowed the frame within which ideas were generated from the focus statement. Therefore, in lieu of using a definition, the facilitators engaged participants in a discussion to stimulate their thinking about the meaning of cultural competence. The discussion broke this concept down into separate components, beginning with asking participants to think out loud about the meaning of culture and then competence. Participants were asked to put the ideas of culture and competence together, leading participants into the official brainstorming data collection process. By removing any preconceived definition of cultural competence the brainstormed list was to become the participants' conceptual definition of the construct.

#### *Developing the Focus Statement*

The development of the focus statement is a critical step in the preparation stage, as it shapes the process and outcome of the study (Concept Systems, 2001). It is the foundation on which the remaining stages of the Concept Mapping process are built. The focus statement must be specific, action-oriented, and focused on the purpose of the study.

*Pilot study.* The planning committee was charged with the responsibility of developing the focus statement (or focus/research question) to be used for gathering the descriptive statements. The committee developed the following focus statement that was used in the pilot study:

*Complete the following statement with an example:*

*I believe a level of cultural competence is achieved in a system of care when \_\_\_\_\_*

To increase the level of understanding, the statement was adapted for the adolescents and some caregivers participating in the brainstorming as follows:

*I know people respect me when \_\_\_\_\_.*

Translating the concept of cultural competence into Spanish for the Spanish-speaking groups in the pilot study proved to be a challenge but was accomplished with input from several Spanish-speaking resources. The first attempt was made using the following statement:

*Yo se que los servicios a familias son culturalmente competentes cuando \_\_\_\_\_.*

When participants did not appear to understand this statement, a second focus statement was offered as follows:

*Yo se que los servicios a familias son respetosos cuando \_\_\_\_\_.*

*Revisions for current study.* The pilot study experience indicated that the original focus statement was too broad and contained too much rhetoric, making it unclear and too difficult for some participants to comprehend. The simplified version used with youth was easier to understand, but did not capture the entire focus of the study. Moreover, feedback from participants in the pilot study suggested that the assessment focus on a specific aspect of the system of care.

Systems of care reform efforts represent “a *philosophy* about the way in which services should be delivered to children and their families” (Stroul & Friedman, 1996, p.

3). Likewise, “wraparound is a philosophy and overall approach which mandates that services be tailored to the specific needs of all children and families...” (VanDenBerg & Grealish, 1996, p. 8). Therefore, the author of this study chose to focus the cultural competence assessment on the service delivery component of systems of care implementation. In addition, a determination was made that participants needed to hear the focus statement in a variety of ways to fully capture the intent of the question. Three focus statements that were considered to essentially reflect the same ideas were developed to offer participants alternative ways of hearing the question. The focus statements were designed such that any one participant response could complete any of the three statements. Participants were asked to complete the following sentence(s) with specific examples:

1. *I know services to families are culturally competent when \_\_\_\_\_.*
2. *I know services to families are respectful when \_\_\_\_\_.*
3. *I know services are culturally responsive when \_\_\_\_\_.*

The Spanish translations used in the pilot study ended up being used also in this study.

These statement options were as follows:

1. *Yo se que los servicios a familias son culturalmente competentes cuando \_\_\_\_\_.*
2. *Yo se que los servicios a familias son respetosos cuando \_\_\_\_\_.*
3. *Yo se que los servicios a familias son culturalmente sensible cuando \_\_\_\_\_.*

Although used in a less formal process as is described in the Idea Generation stage, the statement used with the youth was revised as follows:

Complete the following statement with specific examples: I know that people working with me and my family respect us when \_\_\_\_\_.

### *Logistical Arrangements*

*Pilot study.* Systems of care and wraparound philosophies emphasize the importance of community-based care. In this regard data collection efforts needed to be structured to offer participants the greatest opportunities for participation. The research team garnered some assistance from the systems of care staff in identifying appropriate data collection locations, but the bulk of the logistical arrangements fell on the research team. Efforts to secure locations were delayed for numerous reasons, resulting in delays in announcing the locations. Data collection for the pilot study was, however, held in locations thought to be most accessible and comfortable for participants. While efforts to use community-based locations did not seemingly increase participation for the pilot, they will nonetheless be retained for this study based on their congruence with underlying philosophies and what were perceived to be issues specific to the pilot study.

*Revisions for current study.* Unlike the pilot study, the other four systems of care communities were responsible for making their respective logistical arrangements for the study. This decision was made because it is believed that community members are the most knowledgeable about their communities. They have the greatest access to families and familiarity with the community and potential needs of participants.

Each community selected locations they believed were most central with easiest access for systems of care participants. In the RUR-W, the largest rural community, staff greatly assisted in providing transportation for families. Some families in both rural communities drove up to 60 and 90 miles one way to participate in the assessment. Reimbursement for family participant transportation expenses was offered in all four communities. Likewise, childcare provisions were covered for family participants at the same location where the meetings were held. Food and beverages were provided at all meetings for all participants.

The design revisions outlined in the preparation stage were largely based on the participatory philosophy of the researcher. A participatory philosophy means local community members not only participate in planning the study, but also participate in the implementation of the study. It is believed that greater community participation was ultimately achieved by using more inclusive processes.

#### *Idea Generation*

The assessment team facilitators guided participants in the brainstorming of descriptive statements of cultural competence based on the focus statements previously described. A minimum of 30-40 statements is required to ensure a valid statistical analysis process (Concept Systems, 2001).

*Pilot study.* Two separate meetings were held for this stage of the Concept Mapping process. One meeting was held during the day targeting professionals, but family members were welcome to attend this meeting if desired. A second meeting was held in the evening targeting caregivers and youth. Professionals were not invited to

attend this meeting to ensure the greatest opportunity for open dialogue with families served through the system of care. The caregiver meeting was facilitated in Spanish with statements later translated into English. A separate group was held with youth simultaneous to the caregiver group. While separate group meetings were appropriate, they were spread out over the course of a week. This time delay was not feasible for the research in the other four communities.

*Revisions for current study.* A series of three-day meetings were facilitated in each of the four communities. Day One consisted of the statement generation process. It was suggested to communities that separate groups be held for families and professionals, but that the format should be based on the needs of their local communities. The stipulation for communities was that all of the structured focus groups had to be scheduled for the first day. Two group meetings with adults (caregivers and professionals) were held in all four communities. A bi-lingual English/Spanish-speaking group was conducted in the RUR-W community. In general, the Professional (Non-Family) meetings were held during the day and the Family meetings were held in the evening. Two communities (RUR-W and RUR-E) held completely separate Day One meetings for Family and Non-Family participants. The other two communities (URB-N and URB-E) included Family and Non-Family participants in the two meetings each held on Day One. Each brainstorming session lasted between one and one-half to two hours.

Upon arrival to the meetings, Family member participants were asked to sign in, giving consent for themselves and, if appropriate, their youth to participate. Youth were also asked to sign in and give their consent to participate (see Appendix A). In addition,

Professional (Non-Family) participants were asked to sign in, giving consent to participate. Families specifically involved in wraparound processes had previously signed consent forms related to evaluation activities and working with researchers from the University of Texas at Austin (see Appendix A). This study's consent form was read and discussed aloud with all participants. In addition, all participants were asked to complete a demographic form (see Appendix A) to capture specific characteristics of those participating in the data generation stage. These initial processes took about one-half hour to complete.

As previously indicated, it was also important for the communities to get perspectives from their youth. Rather than using Concept Mapping, a separate focus group data collection process combined with a modified Nominal Group prioritization process was used with youth. The written process guiding the youth groups is included in Appendix B. The youth process was modeled as closely to that of the adults as possible and is described accordingly throughout this section. However, note that all youth participation occurred only on Day One during the same time as the adult groups.

Three communities recruited youth for the study. In these communities one contracted facilitator and the principal investigator conducted the adult groups, and one contracted facilitator and the family evaluator conducted the youth focus groups. Each group included a bilingual team member. When only one meeting was being held at a time, all four team members participated in the adult group. In these meetings, the contracted facilitators shared facilitation. The principal investigator recorded responses for overhead display, and the family evaluator recorded responses separately as a back up

measure. Bilingual brainstorming facilitation was conducted in the two rural communities.

The facilitated adult and youth focus group discussions divided the concept of cultural competence into separate components. The discussion began with asking participants to think out loud about the meaning of culture. Participants were then asked to think out loud about the meaning of competence. As the discussion proceeded, adult participant comments were visible to the group via an overhead projector. The resulting lists describing the separate concepts of culture and competence are included in Appendix C. This part of the youth discussion was not recorded but instead was used as a way to get the group engaged in dialogue.

Finally, participants were asked to put their ideas of culture and competence together. Once the discussion appeared to be moving into responses that could complete the focus statements, participants were led into the official brainstorming data collection process. The adult groups were facilitated as open dialogues applying general rules of brainstorming. The facilitator guided the discussions such that everyone had an opportunity to participate. Again, as adult responses were generated the principal investigator typed them into a computer where they were projected onto a wall for all participants to view. Youth statements were captured on flip chart paper and posted on the walls. The facilitators and recorders worked with participants to ensure the statements were written in the participants' words and clearly articulated participant ideas. Index cards were distributed to adult participants in the event they had ideas to include but were not comfortable voicing in front of the group. Participants could either leave their cards at

their seats or turn them in as they left the room. All index cards left behind were collected and reviewed for additional input. Every adult and youth family participant received a Wal-Mart gift card in the amount of \$10.00 to compensate them for their time.

Throughout Day One the research team also worked to prepare for the next day's tasks. This included working with the local systems of care to get feedback on the process being conducted and to confirm logistical arrangements and access to a computer and photocopying machines. At the conclusion of the second meeting on Day One, statements generated from each of the brainstorming sessions were combined into one list without any data reduction. Using the combined list, sets of sort cards and rating sheets were prepared for Day Two.

### *Structuring Ideas*

The structuring stage of Concept Mapping involves the sorting and rating processes. Participants sort the ideas generated into conceptual piles to make meaning from the data. Participants then rate the statements based on designated criteria to assign value to the data. The Concept Systems software offers the user a manual or electronic option for sorting and rating the data. The electronic option requires participants to have access to a computer and a comfortable level of computer literacy. It also requires a substantial amount of computer resources if conducting these processes in a group setting. This study used the manual option as described in this section.

Using the Concept Systems process, a minimum of 10 to 15 sorts is required to ensure a valid multidimensional scaling analysis (Trochim, 1993; Jackson & Trochim, 2002). There is no set number of raters required for the process; however, reliability of

the data increases with a greater number of ratings included in the analysis. A Pearson's product moment correlation coefficient is generated based on rating comparisons between groups of participants or between rating criteria. Thus, correlations of ratings between groupings that consist of larger numbers of participants produce more meaningful information. Prior to the study the researcher determined that no sub-grouping rating comparisons would be made with less than five persons in each subgroup. In their review of Concept Mapping's use in mental health, Johnsen and colleagues (2000) previously suggested using five as a minimum to constitute a group.

### *Sorting*

*Pilot Study.* A second set of meetings was scheduled for the adults to participate in the sorting phase of the methodology. Each participant was given a set of computer-generated business cards, with a separate card for each brainstormed statement. Participants were then asked to individually sort the set of cards into piles in whatever way made the most sense to them. They were then asked to place a rubber band around each pile and give each pile a short label that reflected the pile's contents.

*Revisions for current study.* The current study followed similar procedures outlined for the pilot study, with more specific instructions to participants and more flexible meeting times. Since the sorting and rating processes are completed on an individual participant basis, a more flexible schedule for completing these tasks on Day Two was an option. The RUR-W community chose to schedule separate meeting times for adult Family and Professional (Non-Family) participants. The Non-Family meeting was held during the day, and the Family meeting was held in the evening. The other three

communities chose to schedule a large block of time during which Family and Non-Family participants could arrive to complete the sorting and rating tasks. These times varied between 10:00 a.m. and 7:00 p.m. The youth focus group process (conducted on Day One) did not include any type of sorting activity.

Participants were asked to sign in again on Day Two. There were a number of additional participants for Day Two across communities who had not participated in Day One. Demographic forms were completed by all those not in attendance on Day One. Returning participants were reminded of the process occurring the day before to re-focus them on the tasks for Day Two. The Concept Mapping methodology is flexible in that given a shared understanding of the ideas generated, different groups of participants are able to complete the various tasks of the method. Thus, additional systems of care participants were given brief descriptions of the Day One process in an effort to help them contextualize the statements and tasks before them.

Data were also collected on Day Two from one additional group in the URB-N community. The researcher and local staff planner learned on Day One that a separate wraparound and systems of care training for direct service providers was going to be held during the same timeframe scheduled for the sorting and rating on Day Two. Since Day One included low participation from direct providers, permission was sought and obtained from the lead trainer to use one and a half hours of their training time to seek volunteer participation in the cultural competence assessment. Although small in number, all trainees present agreed to participate in the sorting and rating process.

Each adult participant was given a set of cards, with a separate card reflecting each statement generated. Participants were asked to individually sort the set of cards with instructions to organize the cards into piles in whatever way made the most conceptual sense to them. Participants were instructed not to sort the cards according to any kind of rank ordering. They were then asked to place a rubber band around each pile and give each pile a short label that best reflected the pile's contents.

### *Rating*

*Pilot study.* The final task for the study's planning committee was to determine the criteria to be used in giving interpretive value to the statements during the rating phase of the assessment. The committee decided on three rating criteria: importance, frequency of demonstration, and systems of care policies. During the second meeting and after the participants completed the sorting process each participant was asked to rate the statements using predefined rating scales to place interpretive value on each statement.

The first two scales were rated by all participants as follows: (1) the importance of each indicator for meeting the unique needs of families, and (2) frequency of demonstration of the statement in their system of care. The third rating criterion, level of statement inclusion in systems of care policies, was initially planned as a rating criterion for all participants. However, during the data collection process it was noted that caregivers receiving services did not have knowledge of systems of care policies, and therefore, were not appropriate raters for this criterion.

Five-point Likert-type scales were used for criteria one and two to obtain a more varied set of responses. A four-point Likert-type scale was used for criterion three,

Policy, which later was collapsed into a three-point Likert scale for analysis. It was believed, and ultimately verified, that the level of participant knowledge related to systems of care policies would not produce enough variation to warrant a five-point scale. The following rating questions and Likert scales were used in the pilot study based on planning from the statewide committee:

1. How important is this example for meeting the unique needs of families?  
1-5 Scale: 5 = Extremely Important; 4 = Very Important; 3 = Fairly Important; 2 = A Little Important; 1 = Not Important
2. How often is this example demonstrated in your community's system of care?  
1-5 Scale: 5 = Always Demonstrated; 4 = Usually Demonstrated; 3 = Sometimes Demonstrated; 2 = Rarely Demonstrated; 1 = Never Demonstrated
3. Do the individuals and organizations you work with include this example in their written policies?  
1-4 Scale: 4 = All include in written policies; 3 = Some include in written policies; 2 = None include in written policies; 1 = I don't know

For purposes of analyses, the Policy rating scale was changed to a 1-3 scale as follows:

3 = All agencies include example in written policies; 2 = Some agencies include example in written policies; 1 = No agencies include example in written policies

The "I don't know" responses were analyzed separately to obtain a percent of total responses reflecting no knowledge of policies.

*Revisions for current study.* The general rating design used in the pilot was retained for the current study, with the exception of the Policy scale. As in the pilot study, during the second meeting and after the participants completed the sorting process, each participant was asked to rate the statements using the predefined rating scales to place interpretive value on each statement. The first two rating criteria were the same as used in the pilot study and were rated by all adult participants: (1) the importance of each indicator for meeting the unique needs of families; and (2) frequency of demonstration of the statement in their system of care.

The third criterion, Policy, was not rated by individuals participating solely as family members. Substantial changes were made to the Policy scale based on the pilot and related participant feedback. Participants felt that the focus of the initial question on systems of care policy was too broad, making it difficult to answer. However, since a key element of systems of care is policy change, the researcher believed that the question could not be completely omitted. The Policy rating scale was revised to include the following question to be answered prior to participants completing the actual rating scale:

My level of knowledge about our *system of care* policies on cultural competence

is: *(please check one)*

No Knowledge \_\_\_\_\_; A little Knowledge \_\_\_\_\_; A lot of Knowledge \_\_\_\_\_;

Extensive Knowledge \_\_\_\_\_

The actual rating scale was revised to focus only on the policies of the agency for which the individual completing the scale is employed. Following is the revised policy rating question and Likert scale:

3. To what extent is this statement covered under your agency's policies?

1-3 Scale: 3 = Fully covered; 2 = Somewhat covered; 1 = Not covered;

0 = I don't know

Using these scales, participants received additional instructions to compare each statement against all others in the set of statements. They were instructed to use the entire range of the rating scale throughout their ratings. Written instructions were also furnished to participants for reference along with the verbal instructions. Copies of the blank rating sheets and sorting and rating instructions are included in Appendix D. Members of the research team were available at all times to answer questions or assist participants as needed.

In the RUR-W community, the family evaluator sat with a group of five Mexican American participants and orally translated the statements into Spanish in order to engage participants in the rating process. The family evaluator read the question to participants and gave them time to complete the appropriate item on the scaling form before moving on to the next item. Given the short turnaround from statement generation to sorting and rating, the statements could not be translated into Spanish in written form. This group of participants did not participate in the sorting process.

While the youth group (conducted on Day One) did not include any type of sorting activity, it did include a rating process. Combined with the focus group was a Nominal Group prioritization process. Youth used a dot voting technique to rate their own statements on two criteria: importance and demonstration. To avoid as much peer pressure as possible, youth were first asked to individually pick the top five examples

they thought were the most important for them and their family. They then used a set of colored dots labeled 1-5 to individually vote by placing their dots next to statements. The same process was then used with a different set of colored dots labeled 1-5, to individually pick the top five examples they thought people working with them actually do the most often. Youth and facilitators totaled the points for both importance and demonstration before the end of the focus group.

The length of time for completing the sorting and rating tasks averaged around one and one-half hours. Each adult Family participant received a Wal-Mart gift card in the amount of \$25.00 to compensate them for their time. At the conclusion of Day Two the research team gathered all of the information together from the two days and began preparing for Day Three. Tasks completed for Day Three included preparing preliminary results from the youth focus group, preparing some separate analyses of the Policy rating scale, data entry of all participant sorts and ratings, and preliminary analysis of the Concept Mapping results.

#### *Representation of Ideas*

Using the sorting and rating data obtained from participants, separate cluster maps were generated for each community. Concept Maps were produced using multivariate statistical techniques, including multidimensional scaling and hierarchical cluster analysis to provide pictorial representations of relationships and relevance of the identified processes (Trochim, 1989). Each cluster generated is a potential domain of measurement for the construct under examination.

Multiple processes were used to determine the final number of clusters for each community's map, including: (1) examination of the cluster merges during the cluster analysis, (2) examination of bridging values produced to indicate statement position on the map, (3) the research team's conceptual understanding of the statement groupings, and (4) interpretive feedback by community participants. It is critical to note that interpretation of the Concept Mapping results in this study was greatly informed through the interpretive feedback received from systems of care participants. The cluster determination processes are standard in this form of the Concept Mapping methodology and were used accordingly in both the pilot and current study.

#### *Multidimensional Scaling Analysis*

Multidimensional scaling is a multivariate statistical technique developed in the social sciences to examine various societal structures (Davison, 1983). According to Davison, the technique is much like the more traditionally used factor analysis, except that it offers a simpler, more easily interpretable solution. The MDS analysis is central to the overall Concept Systems analytic process (Concept Systems, 2001). The nonmetric multidimensional scaling (MDS) analysis uses the individual sort data to create two-dimensional spatial maps of points representing relational distances between the brainstormed statements (Trochim, 1989). The point map created illustrates the underlying structure of how participants conceptualized the relationship between statements. Kruskal and Wish (1978) refer to this map as a "geometric configuration of points" reflecting the "hidden structure" in the data (p. 7).

Trochim (1989) describes the MDS technique as it is used for Concept Mapping. As participant sort data are entered into the Concept Systems software, individual square similarity matrices are produced for each participant. Each matrix consists of the same number of rows and columns as there are statements. Values in the matrix are either 0 or 1, where a 1 indicates that the two statements (row by column) were placed in the same pile. The individual sort matrices are then combined to produce a group similarity matrix, which indicates how many people sorted each pairing of statements in the same pile. Thus, values can range from zero to however many participants sorted the data. This combined matrix of proximities (Kruskal & Wish, 1978) becomes the input for the MDS analysis, resulting in points placed into a bivariate distribution of X-Y coordinates on a graphical map.

The MDS analysis provides a goodness-of-fit measure called a Stress Value. The stress value is the “square root of a normalized ‘residual sum of squares’,” resulting from a number of computational iterations that configure the model (map) to the data (Kruskal & Wish, pp. 49-50). The stress value often improves as additional dimensions are added to the solution. However, since a fixed two-dimensional solution is used in Concept Mapping, adding dimensions is not an option. Assuming dimensions are added to improve the model fit and that there are high levels of measurement or sampling error, stress values should not generally go beyond .10 to .15 (Davison, 1983; Kruskal & Wish).

Stress values attained in Concept Mapping analyses are slightly higher than those generally suggested. Typical values range between .15 and .35, with an average range of .27 to .30 (Trochim, 1993). W. M. K. Trochim (personal communication, January 30,

2003) asserts that adding the cluster analysis on top of the MDS enhances this process, in essence adding another dimension to the solution. However, since stress values in Concept Mapping are based on aggregated MDS values, they cannot alone be relied upon to determine the interpretability of the map. In addition, more complex concepts will result in higher stress values than less complex constructs. (See Trochim, 1989, for a more detailed description of the MDS analysis process and why a two-dimensional solution is preferred for Concept Mapping.)

### *Hierarchical Cluster Analysis*

After the MDS solution is obtained, data are analyzed through hierarchical cluster analysis. Using the MDS results as the mathematical basis for the cluster analysis procedure, the individual statements plotted on the X-Y map are grouped into conceptual clusters based on similarity of ideas (Trochim, 1989). The agglomerative cluster analysis method was chosen because it begins with each statement as its own cluster and then is joined with other statements based on Ward's algorithm for cluster analysis. Concept Mapping uses Ward's method for agglomerating clusters (Hair, Anderson, Tatham, & Black, 1998) because it uses a sum of squares Euclidean distance measure to decide cluster merges (Concept Systems, 2001). Making the cluster analysis dependent upon the MDS solution forces the cluster analysis process to partition the map created by the MDS into clusters (Trochim, 1989).

There is no set number of clusters predetermined by the statistical analysis, rather it is the task of the researcher to determine how many clusters make sense for the set of data analyzed (Trochim, 1989). There is no objective standard or mathematical solution

to determine the most appropriate final number of clusters (Hair, Anderson, Tatham, & Black, 1998; Shern et al., 1995). The researcher generally begins by looking at a higher number of clusters (e.g., 20 clusters) and examining how the clusters are merged as the number of clusters decreases. Trochim suggests erring on the side of more clusters than fewer. The general rule is to arrive at the best cluster solution that retains the multidimensional scaling results, whereby no two clusters overlap, and that captures the level of specificity desired within the context of the information. Since cluster structures are determined by statistical analysis and the number of clusters is determined by the research, Jackson and Trochim (2002) submit that the clustering process is actually a “blending of human judgment based on the more objective mathematical algorithm of cluster analysis” (p. 320). The most parsimonious cluster solution that most accurately reflected the ideas of the communities were chosen. A key process employed in this research was involving participants in determining the final cluster solution for their respective maps. This process is described in the Interpretation section.

### *Bridging analysis*

Bridging values are generated through a computation developed by Dr. Bill Trochim. These values allow the analyst to examine what content is associated with different areas of the point map (Concept Systems, 2001). Statements (or clusters) with lower bridging values indicate greater meaning for their place on the map. That is, they are considered anchor statements (or clusters) that were most often sorted together by participants. Statements with higher bridging values mean they were more often sorted with other statements across the map and serve as bridges to the other clusters. Points

sorted with points farther away on the map are placed somewhere in the middle of all of its pairings. The bridging value is computed essentially by linking pairs of points with their distances and weighting similarities by the distance on the map (W. M. K. Trochim, personal communication, January 30, 2003). The bridging values are helpful in examining the cluster merges when determining the most meaningful cluster solution.

#### *Sort Pile Label Analysis*

The final map analysis involves the labeling of the clusters. Dr. Bill Trochim developed a centroid analysis to choose the best statistically fitting label (generated by the sorters) for each cluster. Jackson and Trochim (2002) offer a description of this analysis. The average x and average y values of the MDS coordinates for each point within a cluster are selected to compute a centroid for each cluster. Then, a sort pile label centroid is computed for every label developed by every sorter by using the average x and average y values of the MDS coordinates for every statement in the sorter's labeled pile. Lastly, after computing the Euclidean distance between the cluster centroid and the pile label centroid, the pile label with the smallest Euclidean distance is chosen. Based on this analysis, the top ten labels are available to the analyst from which another label can be chosen if it appears more appropriate. In addition, the analyst has the option of creating a new label if the data suggest the need. Again, participants played a key role in selecting the final cluster labels, as described in the Interpretation section.

### *Rating Analyses*

The rating scales completed by participants created average ratings for each statement and average ratings for each cluster for all three rating criteria. These ratings can be included on the pictorial maps for ease of understanding the data gathered. Statements can be represented in the form of stacked blocks, with more blocks stacked on top of one another meaning higher values for the statement and vice versa. Similarly, average cluster ratings are depicted in the form of cluster layers. A higher number of layers in a cluster indicates higher average aggregate ratings of the statements in the cluster, with lower ratings depicted by fewer layers. These same average ratings were used to generate pattern matches to compare ratings between groupings of individuals or between averages of rating scales, as discussed in the next section.

### *Interpretation*

Based on the participant ratings, group comparisons—called pattern matches in Concept Systems—were made within each community and across communities in the aggregate phase. The number of comparisons made depended on the number of participant responses available for each grouping and differed slightly among systems of care communities. Group comparisons, generated from the demographic information completed by participants, consisted of no fewer than five participant ratings in a group. These pattern matches, or group comparisons, produced a Pearson's  $r$  to assess the strength of relationship (level of consistency) between groups' patterns of average ratings on each criterion. Pattern matches were also produced comparing participant ratings of importance and frequency of demonstration. This comparison became a key finding for

establishment of a baseline in each community. Pattern matching based on participant ratings is a standard process in this Concept Mapping methodology and was used accordingly in the pilot study as well.

In keeping with the philosophies of systems of care, wraparound, participatory methods and the Concept Mapping methodology, participants assisted in the interpretation of the data. Similar to the process used in the pilot study, a final meeting was held on Day Three of each community assessment to obtain participant input into the findings. Following an initial analysis of the data by the research team, a selected number of systems of care members (chosen by local communities) attended a session to assist the researchers in interpreting the preliminary assessment results. This group was generally fairly small, averaging around seven participants. There was no Family representation in one community interpretation meeting.

During this feedback session participants engaged in dialogue, led by the principal investigator, about potential meanings of the results. Initial results from the map analyses were used to generate discussion. Participants were first given a “tour” around the map with explanations about the meaning of where statements were located on the map. The preliminary interpretation assessed by the research team was then shared with the participants. By walking the participants through the team’s thinking about the cluster arrangements and numbers of clusters, participants quickly understood what was needed from them during this meeting. Variations in the number of clusters were examined, along with the labels assigned by the software. Once the participant groups decided on

the number of clusters necessary to best reflect their data, they were then engaged in labeling the clusters.

The cluster labeling discussion was used as a means of getting at some of the deeper meanings of the data groupings. The ten best fitting labels assigned by participants during the sorting process were discussed with regard to the statements included in each cluster. In each community the dialogue generated through the labeling process helped the research team understand more about the contextual meanings behind the data. In the final map, some original labels were maintained, some alternate labels assigned by sorters were chosen, and in many cases new labels were generated. In some cases the new labels were combinations of sorter labels, and in other cases completely new labels were created.

Once the final map was determined, cluster rating maps and pattern matches were produced and shown to participants. A minimal amount of group comparisons along with results from the overall community data were shared at this time. Again, the results generated much discussion among participants, assisting the research team in understanding some of the dynamics specific to the results in each community. The Concept Mapping methodology provided a means to immediately share some of the results from the study back with the community.

#### *Utilize Maps*

The last stage of the process is specifically related to taking the information generated and developing related action plans. While it was not the initial intent of the researchers to actively participate in this stage of the process, the pilot study resulted in a

community-identified need for a limited amount of researcher involvement. In order to use the data gathered for planning and implementing policy, assistance was needed in translating the findings into identified areas of need related to cultural competence within the systems of care philosophical framework. In preparing the individual community reports and the aggregated report across communities, the principal investigator used her knowledge of the communities and systems of care in combination with results of the community assessment to identify strengths and areas of need, and made recommendations related to cultural competence training and technical assistance. Detailed reports were produced and written in a way that communities could use the information to self-advocate for local support. In addition, the aggregate report was written specifically for the state legislated committee overseeing development of the four systems of care to support their decision-making and policy processes at a state system level.

#### *Aggregate Assessment*

During the individual community assessments participants were asked about their level of willingness to participate in an aggregate phase of the study. Participant response was to be a primary determining factor in conducting an aggregate assessment. A minimum of ten participant volunteers from each community was set by the principal investigator to substantiate pursuing the aggregate study. Given the large number of participants indicating a willingness to participate in an aggregate study, the second phase of the research across the four communities was feasible on this criterion. The second criterion established was feasibility of an aggregate summary process based on results

from individual community assessments. Once the separate pictures of cultural competence were initially developed for each community, the findings suggested the practicability of an aggregate assessment.

In addition to the primary data collection effort of Concept Mapping this study also employed methods of secondary analysis of qualitative data (Thorne, 1994). In the final two phases of this study an approach of analytic expansion and retrospective interpretation (Thorne) was employed whereby an original data set was used to advance to the next level of inquiry and consider other questions not previously examined (Hinds, Vogel, & Clarke-Steffan, 1997; Thorne, 1994).

In the first analysis of secondary data, the principal investigator worked with the family evaluator to synthesize the ideas generated in all four communities. Two sets of sort cards were produced reflecting all statements generated across the communities. Each community's set of statements was printed on different colored paper to enable tracking during the data reduction process. Based on previous participant sorts and conceptual understandings from the individual community interpretation sessions, the principal investigator and family evaluator engaged in separate data reduction processes. The principal investigator sorted all statements into piles that grouped statements into what appeared to be duplicates or statements very similar in meaning. The family evaluator sorted the cards into conceptual groupings of similar topics and meanings.

The principal investigator and family evaluator then met over the course of several days to compare their results and come to consensus on one unduplicated list of statements. Hill, Thompson and Williams (1997) proffer a similar qualitative consensual

methodology. Statements from within and across communities that were combined into one statement were grouped and stapled together in a pile, whereby the number of communities generating any one specific idea could quickly be identified by the different colors of paper. Statements were retained in the words of participants as often as possible. In many cases words from different statements were combined but still retained participant words. In a few cases statements were reworked to reflect a similar idea expressed in multiple ways across communities. The results of this process were captured in a separate database developed and maintained by the principal investigator. From the color coded statement cards in the unduplicated statement piles, common and unique ideas generated across communities were identified and tracked in the database.

Sets of sort cards and rating sheets were produced from the newly combined list of statements. Ninety-nine packets were distributed to previous participants through the mail, and one packet was distributed in person to a community staff member volunteering to participate but who had not participated in phase one of the assessment.

Approximately one month past the return deadline (after the December holiday season) a second mailing was sent to participants who had not yet returned their packets. For the second mailing, all statements, the demographic form, instruction sheets, and rating forms were translated into Spanish in an effort to increase the return rate for the Spanish-speaking participants. The statements and rating forms were additionally back translated into English to ensure accuracy. The Spanish translated forms are also included in Appendix A. Since the majority of people returning packets in the first round completed the sorting process, sorting packets were not included in the entire second

mailing. Rather, sort packets (in English only) were mailed only to participants with selected demographic characteristics that appeared to need additional representation. In both mailings participants receiving sort cards were invited to participate in sorting and/or rating the compilation of statements. All packets were mailed first class via the United States Postal Service and included self-addressed, postage-stamped return envelopes for returning completed packets. Upon receipt of their returned and completed packets, all Family participants were mailed an additional \$25.00 Wal-Mart gift card.

The principal investigator conducted separate data analyses for the aggregate phase of the research. These analyses were conducted based on the experiences and input received during the individual community assessments. A combined concept map was produced keeping labels as close to the data as possible to reflect the words of the participants. New rating comparisons across communities were made based on the available groupings using the same cut off criterion as the individual community assessments (at least five participants per group).

#### *Theoretical Model Comparison*

The aggregate assessment began the process of comparing conceptualizations across the communities. Common and unique concepts were first determined through the data reduction process. To complete the final phase of the study, a second form of secondary analysis of qualitative data was employed. Two original data sets from the Concept Mapping process were used to advance the study to the next level of inquiry in consideration of the research questions (Hinds, et al., 1997; Thorne, 1994). The principal investigator qualitatively compared the clusters from each map for common and unique

concepts, with statements within the clusters used as a method of clarifying overall thematic meaning of the cluster.

To compare results from the individual community and aggregate assessments for congruence with current models of cultural competence, a structured schema needed to be developed. This analysis involved a deductive content analysis using an a priori classification scheme (Franklin, 1996). The group relational competence theoretical model was used to formulate a matrix through which elements of current models and concepts gathered through the study could be compared. A template of this matrix is included in Appendix E. Use of Concept Mapping to compare a theoretical framework with program practice was previously demonstrated by Shern, Trochim and LaComb (1995). In that study the authors “impressionistically” compared an a priori theoretical concept map to a program’s operationalization of the theory.

A similar process was conducted for this study. Rather than a theoretical concept map, a matrix was used to make the qualitative “impressionistic” content comparisons. Elements from current practice models described in the previous chapter were first matched with the appropriate matrix cells. Concepts generated from the community maps were then coded and placed in the matrix cells.

The principal investigator reviewed each statement from every community for its placement within the theoretical framework. Every statement within each cluster was coded using the dimensions and operational examples provided by Spitzberg and Cupach (1984, 1987) and Spitzberg (1989). The dimensions and operationalizations are included in Appendix E. The coding for Motivation, Knowledge, Skills, and Policy issues

(Barriers/Targets for change) was examined for reliability by comparing codes assigned to each statement against the codes assigned for all statements grouped together to create the aggregated statement during the aggregated data reduction process.

Operationalization of contextual expectations is less defined by Spitzberg (1989), and thus was left to more subjective assessment by the researcher. Codes assigned to expectation themes are provided in the findings for the reader. Themes from statements within each community's map clusters and aggregate map clusters were identified and placed within the appropriate matrix cells to reflect the identified dimensional fit with the group relational model.

A qualitative content comparison (Franklin, 1996) was then made among the models and community conceptualizations to identify common and unique concepts of cultural competence across models and community conceptualizations. The overall conceptual focus of each community's map was then examined for congruence with the assumptions and emphases of current models of culturally diverse practice. Results from all phases of the study assisted the researcher in discerning the viability of the mixed-method, participatory Concept Mapping research methodology used in this study as a reliable and valid approach to community-based conceptualizations and assessments of cultural competence.

## CHAPTER 4

### FINDINGS

This research study, in combination with the practical application of the community assessments, produced a substantial amount of information. This Findings chapter includes results from each distinct component of the study: individual community assessments, the aggregated assessment, and the comparisons of cultural competence theoretical models. To provide the most clarity for addressing the research questions, findings are presented in a progressive structural framework. The findings from both data collection phases of the study, the individual community assessments and the aggregated study, are presented first, as these results provide the foundation for understanding the theoretical model comparisons. The findings from the youth focus groups are included in Appendix F.

#### **Concept Mapping Findings**

##### *Concept Mapping Sample Findings*

The study included participants from four systems of care communities in Texas, two urban and two rural, as previously described in Chapter 3. The combined participant sample for the individual community assessments included 188 adults and 34 youth across the four communities (see Table 4). One community, URB-N, did not recruit youth for the study. Adult participants included 117 Non-Family/Professional members (62%) of all levels, from direct care to administration, and 71 Family members (38%). This percentage changed during the individual community sorting and rating phases, with an overall 49% Family and 51% Non-Family members.

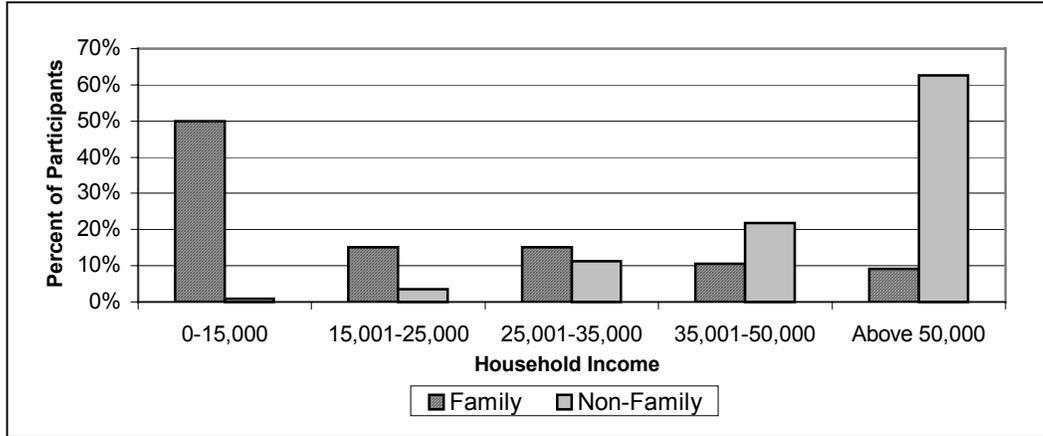
Since Concept Mapping does not require the same participants to brainstorm, sort and rate, there was no specified targeted rate for participant return on Day 2. However, it is preferred to have consistency in participants across the different stages. One-half of all adults attending the brainstorming sessions on Day One returned to participate in the sorting and rating phases on Day Two. The return rate for Family members was 87%, and the return rate for Non-Family/Professional members was 44%. There were 36 additional Family and Non-Family participants who attended Day Two only.

Table 4. Number and Demographics of Participants Across Communities

<i>Category</i>	<i>Total</i>		<i>URB-N</i>		<i>RUR-W</i>		<i>URB-E</i>		<i>RUR-E</i>	
	<i>N</i>	<i>%</i>								
<i>Total Adult Participants</i>	188		58		66		33		31	
<i>Adult Family Member</i>	71	38%	9	16%	42	64%	9	27%	12	39%
<i>Adult Non-Family</i>	117	62%	49	84%	24	36%	24	73%	19	61%
<i>Total Youth Participants</i>	34		---		21		7		6	
<i>Gender</i>										
Female	144	77%	43	74%	46	70%	31	94%	24	77%
Male	44	23%	15	26%	20	30%	2	6%	7	23%
<i>Race/Ethnicity</i>										
Asian American	6	3%	2	3%	---	---	4	12%	---	---
Black/African American	25	13%	7	12%	3	5%	11	33%	4	13%
Mexican American	28	15%	3	5%	24	36%	1	3%		
White/European	116	62%	42	72%	34	52%	15	45%	25	81%
Biracial/Other Group	9	5%	4	7%	3	5%	1	3%	1	3%
No Response	4	2%	---	---	2	3%	1	3%	1	3%

Figure 4 represents the reported household income of participants across communities. As illustrated in this graph, there is a distinct difference between the incomes of Family and Non-Family participants. There were few Non-Family participants reporting a household income less than \$25,000, and few Family participants reported a household income of more than \$35,000. Most household incomes reported were at either extreme of the continuum.

Figure 4. Total Participants - Household Income



Finally, since one practical application of the study was to identify needs for training and technical assistance, it was important to gauge how much recent cultural competence training participants had received. Figures 5 and 6 reflect the number of cultural competence trainings attended by participants over the past two years. Nearly half (47%) of all participants received no training related to cultural competence. Of the Non-Family participants, 37% attended no training, 33% attended one training only, and another 18% attended two trainings related to cultural competence in the past two years.

Figure 5. Cultural Competence Training Attended - All Participants

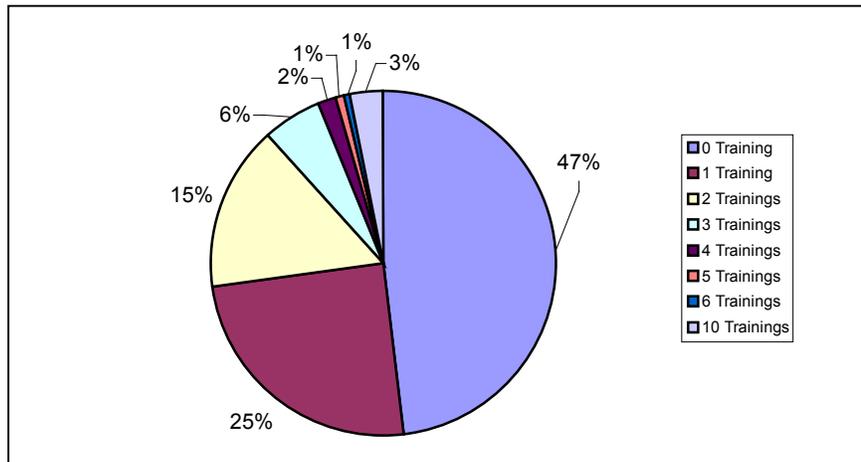
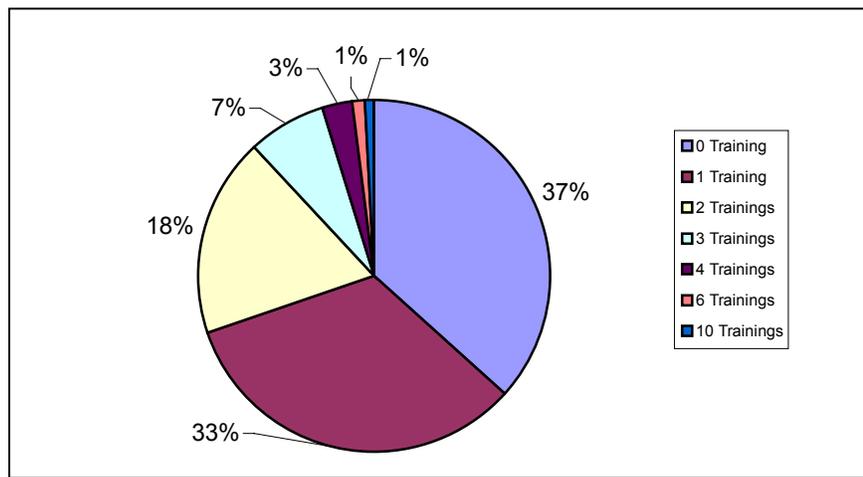


Figure 6. Cultural Competence Trainings Attended - Non-Family Members



Overall, 152 people (40% Family members and 60% Non-Family members) participated in the brainstorming sessions. A total of 129 participants (49% Family and 51% Non-Family) originally sorted and rated the statements across individual community assessments. Concept Mapping requires a minimum of 10 sorts to ensure a valid analysis (Jackson & Trochim, 2002). Each community had at least twice the required number of sorters.

Of the 100 packets distributed for the aggregated phase of the assessment, a total of 45 adults returned completed information, and another three packets mailed to family members were returned as undeliverable. This resulted in a 46% overall return rate  $[45/(100-3) * 100]$  (Dillman, 1978). According to Rubin and Babbie (1997), a 50% return rate on mail surveys is considered adequate for analysis and reporting, but achieving representativeness of the sample is more important than the actual response rate. As described below, the aggregate sample was fairly representative of the original total sample. Given the length of time required to complete the entire sorting and rating

process (approximately one to one and one-half hours), the return rate seems adequate for this study.

Tables 5 and 6 reflect the demographic makeup of the total participants in the aggregate study. Figure 7 specifically illustrates the differences in Family and Non-Family household income of aggregate participants.

Table 5. Number and Demographics of Participants in Aggregate Study

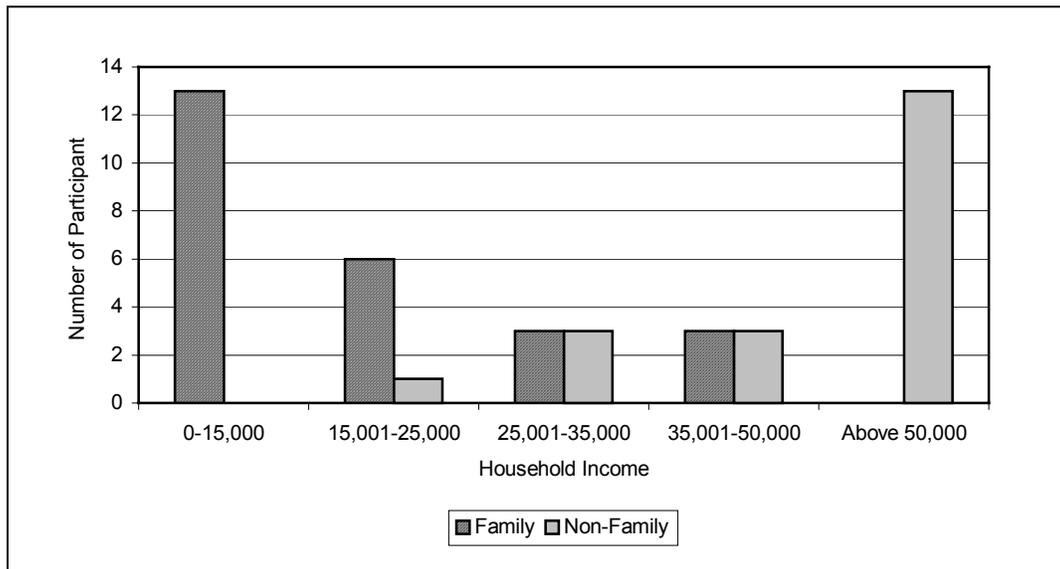
<i>Category</i>	<i>Aggregate Total</i>		<i>URB-N</i>		<i>RUR-W</i>		<i>URB-E</i>		<i>RUR-E</i>	
	<i>N</i>	<i>%</i>	<i>N</i>	<i>%</i>	<i>N</i>	<i>%</i>	<i>N</i>	<i>%</i>	<i>N</i>	<i>%</i>
<i>Total Adult Participants</i>	45	100%	8	18%	25	56%	6	13%	6	13%
<i>Adult Family Member</i>	26	58%	3	38%	16	64%	4	67%	3	50%
<i>Adult Non-Family</i>	19	42%	5	63%	9	36%	2	33%	3	50%
<i>Gender</i>										
Female	34	76%	6	75%	18	72%	6	100%	4	67%
Male	11	24%	2	25%	7	28%	---	---	2	33%
<i>Race/Ethnicity</i>										
Asian American	---	---	---	---	---	---	---	---	---	---
Black/African American	5	11%	2	25%	1	4%	1	17%	1	17%
Mexican American	10	22%	---	---	10	40%	---	---	---	---
White/European	28	62%	6	75%	13	52%	4	67%	5	83%
Other Group	2	4%	---	---	1	4%	1	17%	---	---

Table 6. Participant Household Income in Aggregate Study

<i>Category</i>	<i>Aggregate Total</i>				<i>URB-N</i>		<i>RUR-W</i>		<i>URB-E</i>		<i>RUR-E</i>	
	<i>F</i>	<i>F%</i>	<i>NF</i>	<i>NF%</i>	<i>F</i>	<i>NF</i>	<i>F</i>	<i>NF</i>	<i>F</i>	<i>NF</i>	<i>F</i>	<i>NF</i>
<i>Household Income</i>												
0-15,000	13	52%	---	---	2	---	9	---	---	---	2	---
15,001-25,000	6	24%	1	5%	---	---	3	1	3	---	---	---
25,001-35,000	3	12%	3	15%	---	3	2	---	---	---	1	---
35,001-50,000	3	12%	3	15%	---	1	2	2	1	---	---	---
Above 50,000	0	0%	13	65%	---	2	---	6	---	2	---	3
<i>Total Participants</i>	25	100%	20	100%	2	6	16	9	4	2	3	3

Note. F=Family Participant; NF=Non-Family Participant

Figure 7. Household Income by Role for Aggregate Participants



Aggregate percentage breakdowns of participants by community and by demographic characteristics were similar to percentages of participants originally participating in the individual community sorting and rating processes. The RUR-W community was slightly over-represented in the aggregate study (56%) compared to its original sorters and raters (43%), with URB-E and RUR-E slightly underrepresented by about 6% each. Participation from the URB-N community varied by only 1%. There was a slightly greater level of Family participation in the aggregate study (58% compared to original 49%) over Non-Family participation (42% compared to original 51%). The percentage of participants identifying as Black/African American was 5% greater in the aggregate study, and the percentage of participants identifying as Mexican American decreased by 5% from the original sorters and raters. The overall percentage of male and female participation varied by only 1% in the two phases of the study.

### *Concept Mapping Idea Generation Findings*

Each community generated twice the minimum of 30-40 statements required to ensure a valid Concept Mapping analysis. Appendix G includes the statements generated by each community. As previously indicated, participants generated statements by completing the following sentence(s) with specific examples:

4. *I know services to families are culturally competent when \_\_\_\_\_.*
5. *I know services to families are respectful when \_\_\_\_\_.*
6. *I know services are culturally responsive when \_\_\_\_\_.*

The URB-N community brainstormed 80 statements; RUR-W brainstormed 76 statements; URB-E brainstormed 82 statements; and RUR-E brainstormed 65 statements. Participants were given no upper limit for statements. In general, each of the two groups generating ideas in each community brainstormed approximately one-half of the community's total statements.

Statements from each community were then compared with one another and reduced into one unduplicated list. Of the 303 statements originally generated across communities, 117 individual statements common and unique to communities were identified during the data reduction process: four statements were common across all communities, 20 were common to three communities, 44 were common to two communities, and 49 statements were unique to individual communities. Appendix H includes a complete account of which statements were combined along with the statement in the unduplicated list developed to represent combined statements.

*Concept Mapping Structuring, Representation, and Interpretation of Ideas:*

*Cluster Map Generation*

Conceptual maps were produced for each community reflecting how they viewed the relationship among the data elements. Based on the participant sorts, the multidimensional scaling analysis generated a structural configuration for the community's map. The cluster analysis provided multiple schematic solutions (numbers of clusters) for conceptualizing the map configurations. Communities each chose the cluster map solution that they believed best represented their ideas of cultural competence. One community selected a seven-cluster solution, two communities selected eight-cluster solutions, and one community selected a nine-cluster solution. Clusters generated in all communities reflect many systems of care and wraparound values and principles.

Each community's map is first examined individually, followed by an examination of clusters across individual community maps. Finally, the aggregated map is presented to illustrate how participants across communities structured the combined set of ideas.

*Individual Systems of Care Community Maps*

A number of map styles are available from the Concept Systems software. The following maps, called point cluster maps, were chosen for inclusion based on their efficiency in representing the results from the multidimensional scaling and cluster analyses. The multidimensional scaling analysis provides a stress value to indicate fit of the map to the data. Typical values achieved in Concept Mapping range between .15 and

.35, with an average range of .27 to .30 (Trochim, 1993). All maps generated for this research fell within the recommended range.

Each point on the map represents a statement; thus, the map represents how each individual statement is related to all the other statements generated. This relationship is indicated by how far apart or how close together the statements are placed on the map. Next to each point is the statement number. Points placed closer together means those statements were perceived more similar in meaning and were more often sorted together by the participants. The farther away the points are from each other, the less similar they were perceived in meaning and the less often they were sorted together. The statement relationships give structural meaning to the data.

*URB-N system of care.* The first map (see Figure 8) reflects the ideas from the URB-N system of care in its selected eight-cluster solution. While a complete listing of the clusters and the statements embedded within them is provided in Appendix G, Table 7 includes some examples of statements in the clusters. Ideas from this system of care community reflected greater emphasis on issues related to policy and legislation than the other three communities. The Professional group brainstorming session took place during a regularly scheduled meeting of the system of care governing board, which places high priority on policy-related issues.

While many Non-Family/Professional participants were present for Day One, this community had the lowest Professional return rate (23%) and the lowest Family return rate (63%) of all communities. This community had one of the two lowest overall levels of family representation in the study, and recruited no youth for the assessment. It

additionally had the lowest amount of diversity among participants. The data include no families of color. Input from 22 participants is included in the statistical analyses.

Figure 8. URB-N Point Cluster Map (stress value = .286)

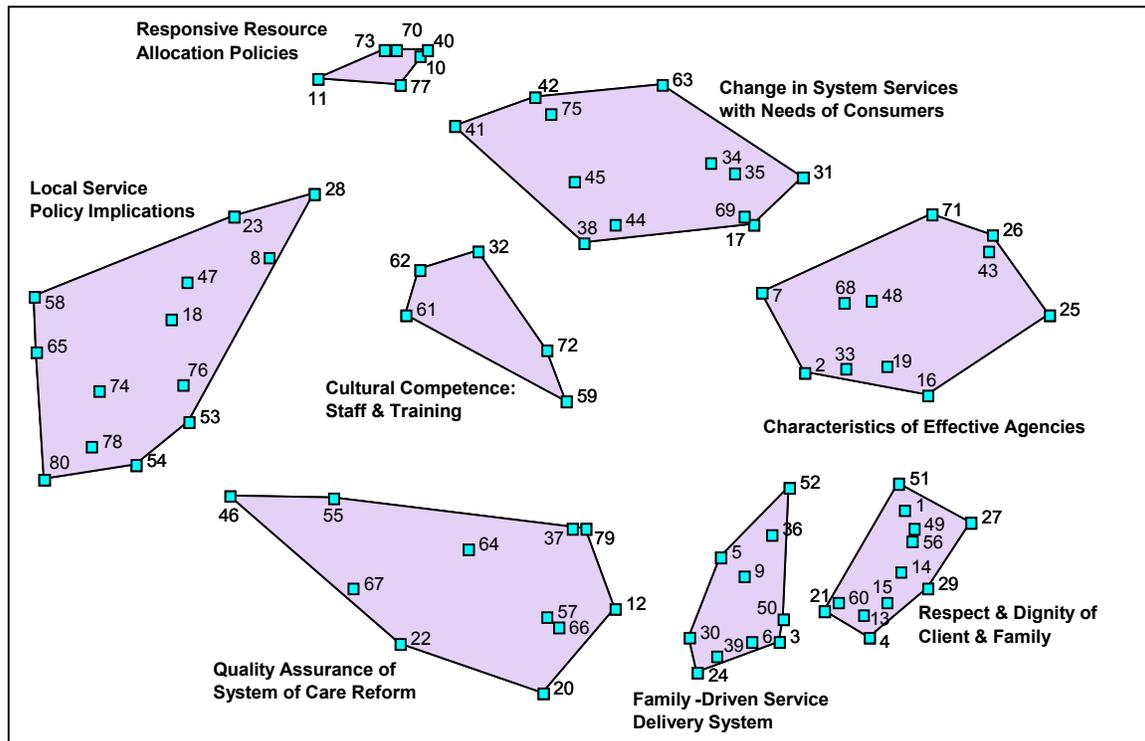


Table 7. Examples of Statements in URB-N Clusters

**Cluster 1: Respect & Dignity of Client & Family** - services and programs are offered at family-friendly times; all families feel comfortable accessing care; services are accessible regardless of families' financial resources

**Cluster 2: Family-Driven Service Delivery System** - they understand what's important to me; they are inclusive of all persons; professionals respect parents' choices

**Cluster 3: Quality Assurance of System of Care Reform** - people get better; plans are put in writing so everyone can be accountable; children start to take responsibility for their own healthcare

**Cluster 4: Characteristics of Effective Agencies** - there are no more waiting lists; we practice what we preach about individual and community acceptance; the system has the flexibility to provide unique/non-traditional services to families

**Cluster 5: Responsive Resource Allocation Policies** - public policy permits flexibility; legislators understand the programs they are funding; legislators are sensitive to the needs of families

Table 7. (continued)

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**Cluster 6: Change in System's Services with Needs of Consumers** - all decision-making bodies reflect the community; the society in which we live changes its value system to prioritize the health of its citizens; relationships and history of ethnic groups in [this] County are understood

**Cluster 7: Cultural Competence: Staff & Training** - individual staff make efforts to educate themselves about countries and religions of people different from them; organizations insist on providing cultural competence training at least annually at all levels; you don't hear professionals make remarks based on ethnic origins

**Cluster 8: Local Service Policy Implications** - all the agencies work together; educational system is prepared to be positive participants; services change with the changing needs of the community

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*RUR-W system of care.* The second map (see Figure 9) reflects the ideas from the RUR-W system of care in its selected seven-cluster solution. Again, a complete listing of the clusters and the statements embedded within them is provided in Appendix G. Table 8 includes some examples of statements in the clusters. Ideas from this system of care community greatly reflect issues related to relationships in service provision, including interaction between families and providers, interaction between providers, and service system practices.

This community had the largest number of participants overall (n=66), one of the highest levels of diversity among participants, and recruited the most youth for the assessment (n=21). Indeed, this community overall had more Family member participation (64%) than Professional/Non-Family participation (36%). A total of 36% of RUR-W participants were Mexican American, and this community had the highest rate of male participation (30%) of all four communities. A total of 92% of Family participants and 65% of Professional participants returned for Day Two. Input from 56 participants is included in the statistical analyses.

Figure 9. RUR-W Point Cluster Map (stress value = .226)

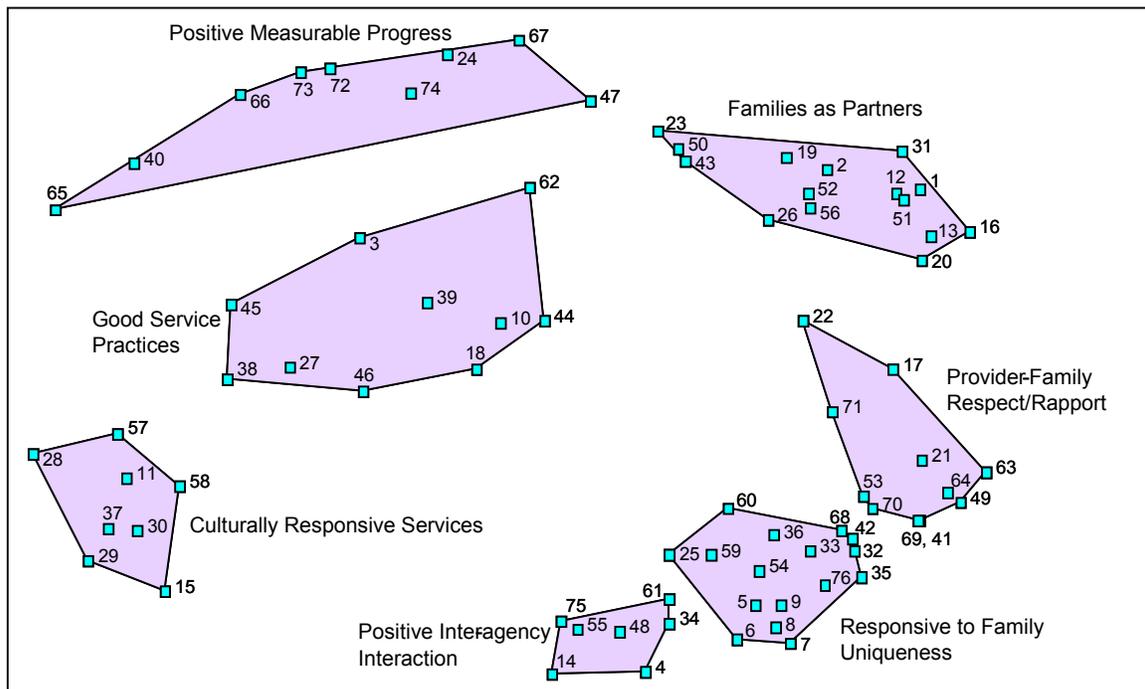


Table 8. Examples of Statements in RUR-W Clusters

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**Cluster 1: Families as Partners** - families have a voice and choice about what's going on; families are active in all aspects of services; families report back that they feel respected; I know I am part of the team

**Cluster 2: Good Service Practices** - family programs fit the scheduling needs of the family; there is easy accessibility for families to providers; not only parents are treated with respect, but so are the kids

**Cluster 3: Positive Measurable Progress** - there are ways to measure achievement; the needs of the family are met; families can tell there is change/growth in themselves; kids learn to express their feelings with words instead of with anger

**Cluster 4: Culturally Responsive Services** - there are a lot of options for services; services are provided in different languages; employees are representative of the population

**Cluster 5: Positive Inter-agency Interaction** - providers don't pass the buck from one organization to another; providers are educated to cultural differences; providers use a multi-disciplinary approach

**Cluster 6: Responsive to Family Uniqueness** - providers listen; providers work with the entire family rather than only the child; providers are willing to ask questions to learn about families' cultures; providers don't impose their own solutions on families; providers care

**Cluster 7: Provider-Family Respect/Rapport** - trust is built between providers and families; providers value family's input; providers have good communication with the children

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*URB-E system of care.* The third map (see Figure 10) reflects the ideas from the URB-E system of care in its selected eight-cluster solution. See Appendix G for a complete listing of the clusters and statements. Table 9 includes some examples of statements in the clusters. This system of care community also focused on aspects of care related to interaction and methods of practice. Specifically, clusters include multiple ideas related to individualizing services, especially with regard to providers being nonjudgmental, coordination and continuity in service provision, and family empowerment.

The URB-E community had 33 participants overall. Although its numbers were smaller, it had the greatest ethnic diversity among all communities, including the most representation of Black/African American (33%) and Asian American (12%) participants. It also recruited seven youth for the assessment. However, Family participation was the second lowest overall and male participation was the lowest among all four communities. The return rates for Day Two were 88% for Family participants and 68% for Professional/Non-Family participants. Input from 26 participants is included in the statistical analyses.

Figure 10. URB-E Point Cluster Map (stress value = .267)

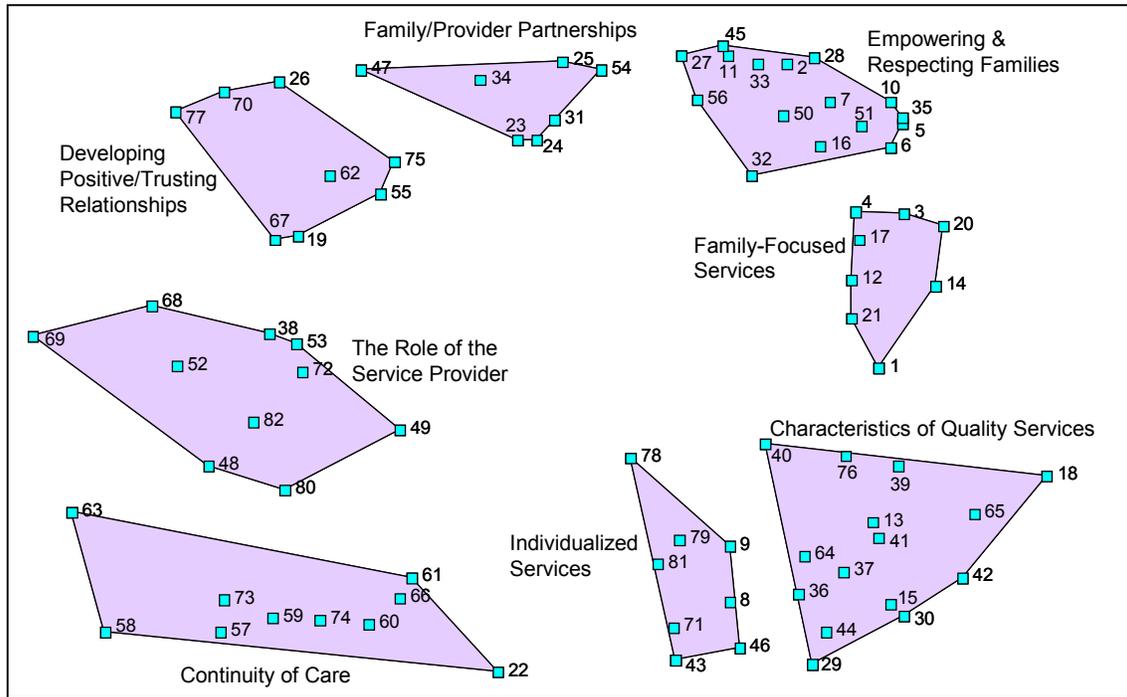


Table 9. Examples of Statements in URB-E Clusters

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**Cluster 1: Family-Focused Services** - services are individualized; families' specific needs are met; family strengths are highlighted and utilized; families help plan the services

**Cluster 2: Empowering & Respecting Families** - families feel understood; family voice and choice are prioritized; the existing culture of the family is preserved; families feel cared about; families are respected

**Cluster 3: Developing Positive/Trusting Relationships** - communication is open; families and service providers don't stereotype or make assumptions about the other; families and providers develop relationships that foster mutual trust and respect; individuals are empathic

**Cluster 4: Family/Provider Partnerships** - family feels comfortable to approach the service provider regarding need for change; families feel the community providers work together; everyone feels equal in the service process

**Cluster 5: Individualized Services** - there is equal opportunity for services for all individuals; there is a culturally appropriate way to meet the needs of culturally and racially diverse groups; services include everyone with mental illness and their families

**Cluster 6: Characteristics of Quality Services** - services are within the neighborhood; services lead to progress; needs-based services are provided; services are easily accessible and convenient

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Table 9. (continued)

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**Cluster 7: Continuity of Care** - there is a continuum of services; there is continuity of care for people across developmental stages; there is coordination among service providers and families

**Cluster 8: The Role of the Service Provider** - accurate and relevant information about services is given to families; service providers and families work as a team; there is productive cross-cultural intervention

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*RUR-E system of care.* The final individual system of care map (see Figure 11) reflects the ideas from the RUR-E community in its selected nine-cluster solution. See Appendix G for a complete listing of the clusters and statements. Table 10 includes some examples of statements in the clusters. This system of care community had the least number of statements (65), but chose the greatest number of clusters. The ideas reflected in this community's map focused a substantial amount of attention on what were conceptualized as barriers to services. These barriers included issues related to preventing practitioners and systems from culturally responsive care, from accessibility to family responsibilities in the care process.

The RUR-E community had 31 participants overall. There were more participants attending Day Two than Day One, with one more Family (n=9) than Professional/Non-Family (n=8) member participating in the brainstorming session. RUR-E had the lowest levels of ethnic/racial diversity among all communities, with 81% of participants identifying as White/European. It recruited six youth for the assessment. Families comprised 39% of total participants. Eight of the nine Family members participating on Day One returned for Day Two; however, only 38% of Professional/Non-Family participants returned for Day Two. Input from 25 participants is included in the statistical analyses.

Figure 11. RUR-E Point Cluster Map (stress value = .244)

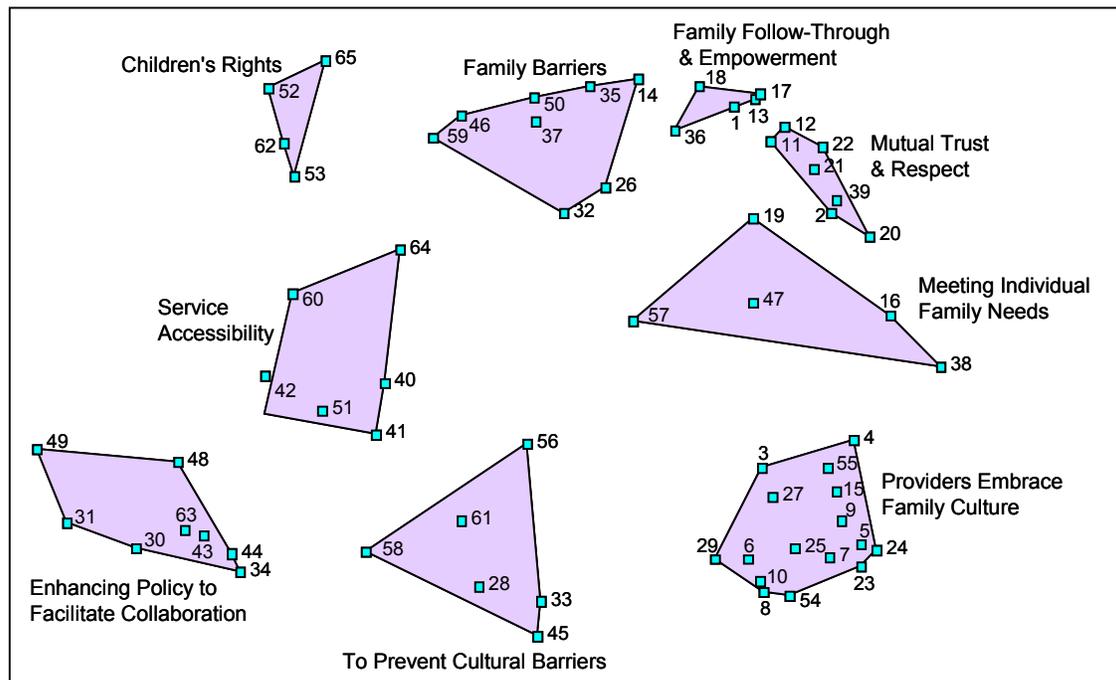


Table 10. Examples of Statements in RUR-E Clusters

**Cluster 1: Family Follow-Through & Empowerment** - families are satisfied with the service; families are able to help themselves; families are in charge of their own services (when working with providers)

**Cluster 2: Mutual Trust & Respect** - families feel they are treated with dignity and respect; families trust the providers; families feel listened to and heard; families don't feel labeled

**Cluster 3: Meeting Individual Family Needs** - people respect the individual as a person; families are able to communicate in their own language

**Cluster 4: Family Barriers** - families can access the services with no barriers (transportation, language, education, cost); families have alternatives for services/treatment/interventions

**Cluster 5: Children's Rights** - children have a voice in what services they receive; the educational needs of all children are met and supported.

**Cluster 6: Providers Embrace Family Culture** - providers draw on families' existing strengths; providers are open to letting families educate them about the family's culture; providers are not judgmental of families' culture

**Cluster 7: To Prevent Cultural Barriers** - forms/documents are translated into the cultural language of families; services meet the needs of the whole community (church, schools, families, work, employers, friends, etc.)

Table 10. (continued)

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<b>Cluster 8: Service Accessibility</b> - services are advertised and families know about them; there is assistance to families to cut the red tape to access services
<b>Cluster 9: Enhancing Policy to Facilitate Collaboration</b> - policy-makers (legislative and agency) change policies to allow providers to do what they need to do for families; county agencies work together to meet the needs of families

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Table 11 summarizes and compares the cluster conceptualizations across all four communities. Community clusters are listed by column, and clusters reflecting similar ideas are placed along the same row. All four systems of care identified four clusters with similar concepts. Cluster row A reflects numerous examples of relational interaction with regard to respect, trust, communication, and valuing family input in the care process. Statements in the row B clusters represent issues related to family empowerment and partnering with families in developing the service plan. Issues that coalesce around service and agency quality are found in cluster row C. Statements in these clusters relate to issues such as staff and agencies reflecting the diversity of the community, accessibility to services, and culturally relevant approaches to service provision. Cluster row D reflects concepts dealing specifically with agency and systems related issues, such as policies, coordinated and collaborative service systems, and provider training.

Table 11. Community Cluster Map Labels

	<b>URB-N</b> (80 statements/ 8 clusters)	<b>RUR-W</b> (76 statements/ 7 clusters)	<b>URB-E</b> (82 statements/ 8 clusters)	<b>RUR-E</b> (65 statements/ 9 clusters)
A	Respect & Dignity of Client & Family	Provider-Family Respect/Rapport	Empowering & Respecting Families Developing Positive/Trusting Relationships	Mutual Trust & Respect
B	Family-Driven Service Delivery System	Families as Partners	Family/Provider Partnerships	Family Follow-through & Empowerment Family Barriers
C	Characteristics of Effective Agencies	Good Service Practices	Characteristics of Quality Services The Role of the Service Provider	Service Accessibility
D	Local Service Policy Implications	Positive Interagency Interaction	Continuity of Care	Enhancing Policy to Facilitate Collaboration
E		Responsive to Family Uniqueness	Individualized Services Family-Focused Services	Meeting Individual Family Needs Providers Embrace Family Culture
F	Changes in System Services with Needs of Consumer	Culturally Responsive Services		To Prevent Cultural Barriers
G	Quality Assurance of System of Care Reform	Positive Measurable Progress		
H				Children's Rights
I	Responsive Resource Allocation Policies			
J	Cultural Competence: Staff & Training			

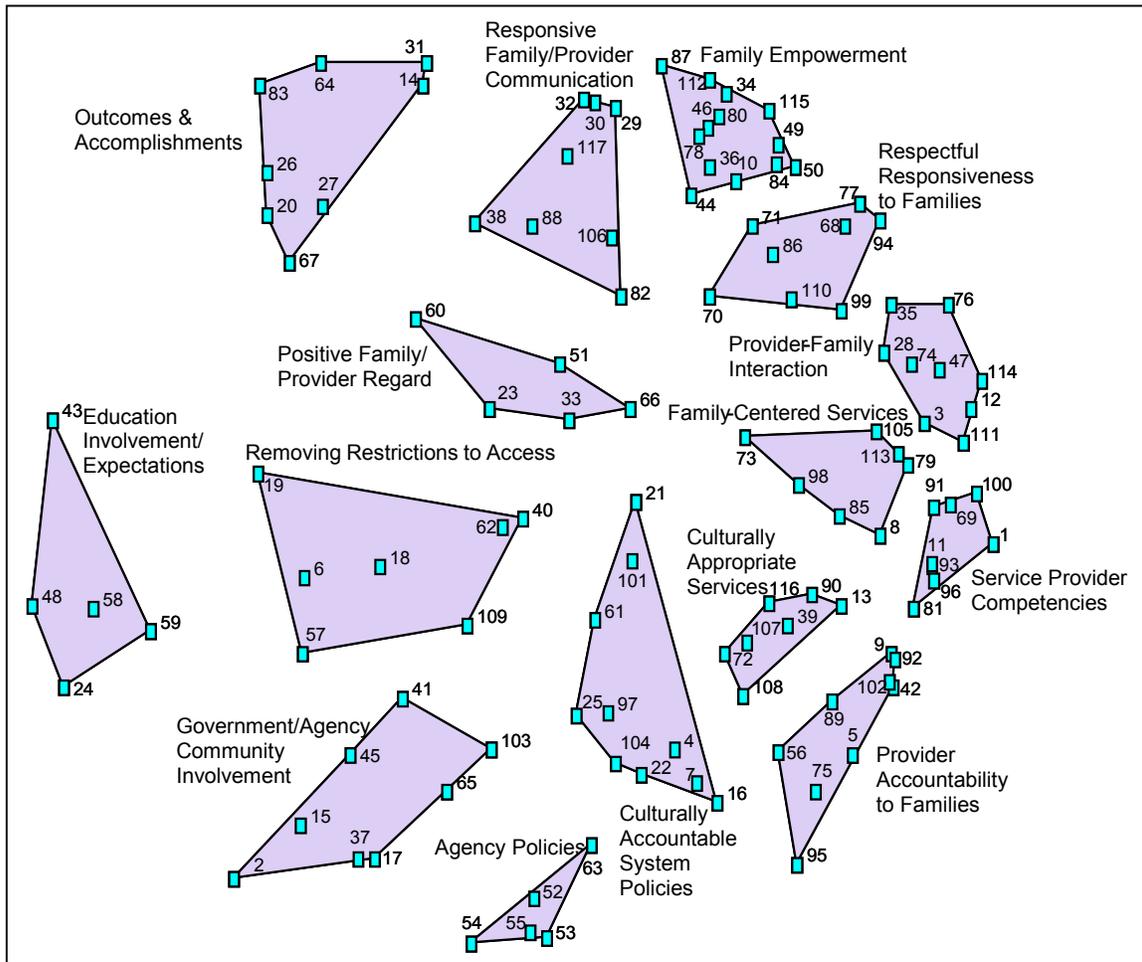
The next two cluster rows (E and F) indicate similar issues identified by three communities. The clusters in row E center on service providers' genuine interest in, commitment to, and regard for families. This includes individualizing services to the needs and strengths of entire family units and their cultures. Statements in row F clusters concern cultural responsiveness of agencies and systems to the persons and communities

they serve. Issues reflected include keeping services and processes grounded in the needs of communities, understanding organizational cultures and cultures of the community, and responding to differences in cultural language.

While all four communities included statements related to achieving goals or meeting families' needs, two communities developed clusters related specifically to outcomes and accountability (row G). These range from child-specific and family outcomes to roles of providers in helping families achieve outcomes. Rows H, I and J reflect cluster issues of specific emphasis for individual systems of care communities. Although some statements similar to those found in these clusters are also found within the maps of other communities, the statements were contextually grouped for specific emphasis in these two community maps.

*Aggregate systems of care map.* The final cluster map (see Figure 12) reflects the ideas from across all four systems of care communities. This map includes the 117 statements included in the synthesized list. A total of 34 participants from across the four communities sorted the statements. Although the minimum number of sorters required for a valid statistical analysis is 10, increased numbers of sorters improve the reliability of the results (Trochim, 1993). The map solution generally stabilizes with a sample size between 30 and 50 (W. M. K. Trochim, personal communication, January 30, 2003). Since participants in the aggregate phase were drawn from the original systems of care community sample, it was reasonable to expect that aggregate participant familiarity with the context and processes of the study would enable the production of a valid and reliable aggregated map solution. The stress value of the aggregated map was .297.

Figure 12. Aggregate Point Cluster Map (stress value = .297)



Based on information from individual community maps, an examination of the cluster merges, statement and cluster bridging values, and the objectives of the research, the researcher chose a 15-cluster solution to represent the combined data. Larger numbers of clusters provides greater detail for comparative purposes. A complete listing of the clusters and the statements embedded within them is provided in Table 12.

Table 12. Aggregate Statements by Cluster

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***Cluster 1: Service Provider Competencies***

- 1 providers take the time to get to know and build rapport with the children and families they are serving.
- 11 the service provider welcomes the involvement of an objective family advocate.
- 69 providers don't assume families won't understand what's going on with the family/situation.
- 81 service providers know when to offer empathetic and/or sympathetic support to families.
- 91 services are child-centered and allow children to have a voice in what services they receive.
- 93 providers work with and provide services to the entire family rather than only the identified child.
- 96 service providers don't impose their own values and beliefs on families.
- 100 providers are willing to ask questions and allow families to be experts on their own cultures.

***Cluster 2: Family-Centered Services***

- 8 the services provided are based on the specific needs of families.
- 73 the roles of each person involved in services are clear (parent, counselor, child).
- 79 service providers truly understand what's important to families.
- 85 services and programs meet the scheduling needs of the family.
- 98 services to families are nonjudgmental and affirming of families' cultures and backgrounds.
- 105 service provision involves mutual understanding between provider and families.
- 113 services are family-driven (families are in charge of their own services).

***Cluster 3: Provider-Family Interaction***

- 3 service providers truly support, value, and preserve the individual cultures of the families.
- 12 service providers and families are able to use humor in their relationships.
- 28 trusting relationships are built between providers and families.
- 35 service providers and families truly work as a team.
- 47 providers value and honor input from the whole family.
- 74 families and service providers are not judgmental about one another.
- 76 parents are kept informed of their child's treatment and progress.
- 111 service providers use family-friendly language that is free of technical jargon.
- 114 when service providers respect parents' choices without being judgmental.

***Cluster 4: Culturally Accountable System Policies***

- 4 services are inclusive of all persons without discrimination.
- 7 a continuum of coordinated services and providers enable smooth service transitions for families.
- 16 the service systems support efforts to broaden services beyond "traditional" service provision.
- 21 services lead to improving families' progress toward meeting their goals.
- 22 agencies work together (combine resources, information, and efforts) to meet the goals of families.
- 25 there is equal opportunity for services for all individuals.
- 61 consumers are not submitted to abusive workers (verbal abuse, physical mgmt, environmental constraints).
- 97 service providers are educated about the cultural differences of families they are serving.
- 101 culturally appropriate services are ensured to meet the needs of families.
- 104 systems and service providers reflect ("look like") the diverse cultures in their community.

***Cluster 5: Provider Accountability to Families***

- 5 service plans are put in writing so everyone can be held accountable.
  - 9 providers think outside the box of their job description and extend themselves in serving families.
  - 42 service providers have a credible reputation for serving families.
  - 56 services are available for mental health/mental retardation dual diagnoses needs.
  - 75 care is developmentally appropriate and not diagnosis driven.
  - 89 service providers make every effort to find help for families without passing the buck to another agency.
  - 92 providers actually do what they say they are going to do.
  - 95 service providers can admit they do not have the understanding necessary for working with a family.
  - 102 service providers consider the culture of the whole person (spiritual, physical, financial, mental, family unit).
-

Table 12. (continued)

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***Cluster 6: Culturally Appropriate Services***

- 13 services to families are provided using a multi-disciplinary approach.
- 39 flexibility is built into the service system to provide unique/non-traditional services to meet family needs.
- 72 there is consistency in who provides services to families.
- 90 services are individualized (not everyone is offered the exact same services in the exact same way).
- 107 services are provided within families' own communities.
- 108 services are available to families regardless of families' financial resources.
- 116 services and supports are strengths-based and draw on the existing resources of families.

***Cluster 7: Government/Agency Community Involvement***

- 2 government's understanding of the community's service needs are supported through appropriate funding allocation structures.
- 15 decision-making bodies change services to meet the needs of the whole community.
- 17 policy (legislated and agency) permits providers the flexibility to do what is needed for families.
- 37 organizations provide community-specific cultural competence training to employees at all levels.
- 41 there is inter-agency cultural and historical understanding.
- 45 community ownership of services is valued by community members and supported by service providers.
- 65 practitioners can actually impact changes in the system of care.
- 103 the cultural demographics of those served reflect the community's population.

***Cluster 8: Agency Policies***

- 52 workers are given rapid due process for accusations made by consumers.
- 53 agency policies allow employees to have case-related grief time.
- 54 professional and direct care staff receive equitable pay.
- 55 staff are hired who have experienced mental health illnesses.
- 63 services and systems are non-competitive.

***Cluster 9: Removing Restrictions to Access***

- 6 "red tape" is not a barrier to families accessing services.
- 18 when services to families remain consistent across political parties.
- 19 employers are supportive of employees who have family members with special needs.
- 40 there is continuity of care for families over the long haul.
- 57 there are no more waiting lists.
- 62 people don't hear professionals make remarks based on ethnic origins.
- 109 agency forms and documents are printed in the cultural language of families.

***Cluster 10: Education Involvement/Expectations***

- 24 educational system is prepared to be positive participants.
- 43 the educational needs of all children are met and supported.
- 48 higher education institutions know their communities and can teach students about alternative types of referrals.
- 58 there is not an over-representation of children in alternative education.
- 59 continuing education is offered to both families and professionals.

***Cluster 11: Family Empowerment***

- 10 families are empowered by the strengths and differences of their culture.
  - 34 families are active in all aspects of services.
  - 36 families are invested in the service process.
  - 44 families have a lot of options for services.
  - 46 families view service providers, policy-makers and agency administrators as helpful and motivating.
  - 49 family voice and choice are prioritized.
  - 50 families are given the time and consideration their situation deserves.
  - 78 opportunities are available for families to support and share information with one another.
  - 80 families feel they are treated with dignity and respect.
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Table 12. (continued)

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<b><i>Cluster 11: Family Empowerment (continued)</i></b>	
84	families know the service providers care.
87	families feel listened to and heard by service providers.
112	families are able to communicate in their own language with service providers.
115	families feel comfortable accessing services and asking questions of service providers.
<b><i>Cluster 12: Respectful Responsiveness to Families</i></b>	
68	families get a response when they make a request.
70	families have a lot of options available when choosing service providers.
71	families are happy to see providers.
77	families are referred to as people and don't feel labeled or stigma associated with receiving services.
86	families' time is respected.
94	families are accurately informed of services and resources that are available to them.
99	families and service providers are willing to share their cultures and beliefs with each other.
110	families can access services and providers with no barriers (transportation, language, education, cost).
<b><i>Cluster 13: Outcomes &amp; Accomplishments</i></b>	
14	families get politically involved in advocating for change in government policies.
20	noticeable progress is made in child outcomes.
26	kids are happy with themselves.
27	children are allowed to be children.
31	communication between parents and their children improves.
64	the elderly are valued.
67	there are ways to measure achievement.
83	kids begin taking responsibility for their own behavior.
<b><i>Cluster 14: Positive Family/Provider Regard</i></b>	
23	people know how to appropriately respond to crisis situations.
33	everyone is treated equally in the service process.
51	services enhance family life.
60	persons don't insult one another by trying to be too culturally polite.
66	animosity is not present between systems and families.
<b><i>Cluster 15: Responsive Family/Provider Communication</i></b>	
29	families understand how to use impartial grievance procedures.
30	the needs of families are met.
32	families are satisfied with the services they receive.
38	families are educated about the organizations' cultures and mandates.
82	there is two-way respectful communication between children and service providers.
88	parents and children are individually treated with respect.
106	the line of communication is always open.
117	families are able to find resources on their own and use new resources to help themselves.

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The low bridging values assigned to the statements and clusters (see Appendix I) indicate that the overall aggregate map is fairly well constructed. Bridging values can range from 0.0 to 1.0. Statements and/or clusters with lower bridging values indicate that they are more anchored in their content placement on the map (Concept Systems, 2001).

Jackson and Trochim (2002) further explain the bridging value statistic as one that “helps the researcher identify the degree to which any given statement is related to ones that are similar in meaning or tend to ‘bridge’ a more diverse set of statements. Statements that are difficult to sort will show up as having a high bridging value” (p. 329).

There were only two clusters indicating bridging values over .50. Ten of the 15 clusters had average bridging values at or below .22. The *Education Involvement/Expectations* cluster had the highest bridging value of .85. As evidenced by the differing content of the statements, these statements have little collective relationship with one another except that they are all related to educational issues. *Outcomes & Accomplishments* was the cluster with the second highest bridging value (.58). Statements embedded in both of these clusters were also sorted differently by participants during the individual community assessments.

The results of the multidimensional scaling and clustering analyses in the aggregate map appear to represent the synthesized list of statements in a meaningful and understandable contextual structure for systems of care. Where the individual systems of care maps grouped statements according to their meaning for the specific community, the aggregate map indicates how a sample of participants from across the four systems of care gave meaning to the entire data set. These findings have implications with regard to measurement of cultural competence that will be discussed in chapter 5.

*Concept Mapping Structuring, Representation, and Interpretation of Ideas:*

*Ratings and Pattern Match Comparisons*

Where the sorting process gives meaning to the statements, the rating data enhances conceptual understanding by offering participants a means for placing value on the statements. As described in chapter 3, participants were asked to rate each of the statements on their level of importance for meeting the unique needs of families, the frequency of statement demonstration, and the level of statement inclusion in agency policies. The Concept Mapping software produces the rating output in various formats that can be illustrated with a variety of graphical maps. One form of output includes the average ratings of each statement generated. While not illustrated in the form of a map, Appendix G also includes the average values of each statement for individual systems of care assessments and for the aggregate assessment.

The second form of output uses the average ratings of each statement across participants to produce an average value for the clusters in which the statements are embedded. One method of illustrating these data is through cluster rating maps. In these maps clusters are drawn with one to five layers to indicate the average cluster value on each cluster relative to the values of all other clusters on the map. Maps can be drawn to reflect the results of the overall group or of specific participant groups based on demographic characteristics. These types of maps were produced for communities to foster discussion during the interpretation stage of the process and to increase understandability of community reports.

Probably the most compelling graphs produced by the Concept Mapping software are called *pattern match comparisons*. In these graphs, average cluster ratings (computed from the averages of each statement in the cluster, i.e., an average of averages) are used to compare the results from one participant group to another, or to compare two different ratings. A Pearson's  $r$  is produced to assess the strength of relationship (level of consistency) between groups' patterns of averages. In these graphs an overall picture is obtained of the differences and similarities in participant conceptualizations.

Average cluster ratings for the three rating criteria were used to develop pattern matches for two specific group comparisons in each individual systems of care assessment: (1) Family and Non-Family participants, and (2) People of Color and White/European participants. Although the researcher had hoped to obtain a large enough sample to compare rating differences between and within ethnic groups of color, the sample attained limited the number of such comparisons. As a result, all persons of color were placed into one group to gain some sense of rating differences between People of Color and White/European participants. The assumptions of universality behind Lum's (2000) process-stage approach to diversity practice support this type of comparison. Additional group comparisons were also made from the aggregate rating data, including comparisons based on geography, gender, disability, and household income. Finally, pattern matches were produced comparing participant ratings of importance and frequency of demonstration. These comparisons became key findings for establishing a baseline in each community.

For purposes of this study, the researcher transferred much of the output from Concept Mapping into tables. These data are included for the aggregate and all four individual systems of care assessments. This method of presentation was determined to be the most efficient means of including the vast amount of data generated. Some of the more compelling pattern match comparison graphs are included to clearly illustrate differences and similarities between groups and the potential utility of the output in generating dialogue around the concepts. Additional data detailing the findings are included in Appendix J.

#### *Individual Systems of Care Ratings and Pattern Matches*

To keep the Concept Mapping findings presentation consistent, the rating data are presented first by systems of care communities and then by the aggregate assessment. This structure also allows the reader to examine differences and similarities in ratings between participant groups within each community. Findings of importance, frequency of demonstration, and policy are presented respectfully throughout this section.

*URB-N system of care.* Participants in this community structured their map around the following eight areas of cultural competence: Respect & Dignity of Client & Family, Family-Driven Service Delivery System, Quality Assurance of System of Care Reform, Characteristics of Effective Agencies, Responsive Resource Allocation Policies, Change in System Services with Needs of Consumer, Cultural Competence: Staff & Training, and Local Service Policy Implications.

Importance: All of the clusters were rated as important. This was expected, as participants were asked to specifically generate ideas that reflect cultural competence.

The intent for this rating was to understand how the specific ideas are valued differently or similarly between groups of participants. Table 13 lists the importance ratings by comparison group. Overall, *Respect & Dignity of Client & Family* and *Family-Driven Service Delivery System* clusters received the highest ratings of importance among all groups, followed by *Responsive Resource Allocation Policies*. There were some notable differences among groups.

Of particular note was the Family group's rating of *Responsive Resource Allocation Policies*. The Family group rated this cluster as the most important, where all other groups rated *Respect & Dignity of Client & Family* most important. The top three ratings were identical for the Overall, Non-Family, People of Color, and White-European groups. All groups, except Family, rated *Change in System Services with Needs of Consumer* as the least important cluster, with average group ratings ranging from 3.78 to 3.93. The Family group rated *Cultural Competence: Staff & Training* as its least important cluster.

Table 13. URB-N Importance Ratings by Participant Group

	Respect & Dignity of Client and Family	Family-Driven Service Delivery System	Quality Assurance of System of Care Reform	Charact. of Effective Agencies	Responsive Resource Allocation Policies	Change in System Services with Needs of Consumer	Cultural Competence: Staff & Training	Local Service Policy Implications
	1	2	3	4	5	6	7	8
Overall (N=22)	4.58	4.37	4.05	3.98	4.27	3.82	3.92	3.95
Family (n=6)	4.33	4.33	4.14	3.96	4.43	3.93	3.90	4.08
Non-Family (n=16)	4.66	4.39	4.02	3.98	4.22	3.78	3.93	3.90
People of Color (n=6)	4.57	4.30	4.14	4.15	4.17	3.85	4.07	3.97
White/European (n=16)	4.58	4.40	4.02	3.91	4.32	3.81	3.86	3.94

Frequency of Demonstration: All clusters were rated below 3.3 in frequency of demonstration, where “3” on the scale was anchored at “sometimes demonstrated.” This difference between importance and frequency was expected and gave the system of care some objectives to work towards. Table 14 includes frequency of demonstration ratings by comparison group. Overall, and similar to Importance, *Respect & Dignity of Client & Family* and *Family-Driven Service Delivery System* clusters received the highest ratings of demonstration. The *Responsive Resource Allocation Policies* cluster was rated the lowest in demonstration by all groups. There were some differences found among the groups.

The Family and White/European groups rated *Family-Driven Service Delivery System* as most demonstrated, while the Non-Family, People of Color, and Overall groups rated *Respect & Dignity of Client & Family* as most demonstrated. The Overall, Non-Family and People of Color groups all rated *Family-Driven Service Delivery System* as the second most demonstrated, while the Family and White/European groups rated the *Respect & Dignity of Client & Family* cluster as the second most demonstrated. The Family group rated *Characteristics of Effective Agencies* as the third most demonstrated, while this cluster did not rank in the top three for any other group.

As part of attaining a baseline for the system of care, a pattern match was made between importance and frequency of demonstration ratings. This comparison for the URB-N community resulted in a moderate level of consistency ( $r = .51$ ) between the two ratings. The *Responsive Resource Allocation Policies* cluster showed the greatest

discrepancy between the ratings, with a high overall level of importance, but the lowest rating of demonstration.

Table 14. URB-N Frequency of Demonstration Ratings by Participant Group

	Respect & Dignity of Client and Family	Family-Driven Service Delivery System	Quality Assurance of System of Care Reform	Charact. of Effective Agencies	Responsive Resource Allocation Policies	Change in System Services with Needs of Consumer	Cultural Competence: Staff & Training	Local Service Policy Implications
	1	2	3	4	5	6	7	8
Overall (N=22)	3.21	3.18	2.99	2.83	2.36	2.62	2.82	2.71
Family (n=5)	2.81	2.83	2.56	2.59	2.16	2.46	2.40	2.26
Non-Family (n=16)	3.36	3.32	3.16	2.92	2.43	2.68	2.98	2.88
People of Color (n=6)	3.74	3.55	3.33	3.32	2.92	3.03	3.23	3.09
White/European (n=15)	3.05	3.07	2.92	2.68	2.17	2.49	2.67	2.62

Policy: One result from the Policy rating question was the finding that 10% of all participant responses indicated no knowledge of related policies addressing the statements. A limitation to this rating question may be that it is sometimes difficult to assign a rating to the inclusion of such specific examples. Since systems of care often require change at the policy level, the intent of the question was to gather information about overall participant knowledge of cultural competence policies across their respective agencies. Table 15 illustrates the rating differences between groups. Family participants did not complete the policy rating. Thus, there are no Family and Non-Family comparisons.

Overall, groups compared generally perceived that more agency policies include statements pertaining to the *Respect & Dignity of Client & Family* and *Family-Driven Service Delivery System* clusters than statements in the other clusters. *Responsive*

*Resource Allocation* was perceived as the cluster least covered in policies. The Policy scale was a 1 to 3 scale, so variation among responses is more limited for this rating. In all clusters except *Family-Driven Service Delivery System* and *Respect & Dignity of Client and Family*, the People of Color group rated cluster statements more often covered in agency policies than did their White/European counterparts. The People of Color group rated *Cultural Competence: Staff & Training* as the second most covered in policy, while the White/European group rated *Family-Driven Service Delivery System* the second most covered.

Table 15. URB-N Policy Ratings by Participant Group

	Respect & Dignity of Client and Family	Family-Driven Service Delivery System	Quality Assurance of System of Care Reform	Charact. of Effective Agencies	Responsive Resource Allocation Policies	Change in System Services with Needs of Consumer	Cultural Competence: Staff & Training	Local Service Policy Implications
	1	2	3	4	5	6	7	8
Overall (N=15)	2.47	2.23	2.04	1.97	1.57	1.82	2.12	1.82
People of Color (n=6)	2.42	2.08	2.10	2.04	1.71	1.88	2.23	1.84
White/European (n=9)	2.51	2.34	1.98	1.91	1.47	1.79	2.02	1.80

*RUR-W system of care.* Participants in this community structured their map around the following seven areas of cultural competence: Families as Partners, Good Service Practices, Positive Measurable Progress, Culturally Responsive Services, Positive Interagency Interaction, Responsive to Family Uniqueness, and Provider-Family Respect/Rapport.

Importance: Again, all of the clusters were rated as important. Because of the large participation in this community more comparisons between groups could be made. Thus, one additional ethnic group of color, Mexican Americans, is included as a group by

itself as well as within the People of Color group. The majority of people identifying as Mexican American were Family participants. Table 16 lists the importance ratings by group. Overall, all of the clusters except *Culturally Responsive Services* were rated above 4.0 (very important). *Positive Measurable Progress*, *Provider-Family Respect/Rapport*, and *Good Service Practices* clusters received the highest ratings of importance among all groups. As illustrated, the cluster rank ordering for importance was similar across groups. However, there were some notable differences and similarities among groups.

Table 16. RUR-W Importance Ratings by Participant Group

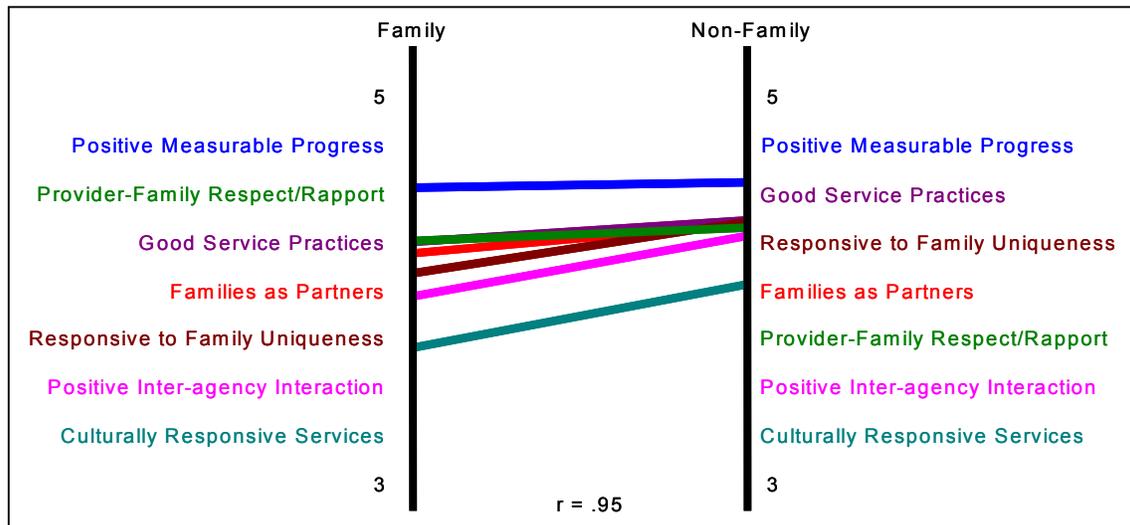
	Families as Partners 1	Good Service Practices 2	Positive Measurable Progress 3	Culturally Responsive Services 4	Positive Inter-agency Interaction 5	Responsive to Family Uniqueness 6	Provider-Family Respect/Rapport 7
Overall (N=54)	4.18	4.22	4.48	3.75	4.01	4.11	4.22
Family (n=37)	4.13	4.19	4.47	3.64	3.91	4.03	4.20
Non-Family (n=17)	4.29	4.30	4.50	3.97	4.22	4.29	4.26
People of Color (n=25)	4.29	4.32	4.54	4.03	4.21	4.19	4.36
White/European (n=27)	4.14	4.18	4.44	3.49	3.86	4.09	4.15
Mexican American (n=20)	4.25	4.24	4.48	4.03	4.16	4.17	4.31

Statements in the *Positive Measurable Progress* cluster were rated as the most important by all groups, and statements in the *Culturally Responsive Services* cluster were rated as the least important by all groups. The *Good Service Practices* cluster was ranked in the top three by all groups except the Mexican American group. The Non-Family group ranked the *Responsive to Family Uniqueness* cluster as one of its third most important clusters, while it was one of the three lowest ranked clusters by all other groups. The *Provider-Family Respect/Rapport* cluster was ranked in second on

importance for all groups except the Non-Family and White/European groups. *Families as Partners* rated in the top three only for the Non-Family and Mexican American groups. As noted in the table, the People of Color group rated all clusters more important than the White/European group. However, the average cluster importance ratings for the Mexican American group were lower than the ratings for the combined People of Color group.

While the overall range of importance ratings may be small, there are noticeable differences between groupings in their conceptualizations of degree of importance. Figure 13 illustrates the importance pattern match comparison between the Family and Non-Family groups. Cluster labels appear down the sides of the ladder in descending order of importance for both groups. Since all importance ratings fell between 3 and 5, the graph is set up to show only a 3-5 scale. The  $r = .95$  shown at the bottom of the ladder indicates that there is a very strong level of consistency between the two groups in their patterns of cluster average ratings of importance. Although the two groups' patterns of cluster averages are nearly the same, the diagonal lines indicate that the Non-Family group rated all clusters higher than the Family group. As indicated by the last diagonal line on the ladder graph, the cluster with the largest rating difference is *Culturally Responsive Services*.

Figure 13. RUR-W Family/Non-Family Importance Pattern Match



Frequency of Demonstration: All clusters were rated between 3.51 and 3.81 in frequency of demonstration, meaning that all groups viewed the clusters within a narrow range above “sometimes demonstrated.” RUR-W experienced the highest demonstration ratings of all four systems of care. Table 17 provides the rating differences among groups in this system of care. The *Provider-Family Respect/Rapport* cluster received the highest rating of demonstration by all groups. Some similarities and differences among groups were noted.

All groups, except the Non-Family and White/European groups, rated *Positive Measurable Progress* among the top three most demonstrated clusters. The Non-Family group’s rating of *Families as Partners* was lower than all other groups. The *Culturally Responsive Services* cluster was rated the least demonstrated by all groups except the Mexican American group. The Mexican American group and the People of Color group (which had two clusters equally rated last) ranked *Responsive to Family Uniqueness* as

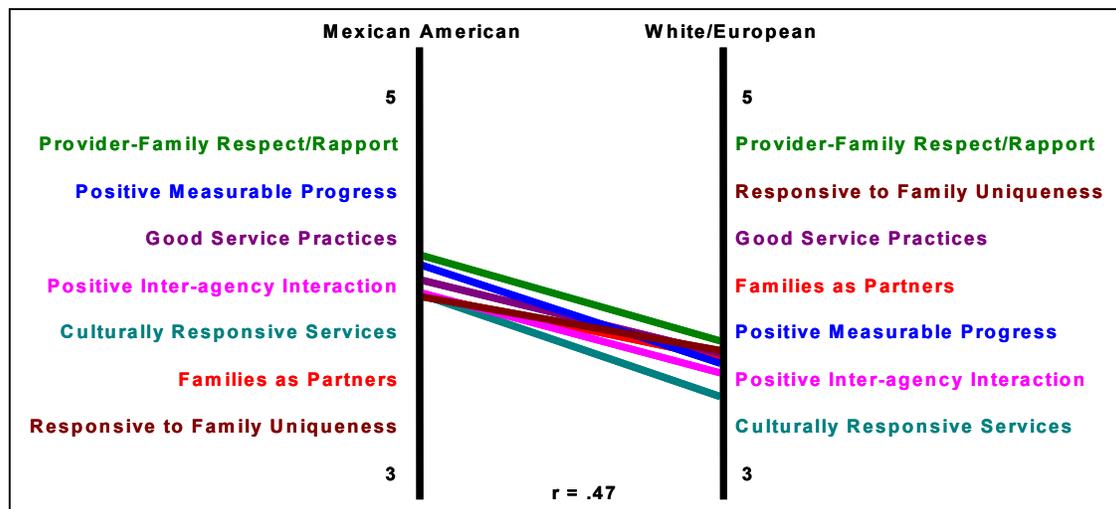
least demonstrated. In contrast, the Non-Family and White/European groups rated this cluster as the second most demonstrated. Demonstration ratings by the Mexican American group were distinctly higher across all clusters than any other group. The input of only five participants of color who were not Mexican American had a lowering impact on the overall People of Color group rating.

Table 17. RUR-W Frequency of Demonstration Ratings by Participant Group

	Families as Partners	Good Service Practices	Positive Measurable Progress	Culturally Responsive Services	Positive Inter-agency Interaction	Responsive to Family Uniqueness	Provider-Family Respect/Rapport
	1	2	3	4	5	6	7
Overall (N=52)	3.63	3.70	3.68	3.51	3.60	3.65	3.81
Family (n=35)	3.73	3.77	3.80	3.58	3.66	3.68	3.88
Non-Family (n=17)	3.44	3.55	3.42	3.36	3.48	3.58	3.67
People of Color (n=25)	3.74	3.84	3.85	3.71	3.76	3.71	3.99
White/European (n=26)	3.55	3.58	3.53	3.35	3.47	3.59	3.64
Mexican American (n=20)	3.89	3.97	4.05	3.90	3.90	3.88	4.10

Again, the overall range of ratings is small, but there were noticeable differences between groupings in their conceptualizations of degree of perceived demonstration. Figure 14 illustrates the demonstration pattern match comparison between the Mexican American and White/European groups. There is a moderate ( $r = .47$ ) relationship between the patterns of average ratings. As indicated by the diagonal lines, the Mexican American participants rated all clusters as more often demonstrated than participants in the White/European group.

Figure 14. RUR-W Mexican American and White/European Frequency of Demonstration Pattern Match



The pattern match between importance and frequency of demonstration ratings for the RUR-W community resulted in a moderate to strong level of consistency ( $r = .70$ ). In that comparison, the *Positive Measurable Progress* cluster indicated the greatest discrepancy between the ratings. This cluster was assigned the highest overall level of importance, but was third in rating of demonstration.

Policy: Seven percent of all participant responses indicated no knowledge of related policies addressing the statements. Table 18 provides the ratings among groups. Again, Family participants did not complete the policy rating. Overall, all groups perceive that more agency policies include statements pertaining to *Provider-Family Respect/Rapport* and *Culturally Responsive Services* clusters than statements in the other clusters. There were a few similarities and differences between groups.

The People of Color group ranked *Families as Partners* as the second most covered cluster in policies, with a rating distinctly higher than the White/European and

overall ratings. The White/European group rated *Positive Measurable Progress* as the most covered in policy, yet the group’s rating was still lower than the People of Color group. The White/European group policy ratings were lower across all clusters than the People of Color group. *Positive Inter-agency Interaction* was rated as least covered in policy by the People of Color group, where the *Responsive to Family Uniqueness* was rated as least covered in policy by the White/European group.

Table 18. RUR-W Policy Ratings by Participant Group

	Families as Partners	Good Service Practices	Positive Measurable Progress	Culturally Responsive Services	Positive Inter-agency Interaction	Responsive to Family Uniqueness	Provider-Family Respect/Rapport
	1	2	3	4	5	6	7
Overall (N=17)	2.18	2.27	2.27	2.29	2.14	2.13	2.32
People of Color (n=5)	2.50	2.46	2.33	2.50	2.20	2.43	2.62
White/European (n=12)	2.05	2.19	2.25	2.20	2.12	2.01	2.19

*URB-E system of care.* Participants in the URB-E community structured their map around the following eight areas of cultural competence: Family-Focused Services, Empowering & Respecting Families, Developing Positive/Trusting Relationships, Family/Provider Partnerships, Individualized Services, Characteristics of Quality Services, Continuity of Care, and The Role of the Service Provider.

Importance: Again, all of the clusters were rated as important. Overall, all of the clusters except *Family/Provider Partnerships* were rated above 4.0 (very important). Table 19 lists the importance ratings by comparison group. *Family-Focused Services*, *Individualized Services*, and *Continuity of Care* clusters received the highest ratings of

importance overall among groups. As illustrated in the table, the cluster order of importance was similar across groups, with only a couple of exceptions.

All groups rated statements in the *Family-Focused Services* cluster as the most important, and rated statements in the *Family/Provider Partnerships* cluster as the least important. The People of Color group rated all clusters as more important than the White/European group. With only a couple of exceptions, average cluster importance ratings by the White/European group were lower than all other groups. The Importance cluster ordering was similar for the Family and People of Color groups.

Table 19. URB-E Importance Ratings by Participant Group

	Family-Focused Services	Empowering & Respecting Families	Developing Positive/Trusting Relationships	Family/Provider Partnerships	Individualized Services	Characteristics of Quality Services	Continuity of Care	The Role of the Service Provider
	1	2	3	4	5	6	7	8
Overall (N=26)	4.39	4.19	4.17	3.93	4.31	4.09	4.25	4.19
Family (n=8)	4.47	4.18	4.20	3.98	4.30	4.01	4.39	4.20
Non-Family (n=18)	4.36	4.20	4.16	3.90	4.32	4.13	4.19	4.18
People of Color (n=12)	4.47	4.26	4.19	3.98	4.35	4.27	4.35	4.28
White/European (n=14)	4.33	4.13	4.16	3.89	4.28	3.95	4.16	4.11

Frequency of Demonstration: Overall, all clusters were rated between 3.36 and 3.70 on frequency of demonstration, with *Individualized Services* and *Developing Positive/Trusting Relationships* receiving the highest ratings of demonstration. However, there were a number of inconsistencies in ratings across groups. Table 20 lists the ratings for each group.

The Non-Family group was the only group not placing *Developing Positive/Trusting Relationships* in its top three most demonstrated clusters. All groups, except Family participants, rated *Individualized Services* in the top three most demonstrated clusters. While *Characteristics of Quality Services* was rated more often demonstrated by most groups, the People of Color group rated this cluster as one of two least demonstrated. The Non-Family group was the only group to rate *The Role of the Service Provider* in the top three most demonstrated clusters, whereas the Family group alone rated *Empowering & Respecting Families* in the top three most demonstrated clusters. The *Continuity of Care* cluster was rated the lowest in demonstration by all groups except the Non-Family and People of Color groups. All groups except the Family group rated *Family/Provider Partnerships* among the least demonstrated of all clusters.

Table 20. URB-E Frequency of Demonstration Ratings by Participant Group

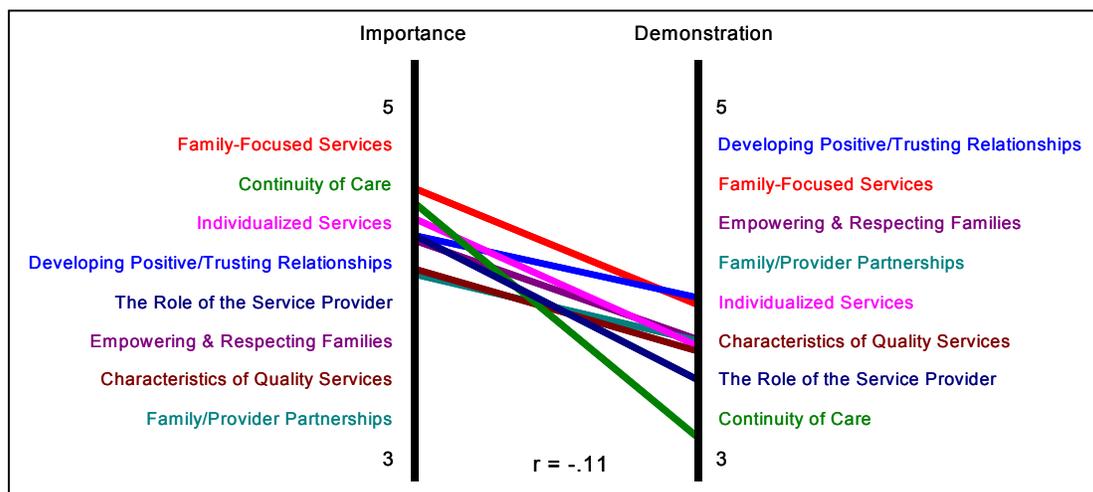
	Family-Focused Services	Empowering & Respecting Families	Developing Positive/Trusting Relationships	Family/Provider Partnerships	Individualized Services	Characteristics of Quality Services	Continuity of Care	The Role of the Service Provider
	1	2	3	4	5	6	7	8
Overall (N=26)	3.63	3.56	3.69	3.47	3.70	3.62	3.36	3.62
Family (n=8)	3.81	3.61	3.85	3.61	3.58	3.55	3.06	3.39
Non-Family (n=18)	3.56	3.53	3.62	3.41	3.76	3.65	3.49	3.73
People of Color (n=12)	3.73	3.63	3.74	3.58	3.72	3.58	3.65	3.64
White/European (n=14)	3.55	3.50	3.65	3.38	3.69	3.65	3.11	3.62

The overall pattern match between importance and frequency of demonstration ratings for the URB-E community resulted in a weak level of consistency ( $r = .31$ ). Multiple clusters were ordered differently on the two sides of the graph, but *Continuity of*

*Care* indicated the greatest discrepancy between the ratings. This cluster was assigned the third highest overall level of importance, but was last in rating of demonstration.

Of particular note in this community’s pattern match comparisons was the importance-frequency of demonstration comparison for Family members. Figure 15 illustrates a negative correlation ( $r = -.11$ ) between the Family group’s two ratings. This very weak relationship means that the clusters rated more important were rated less demonstrated and the clusters rated less important were rated more often demonstrated.

Figure 15. URB-E Importance-Frequency of Demonstration Family Member Pattern Match



Policy: The Policy rating question resulted in the finding that 7% of all Non-Family/Professional participant responses indicated no knowledge of related policies addressing the statements. Table 21 includes the ratings of Professional participants. Overall, all groups perceive that more agency policies include statements pertaining to the *Individualized Services* cluster than statements in the other clusters. Some differences and similarities between groups were noted.

Across groups, statements in the *Characteristics of Quality Services* and *The Role of the Service Provider* clusters were rated the second most covered by agencies' policies. *Continuity of Care* and *Developing Positive/Trusting Relationships* were rated the least most covered in policies. The People of Color group rated all clusters except *Individualized Services* as more often covered in policies than did the White/European group.

Table 21. URB-E Policy Ratings by Participant Group

	Family-Focused Services	Empowering & Respecting Families	Developing Positive/Trusting Relationships	Family/Provider Partnerships	Individualized Services	Characteristics of Quality Services	Continuity of Care	The Role of the Service Provider
	1	2	3	4	5	6	7	8
Overall (N=18)	2.34	2.34	2.22	2.24	2.54	2.37	2.22	2.37
People of Color (n=9)	2.52	2.43	2.34	2.33	2.52	2.42	2.29	2.42
White/European (n=9)	2.15	2.24	2.09	2.14	2.56	2.31	2.15	2.31

*RUR-E system of care.* Participants in this community structured their map around the following nine areas of cultural competence: Family Follow-Through & Empowerment, Mutual Trust & Respect, Meeting Individual Family Needs, Family Barriers, Children's Rights, Providers Embrace Family Culture, To Prevent Cultural Barriers, Service Accessibility, and Enhancing Policy to Facilitate Collaboration.

Importance: All of the clusters were rated important, ranging from 3.73 to 4.28. Table 22 provides the ratings of the Overall, Family and Non-Family groups. Note that the table rows and columns for this community are switched to accommodate the larger number of clusters. There were only three People of Color who participated in this community's sorting and rating, thus no group comparison was made with this grouping.

Overall, the *Enhancing Policy to Facilitate Collaboration* cluster received the highest ratings of importance. Statements in the *To Prevent Cultural Barriers* cluster were rated least important across participant groupings. There were some notable similarities and differences among the three comparison groupings.

In contrast to the other two groups, the Family group rated *Service Accessibility* as the most important cluster. Indeed, this cluster accounted for the largest rating discrepancies between Family participants and the other two group comparisons.

*Enhancing Policy to Facilitate Collaboration* was rated first in importance by the Overall and Non-Family groups. The Family group assigned higher ratings of importance to all clusters than the other two groups.

Table 22. RUR-E Importance Ratings by Participant Group

Cluster Name	Overall (N=24)	Family (n=10)	Non-Family (n=14)
1) Family Follow-Through & Empowerment	3.83	3.90	3.80
2) Mutual Trust & Respect	4.24	4.45	4.09
3) Meeting Individual Family Needs	3.97	4.04	3.92
4) Family Barriers	4.04	4.28	3.88
5) Children's Rights	4.15	4.38	3.98
6) Providers Embrace Family Culture	3.91	3.93	3.89
7) To Prevent Cultural Barriers	3.73	3.78	3.69
8) Service Accessibility	4.14	4.47	3.90
9) Enhancing Policy to Facilitate Collaboration	4.28	4.35	4.22

Frequency of Demonstration: All clusters were rated between 2.48 and 2.96 on frequency of demonstration, meaning that all groups viewed the clusters as below “sometimes demonstrated.” RUR-E experienced the lowest demonstration ratings of all four systems of care. Table 23 includes the demonstration rating differences for the three comparison groups. Overall, the *Mutual Trust & Respect* cluster received the highest

rating of demonstration. The demonstration ratings reflected more inconsistencies among group ratings than were reflected in the importance ratings.

Some notable differences between groups were found. While rated most demonstrated overall, the *Mutual Trust & Respect* cluster did not make the top three ratings for the Non-Family group. The *Children's Rights* cluster was rated most demonstrated by the Non-Family group, but did not make the top three ratings for the Family group. The Non-Family group rated six of the nine clusters as more often demonstrated than the Family group, and rated statements in the *Family Barriers* cluster as least demonstrated.

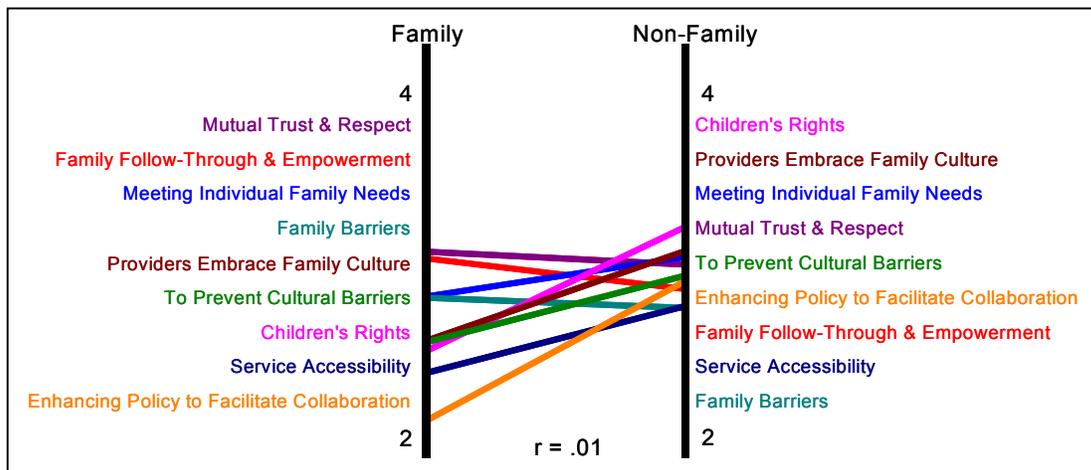
Table 23. RUR-E Frequency of Demonstration Ratings by Participant Group

Cluster Name	Overall (N=23)	Family (n=10)	Non-Family (n=13)
1) Family Follow-Through & Empowerment	2.86	2.96	2.78
2) Mutual Trust & Respect	2.96	3.00	2.92
3) Meeting Individual Family Needs	2.87	2.74	2.97
4) Family Barriers	2.70	2.73	2.67
5) Children's Rights	2.83	2.42	3.13
6) Providers Embrace Family Culture	2.77	2.48	3.00
7) To Prevent Cultural Barriers	2.69	2.47	2.86
8) Service Accessibility	2.51	2.29	2.68
9) Enhancing Policy to Facilitate Collaboration	2.48	2.01	2.82

Finally, the Family group rated *Enhancing Policy to Facilitate Collaboration* cluster much lower in demonstration than the Non-Family and Overall groups. This discrepancy, along with many others between the Family and Non-Family group comparisons of demonstration are illustrated in Figure 16. This pattern match comparison resulted in no agreement ( $r = .01$ ) between these two groups in their perceptions of demonstration.

The overall pattern match between importance and frequency of demonstration ratings for the URB-E community resulted in a weak level of consistency ( $r = -.23$ ). Multiple clusters were ordered differently on the two sides of the graph, but the most obvious discrepancy was noted with the *Enhancing Policy to Facilitate Collaboration* cluster. This cluster was rated the highest overall in importance, but was rated last in demonstration.

Figure 16. RUR-E Frequency of Demonstration Family Member Pattern Match



Policy: One result from the Policy rating question was the finding that 15% of all participant responses indicated no knowledge of related policies addressing the statements. Since there were no comparisons for People of Color and White/European participants, and Family members did not complete the policy scale, Table 24 provides only the overall policy ratings.

Overall, participants perceived that more agency policies include statements pertaining to the *Children's Rights*, *Providers Embrace Family Culture*, *To Prevent Cultural Barriers*, and *Service Accessibility* clusters than statements in the other clusters.

Statements in the *Mutual Trust & Respect* cluster were perceived as the least covered by agencies' policies. As illustrated in the table, the range of ratings across clusters is narrow, with all clusters rated between 1.73 and 1.96. These results reflect ratings between "Not Covered" and "Somewhat Covered" in agencies' policies.

Table 24. RUR-E Policy Ratings by Participant Group

Cluster Name	Overall
1) Family Follow-Through & Empowerment	1.82
2) Mutual Trust & Respect	1.73
3) Meeting Individual Family Needs	1.85
4) Family Barriers	1.80
5) Children's Rights	1.96
6) Providers Embrace Family Culture	1.95
7) To Prevent Cultural Barriers	1.94
8) Service Accessibility	1.94
9) Enhancing Policy to Facilitate Collaboration	1.84

*Aggregate systems of care assessment.* While the number of clusters and final cluster labels for the aggregate study were ultimately chosen by the researcher, the decisions were based on the individual community assessments and input from aggregate study participants. The aggregate map is structured around the following 15 areas of cultural competence as determined by the four systems of care communities: Service Provider Competencies, Family-Centered Services, Provider-Family Interaction, Culturally Accountable System Policies, Provider Accountability to Families, Culturally Appropriate Services, Government/Agency Community Involvement, Agency Policies, Removing Restrictions to Access, Education Involvement/Expectations, Family Empowerment, Respectful Responsiveness to Families, Outcomes & Accomplishments, Positive Family/Provider Regard, and Responsive Family/Provider Communication.

Table 25 illustrates how the clusters from the four individual systems of care communities are embedded within the 15 aggregate clusters. The same format as Table

11 is used for consistency. A new column is included showing the cluster numbers from the aggregate map compared to the cluster numbers from the individual community maps from which the statements in the aggregate clusters primarily originated. Tables 11 and 12 previously presented indicate the cluster labels attached to the cluster numbers.

Table 25. Aggregate and Individual Community Cluster Map Comparison

	<b>AGGREGATE CLUSTER NUMBERS</b>	<b>URB-N CLUSTER NUMBERS</b>	<b>RUR-W CLUSTER NUMBERS</b>	<b>URB-E CLUSTER NUMBERS</b>	<b>RUR-E CLUSTER NUMBERS</b>
	(117 statements/ 15 clusters)	(80 statements/ 8 clusters)	(76 statements/ 7 clusters)	(82 statements/ 8 clusters)	(65 statements/ 9 clusters)
A	12, 15	1	7	2, 3	2
B	2, 3, 11	2	1	4	1, 4
C	1, 9	4	2	6, 8	8
D	4, 8	8	5	7	9
E	5, 6, 14		6	1, 5	3, 6
F	7	6	4		7
G	13	3	3		
H	Statements integrated across map: 1, 10, 13, 15				5
I	7	5			
J	Statements integrated across map: 4, 7, 8	7			

Although the aggregate study reflects only a portion of the original participants, those who responded reflect a fairly comparable representation of the original sample. Noting that findings are limited to participants in each phase of the study, the research questions guiding this study require some examination of results across communities. A qualitative comparison of importance, demonstration, and policy ratings assigned to

clusters in the individual community assessments and those assigned to statements, thus clusters, in the aggregate assessment reflected differences in priorities and needs for the four systems of care. There were a few notable consistencies across communities.

Row A in Table 25 indicates that all four communities generated ideas that were primarily placed in aggregate clusters 12, *Respectful Responsiveness to Families*, and 15, *Responsive Family/Provider Communication*. In reviewing the overall ratings from the five assessments, ideas in cluster 15 were consistently rated among the most important for all four communities and the aggregated assessment. Aggregate cluster 8, *Agency Policies*, with ideas generated from across all communities, was rated least important overall in the aggregate assessment. In the individual assessments, two communities rated these ideas as least important while the other two rated the ideas in the median range of importance ratings. All four communities rated ideas in this cluster among the lowest in demonstration and inclusion in policy. All three communities that developed statements embedded in aggregate cluster 7, *Government/Agency Community Involvement*, rated their respective clusters among the least important of all clusters. Likewise, cluster 7 was rated next to last in importance in the aggregate study.

In reviewing the following rating results of the aggregate study, it is important to keep in mind that similar to the overall sample across the four individual systems of care assessments, half of the aggregate participants were from the RUR-W community. Thus, for example, while aggregate cluster 13 indicates the highest ratings of importance in the aggregate study, ideas in these clusters were primarily originally generated from two communities, with RUR-W rating them the highest on importance in its individual

community assessment. At the same time, the aggregate assessment successfully garnered enough diverse participation from the four systems of care (although limited) to make some additional demographic comparisons that were not available in the individual assessments, such as those based on gender, disability, geography, and income. These comparisons will be reflected in the following findings.

Importance: Overall, there was a good deal of consistency in the clusters rated most important across all comparison groups as indicated in Table 26. All of the clusters were rated important, ranging from 3.21 to 4.08. The *Outcomes & Accomplishments* cluster was rated most important by all comparison groups, except the Non-Family and Urban groups, which rated it second and third respectfully. Two clusters, *Provider Accountability to Families* and *Responsive Family/Provider Communication* were ranked second overall, and were among the top three in importance for most groups. The *Agency Policies* cluster was ranked the least important by all groups, except Males, who rated *Government/Agency Community Involvement* as least important.

There were some additional differences between groups. The Non-Family group rated all but three clusters as more important than the Family group. The People of Color Group assigned the same or higher ratings of importance than the White/European participants to all clusters except *Provider Accountability to Families* and *Culturally Appropriate Services*. The Urban group assigned higher ratings of importance than the Rural group to all clusters. The final comparison noted in the table indicates that Females assigned higher ratings than Males to all clusters except *Agency Policies* and *Respectful Responsiveness to Families*.

Table 26. Aggregate Importance Ratings by Participant Group

Cluster Name	Service Provider Competencies	Family-Centered Services	Provider-Family Interaction	Culturally Accountable System Policies	Provider Accountability to Families	Culturally Appropriate Services	Gov't/ Agency Community Involvement	Agency Policies	Removing Restrictions to Access	Education Involvement/ Expectations	Family Empowerment	Respectful Responsiveness to Families	Outcomes & Accomplishments	Positive Family/ Provider Regard	Responsive Family/ Provider Communication
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
Overall (N=45)	3.79	3.87	3.96	3.90	3.99	3.87	3.49	3.21	3.77	3.68	3.91	3.88	4.08	3.86	3.99
Family (n=26)	3.71	3.79	3.91	3.85	3.99	3.77	3.40	3.30	3.72	3.65	3.88	3.87	4.10	3.92	3.92
Non-Family (n=19)	3.89	3.98	4.02	3.98	3.99	4.00	3.61	3.10	3.83	3.73	3.96	3.89	4.05	3.78	4.08
People of Color (n=16)	3.89	3.97	4.02	3.94	3.96	3.76	3.59	3.53	3.78	3.91	4.01	3.99	4.18	4.05	4.17
White/European (n=28)	3.74	3.86	3.95	3.88	4.02	3.92	3.45	3.05	3.78	3.55	3.87	3.83	4.02	3.78	3.89
Rural (n=31)	3.62	3.73	3.82	3.75	3.85	3.66	3.28	3.08	3.54	3.43	3.77	3.78	3.98	3.75	3.88
Urban (n=14)	4.16	4.16	4.26	4.24	4.32	4.34	3.96	3.50	4.27	4.24	4.23	4.11	4.30	4.11	4.24
Female (n=34)	3.88	3.88	4.02	3.93	4.03	3.91	3.57	3.20	3.80	3.75	3.96	3.87	4.12	3.89	4.01
Male (n=11)	3.50	3.83	3.79	3.82	3.88	3.73	3.25	3.27	3.66	3.47	3.78	3.91	3.95	3.78	3.91

Frequency of Demonstration: There was more variation in cluster ratings of demonstration than importance across comparison groups. Cluster ratings among groups ranged from 2.34 to 3.94. Demonstration ratings are included in Table 27. Overall, demonstration of the *Family-Centered Services* and *Positive Family/Provider Regard* clusters were rated the highest. With one distinct exception, these same clusters were rated the highest across groups. The Rural group rated the *Family-Centered Services* cluster the least demonstrated of all clusters. In contrast, the majority of other groups rated the *Education Involvement/Expectations* cluster the least demonstrated.

With regard to specific group comparisons, distinct differences were again noted. The Non-Family group rated all except three clusters as more often demonstrated than the Family participants. Family participants assigned higher demonstration ratings to *Government/Agency Community Involvement, Agency Policies, and Education Involvement/Expectations*. The People of Color group rated all clusters as more often demonstrated than were indicated by the White/European ratings. All clusters except *Family-Centered Services* were rated higher on importance by the Rural group than by Urban participants.

Table 27. Aggregate Frequency of Demonstration Ratings by Participant Group

Cluster Name	Service Provider Competencies	Family-Centered Services	Provider-Family Interaction	Culturally Accountable System Policies	Provider Accountability to Families	Culturally Appropriate Services	Gov't/ Agency Community Involvement	Agency Policies	Removing Restrictions to Access	Education Involvement/ Expectations	Family Empowerment	Respectful Responsiveness to Families	Outcomes & Accomplishments	Positive Family/ Provider Regard	Responsive Family/ Provider Communication
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
Overall (N=45)	3.37	3.39	3.36	3.32	3.32	3.29	2.98	3.00	3.15	2.89	3.28	3.30	3.29	3.39	3.30
Family (n=26)	3.18	3.28	3.24	3.22	3.17	3.15	3.01	3.07	3.09	2.96	3.29	3.20	3.34	3.28	3.22
Non-Family (n=19)	3.63	3.55	3.53	3.45	3.51	3.48	2.93	2.92	3.24	2.80	3.34	3.45	3.24	3.55	3.41
People of Color (n=16)	3.90	3.94	3.87	3.74	3.74	3.77	3.39	3.25	3.44	3.40	3.85	3.88	3.54	3.76	3.75
White/European (n=28)	3.11	3.13	3.13	3.11	3.09	3.02	2.77	2.85	2.97	2.65	3.00	3.02	3.18	3.20	3.06
Rural (n=31)	3.52	2.63	3.55	3.61	3.56	3.61	3.24	3.27	3.44	3.14	3.50	3.54	3.47	3.64	3.52
Urban (n=14)	3.04	2.87	2.95	2.68	2.78	2.59	2.41	2.44	2.52	2.34	2.78	2.77	2.90	2.84	2.82
Female (n=34)	3.32	3.30	3.31	3.24	3.25	3.19	2.87	2.89	3.07	2.75	3.18	3.21	3.28	3.35	3.21
Male (n=11)	3.52	3.66	3.53	3.58	3.53	3.62	3.34	3.39	3.41	3.34	3.56	3.60	3.34	3.51	3.58

*Additional Importance and Demonstration Comparisons.* In complete contrast to their importance rating comparison, male participants rated all clusters higher on demonstration than female participants. These differences are clearly illustrated through pattern match comparisons (see Figures 17 and 18). The scales for the above comparisons were set to include the complete actual range of importance and demonstration ratings in order to create a comparable graphic comparison. The correlation for the importance comparison ( $r = .85$ ) indicates a strong consistency between the averages, but this correlation drops to moderate consistency ( $r = .66$ ) when the demonstration ratings are compared.

Figure 17. Aggregate Importance Gender Pattern Match Comparison (Female, n = 34 vs. Male, n=11)

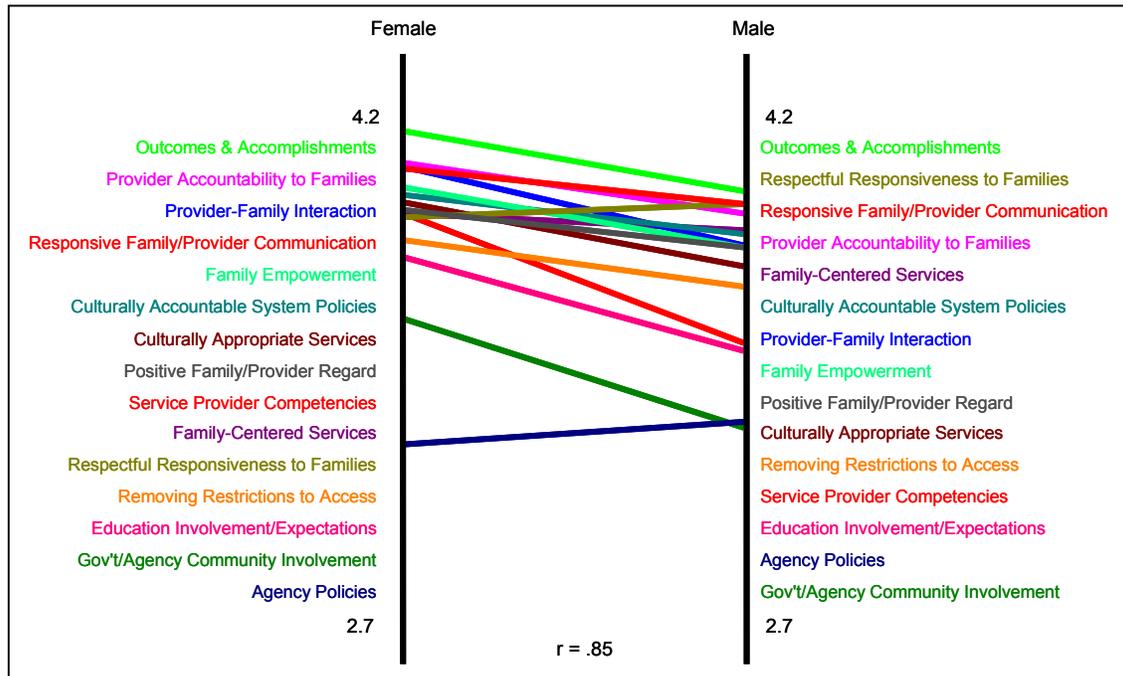
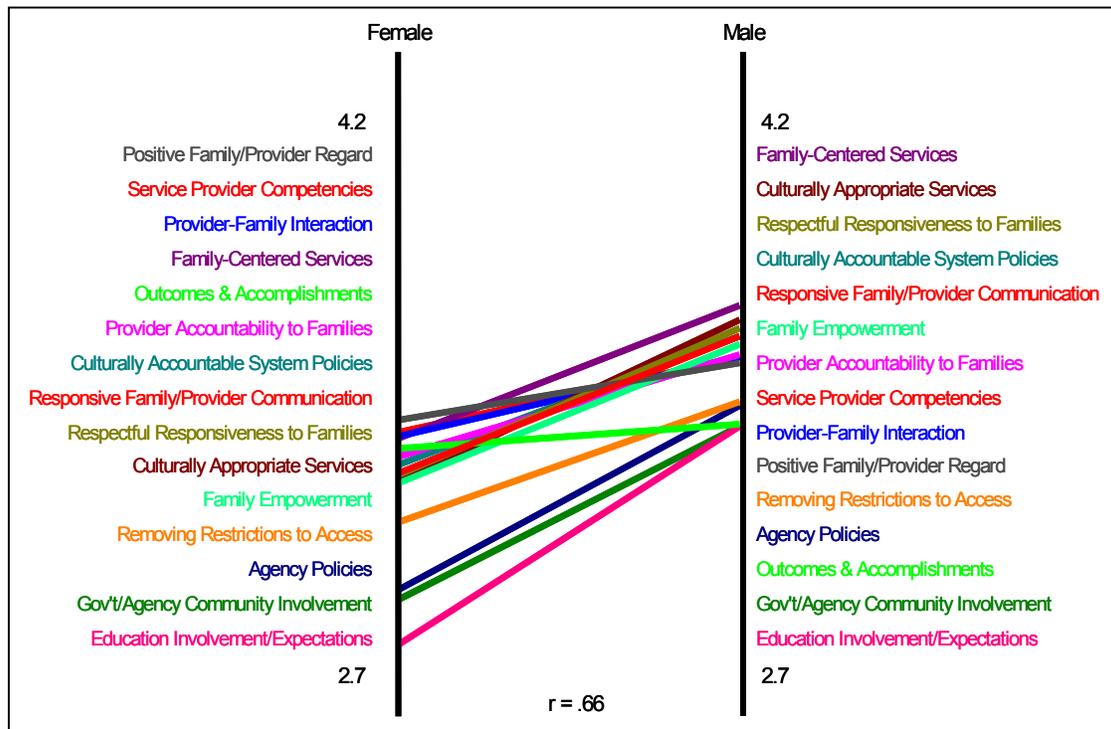


Figure 18. Aggregate Frequency of Demonstration Gender Pattern Match Comparison (Female, n = 34 vs. Male, n=11)



Another comparison available with the aggregate data was between persons with and without a disability. There were eleven people who identified as having a disability, which included both physical and mental disabilities. All of these individuals, except one, were Family participants. Therefore, as a more meaningful comparison, a pattern match was examined between Family participants with and without a disability. Again, Figures 19 and 20 were produced using the full range of the combined scale scores. The importance comparison indicates a strong level of consistency ( $r = .81$ ) between the two groups. However, the demonstration comparison indicates an extremely different level of consistency ( $r = -.19$ ). Family members with a disability rated the statements much less demonstrated than Family members without a disability.

Figure 19. Aggregate Importance Family Member Disability Pattern Match Comparison (Family with Disability, n = 11 vs. Family without Disability, n=16)

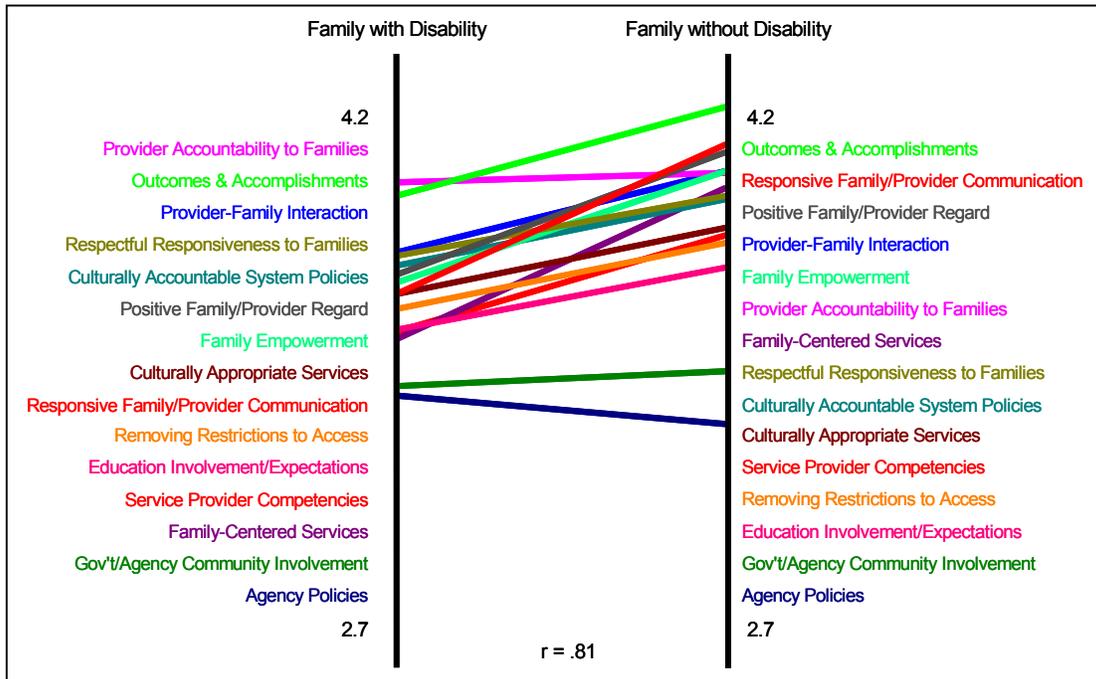
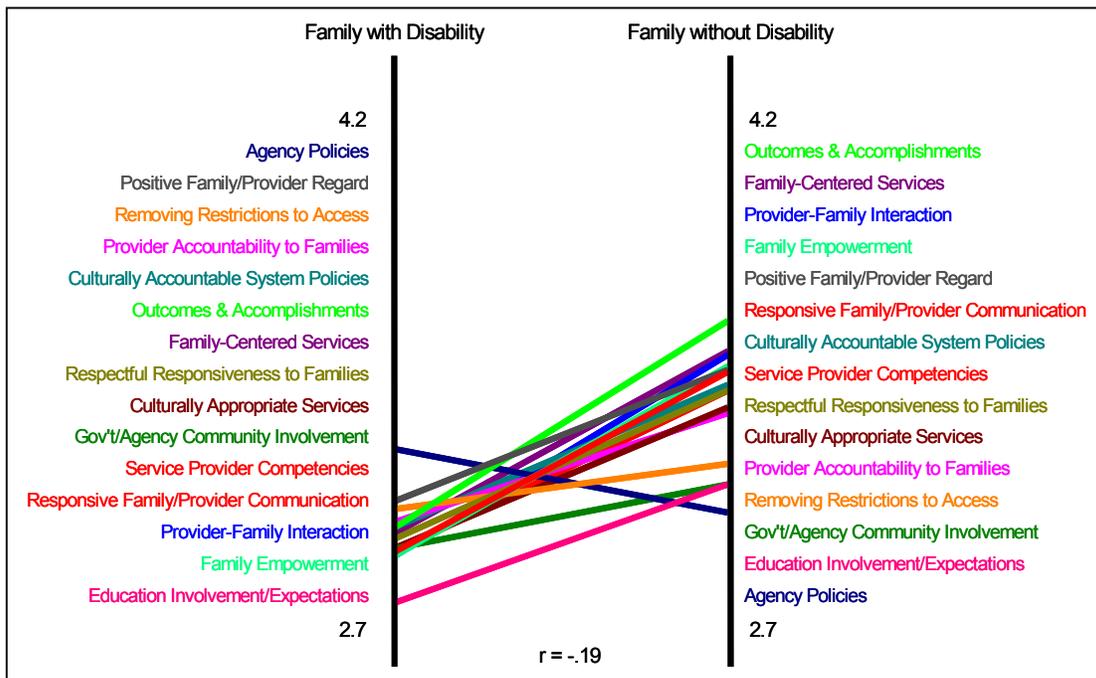


Figure 20. Aggregate Frequency of Demonstration Family Member Disability Pattern Match Comparison (Family with Disability, n = 11 vs. Family without Disability, n=16)



The final set of importance and frequency of demonstration comparison graphs presented is between the Rural and Urban participant groups. As previously indicated, the Urban group assigned higher ratings of importance than the Rural group to all clusters. The comparison in Figure 21 indicates a strong correlation ( $r = .78$ ) between the groups' patterns of average importance ratings. In contrast, Figure 22 illustrates that the Rural group ratings indicate much higher levels of demonstration than the Urban group. Although there is still a moderately strong correlation ( $r = .73$ ) between the patterns of average ratings, the diagonal lines illustrate the distinct difference in rating values.

Figure 21. Aggregate Importance Rural (n=31) and Urban (n=14) Pattern Match Comparison

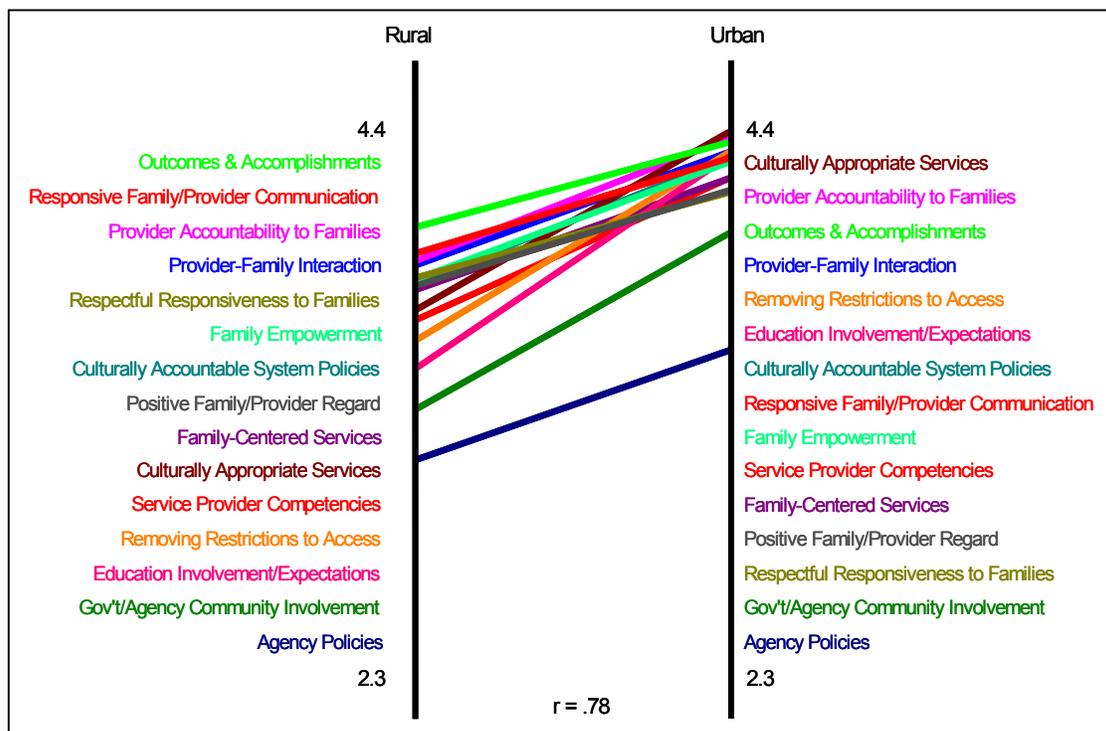
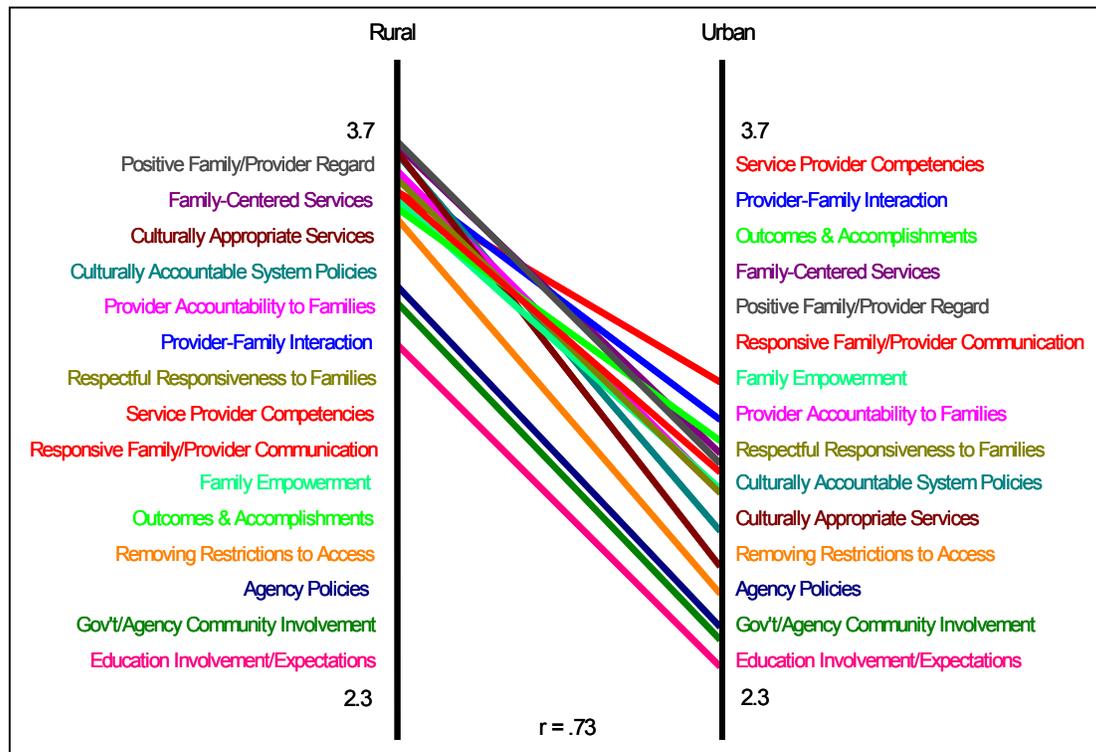


Figure 22. Aggregate Frequency of Demonstration Rural (n=31) and Urban (n=14) Pattern Match Comparison



A number of additional pattern match comparisons were made between importance and frequency of demonstration within groups. For example, comparisons were also made between levels of income. A table reflecting correlation coefficients generated from pattern matches are included in Appendix J. In viewing those comparisons, note that the sample compositions are very close to those of the Family and Non-Family comparisons. Although not necessarily indicated by the correlation coefficients, there were many differences in individual cluster ratings of importance and demonstration among the groupings, most notably when examining differences between the lowest and highest income groupings.

Policy: The final aggregate ratings were related to level of inclusion in agency policies. Similar to the individual community assessments, 9% of all participant responses indicated no knowledge of related policies addressing the statements. Overall, statements related to *Positive Family/Provider Regard* were rated as most often reflected in agency policies. However, for the Rural and White/European groups, statements in the *Culturally Appropriate Services* cluster were rated as more often included in policy. The *Provider Accountability to Families* cluster was rated one of the highest overall on the policy scale. Table 28 reflects policy ratings by group.

Because of the low number of participants completing the policy scale (n=18) and since Family participants did not complete this scale, only two sets of comparisons are presented. The People of Color group rated all clusters the same or higher than the White/European group. This finding was consistent across all three individual community assessments that included People of Color and White/European comparison groups. The Rural grouping rated all but two clusters higher on the policy scale. The *Family Empowerment* and *Positive Family/Provider Regard* clusters were the only two rated higher by the Urban systems of care.

Table 28. Aggregate Policy Ratings by Participant Group

Cluster Name	Service Provider Competencies	Family-Centered Services	Provider-Family Interaction	Culturally Accountable System Policies	Provider Accountability to Families	Culturally Appropriate Services	Gov't/ Agency Community Involvement	Agency Policies	Removing Restrictions to Access	Education Involvement/ Expectations	Family Empowerment	Respectful Responsiveness to Families	Outcomes & Accomplishments	Positive Family/ Provider Regard	Responsive Family/ Provider Communication
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
Overall (N=45)	2.24	2.21	2.22	2.26	2.28	2.31	1.93	1.97	2.05	1.91	2.21	2.19	2.14	2.33	2.25
People of Color (n=16)	2.41	2.36	2.41	2.43	2.47	2.45	2.02	2.03	2.05	1.97	2.40	2.42	2.35	2.56	2.45
White/European (n=28)	2.10	2.08	2.07	2.13	2.11	2.20	1.87	1.92	2.05	1.85	2.04	1.98	1.95	2.13	2.06
Rural (n=31)	2.25	2.27	2.23	2.38	2.30	2.39	2.08	2.20	2.19	2.03	2.20	2.21	2.23	2.27	2.28
Urban (n=14)	2.23	2.09	2.20	2.02	2.23	2.17	1.64	1.57	1.76	1.71	2.25	2.15	1.97	2.46	2.19

## **Theoretical and Conceptualization Comparison Findings**

### *Comparison of Concept Mapping Findings and*

### *Theoretical Models of Cultural Competence*

The last set of findings center on the comparison of individual community and aggregate conceptual maps with the four models of culturally competent/diverse practice outlined in chapter 2: Ethnic-Sensitive Social Work Practice Devore & Schlesinger, (1996), Cultural Awareness Help Seeking Behavior (Green, 1999), Process-Stage Approach (Lum, 2000), and Cultural Competence (Cross et al., 1989). A matrix structured with the elements of the relational competence theory (Spitzberg & Cupach, 1984, 1987; Spitzberg, 1989) in the expanded group relational competence framework described in chapter 2 was used in combination with the practice models to make the comparisons. A content analysis (Hinds, et al., 1997; Franklin, 1996; Thorne, 1994) was conducted to identify key elements of each model embedded in the concept maps.

As illustrated in Table 29, there was much overlap between the practice models and the community conceptualizations. As a point of clarification, no matrix cells related to assumptions for the community conceptualizations are included in the table. The comparative analysis indicated, however, that the relational competence assumptions are well embedded in the community's statements of cultural competence. Indeed, the emphases of all models and community maps appear to be a good fit within the group relational competence framework. The findings presented highlight the differences among all of the models and maps. The reader will clearly detect the similarities throughout the table.

Table 29. Model of Practice and Community Conceptualization Fit with Group Relational Competence Theory

Relational Competence Theory Assumptions <sup>a</sup>								
<i>Model of Practice/Community Conceptualization</i>	<i>Competence is an interpersonal judgment (Impression)</i>	<i>Competence inferences evolve from an interdependent process</i>	<i>Competence inferences are continuous judgments</i>	<i>Personal attributes increase perceptions of competence</i>	<i>Measures of competence reference behavioral &amp; evaluative impressions</i>	<i>Measures of competence relate to functional outcomes</i>	<i>Measures of competence are event-specific</i>	<i>Measures of competence permit self and other assessment</i>
<i>Ethnic-Sensitive Practice</i>	Nonconscious phenomena ...Ethnicity as strength and strife...	Individual and collective histories		All four models inherently assume a contributory role of personal attributes in practitioner competence			Present is most important (not specific to measurement)	
<i>Cultural Awareness</i>	Perceptions of client experience of illness	Language—contextual understanding ...Problems are both personal and social events...				Perceived resolution of illness (not specific to measurement)	Language in context (not specific to measurement)	
<i>Process-Stage Approach</i>	...Common/universal experiences of people of color... Improve quality of psychosocial functioning						Practice considers emic and etic cultural patterns	
<i>Cultural Competence</i>	Accept differences and work within cultural context	Recognition, respect, validation between cultures	Process is as important as outcome			Prioritizes cultural systems in service process	Service goals include preservation of entire culture	Accept differences and work within cultural context

Note. Concepts in matrix adapted from Relational Competence Theory (Spitzberg & Cupach, 1984, 1987; Spitzberg, 1989), and culturally diverse/competent practice Cross et al. (1989), Devore & Schlesinger (1996), Green (1999), and Lum (2000).

<sup>a</sup>Assumption comparisons are primarily based on specifically postulated assumptions of models' authors. Lum (2000) cites no specific assumptions rather the model is based on the identified premises.

Table 29. (continued)

<i>Relational Competence Theory</i>					
<i>Model of Practice/ Community Conceptualization</i>	<i>Interpersonal → System Motivation<sup>b</sup>, Knowledge<sup>c</sup>, Skills<sup>d</sup></i>	<i>Group's Combined Contextual Expectations<sup>e</sup></i>	<i>+/- Relational Perceptions of Interaction Quality,<sup>f</sup> Policies/System Barriers/ Targets for Change</i>	<i>Outcomes/Objectives Obtained</i>	<i>Degree of Relational Competence</i>
<i>Ethnic-Sensitive Practice</i>	<b>M:</b> self awareness; social work values <b>K:</b> human behavior; history of ethnic group; person-in-environment; knowledge of cultural community; client sense of identity; client quality of life <b>S:</b> strengths-based practice; adapting practice to ethnic reality; using agency resources	<b>V/Soc:</b> impact of client issues on relationship <b>P/Surg:</b> restoring responsibility to client; ethical responsibility; knowledge skills in agency policies and services <b>P:</b> voluntary/coercive client referral <b>Surg:</b> knowledge of community resources and power entities	Ethnic reality, including social class; challenges due to racism/discrimination; target power structures for change	Issues of measurement and outcomes of appropriateness/effectiveness are not specifically discussed  Develop strategies for systems change—model examples (planning, administrative, evaluation, community organizing)	
<i>Cultural Awareness</i>	<b>M:</b> professional preparedness (self-exploration of meaning of racial/cultural differences); awareness of self-limitations; interest/openness to cultural differences and relational expectations <b>K:</b> comparative analysis of differences b/t self & client; ethnographic/contextual knowledge; cultural community's resources <b>S:</b> systematic learner approach; getting at deeper level of engagement with diversity; language/communication competence	<b>P:</b> sources of conflict, including race & gender <b>VP:</b> bridge differences among professionals, organizations & cultures of persons seeking help <b>Surg/P/Soc:</b> achieve greater depth of involvement with diversity	Sources of conflict include: legal mandates, policies, funding limitations, internal hierarchies, inadequate training, agency needs for accountability	Appropriateness of communication; ongoing evaluation; qualitative process evaluations; empowerment evaluation models to examine relationship b/t barriers, organizational context and culturally responsive care	Organizational competence → culturally responsive care

Table 29. (continued)

<i>Relational Competence Theory</i>					
<i>Model of Practice/ Community Conceptualization</i>	<i>Interpersonal → System Motivation<sup>b</sup>, Knowledge<sup>c</sup>, Skills<sup>d</sup></i>	<i>Group's Combined Contextual Expectations<sup>e</sup></i>	<i>+/- Relational Perceptions of Interaction Quality;<sup>f</sup> Policies/System Barriers/ Targets for Change</i>	<i>Outcomes/Objectives Obtained</i>	<i>Degree of Relational Competence</i>
<i>Process-Stage Approach</i>	<b>M:</b> sensitivity to ethnic & cultural environment; self-awareness; social work values; inductive learning <b>K:</b> building cultural knowledge (values, theories, strengths, ethnic community); language; history; cognitive-affective behavioral characteristics; societal dilemmas of people of color <b>S:</b> strengths-based approach; establishing relationship; problem examination at multiple levels; psychosocial assessment; setting goals/strategies; task-centered, behavioral strategies	<b>P:</b> experiences of discrimination & oppression <b>Surg:</b> setting goals <b>P/Surg:</b> working as a team <b>V:</b> issues of language <b>V/Soc:</b> relationship with client; common experiences across cultures/unique experiences (etic/emic perspective)	Language; design programs based on needs of communities	Improve quality of psychosocial functioning	
<i>Cultural Competence</i>	<b>M:</b> attitudes; CASSP/Systems of care values; commitment to cultural competence; valuing diversity; cultural self-assessment/self-awareness <b>K:</b> institutionalization of cultural knowledge <b>M/K:</b> dynamics of difference <b>S:</b> connecting with minority community/engaging them with organization; cross-cultural communication; strengths approach/empowering families	<b>P:</b> empowerment models of decision-making <b>V/Surg/Soc:</b> adaptation to diversity  <b>P/V/Surg/Soc:</b> dynamics of difference: cross-cultural system interactions and relationships	System policies; professional training; accessible resources; traditional intervention practices; lack of research; need to include families in system processes	Process outcomes (appropriateness); outcomes (effectiveness); cultural self-assessment	Continuum of cultural competence (6 stages): cultural destructiveness to cultural proficiency

Table 29. (continued)

<i>Relational Competence Theory</i>					
<i>Model of Practice/ Community Conceptualization</i>	<i>Interpersonal → System Motivation<sup>b</sup>, Knowledge<sup>c</sup>, Skills<sup>d</sup></i>	<i>Group's Combined Contextual Expectations<sup>e</sup></i>	<i>+/- Relational Perceptions of Interaction Quality;<sup>f</sup> Policies/System Barriers/ Targets for Change</i>	<i>Outcomes/Objectives Obtained</i>	<i>Degree of Relational Competence</i>
<i>URB-N</i>	Clusters: 1, 2, 5, 6, 7 <b>M:</b> respect and dignity of client/ family; family differences are valued; policymakers sensitive to family/community needs <b>K:</b> policymaker knowledge of family/community needs; knowledge of community culture & histories of agencies/ethnic group relationships <b>S:</b> strength-based; family-driven/ empowerment service approach; nonjudgmental	Clusters: 1-6, 8 <b>V:</b> agency reflects community <b>V/P:</b> mutual respect b/t families & systems <b>Surg:</b> quality assurance—outcomes <b>P:</b> family-driven service delivery; service accessibility <b>P/Surg/Soc:</b> flexible service delivery processes <b>P/Surg:</b> collaborative service system process (agencies as teams in addition to families and workers as teams)	Clusters 1, 3-8 Positive family perceptions of treatment; accessibility of services; accountability; agency practices reflect community's culture; provider training; agency staff policies are supportive of staff; policy challenges related to public policy/ policymakers & funding	Clusters 1, 3, 6 Families feel respected; families comfortable accessing care; outcomes/quality assurance	Captured through level of importance, demonstration and policy ratings
<i>RUR-W</i>	Clusters: 1, 2, 4-7 <b>M:</b> respect for children & families; provider commitment to families <b>K:</b> mutual understanding b/t provider & family; interagency cultural understanding; provider knowledge of cultural differences; <b>K/S:</b> providers are resourceful <b>S:</b> partnering with families; language; providers use multidisciplinary approach; providers acknowledge & respond to family uniquenesses; providers build relationships with families	Clusters: 1-7 <b>V:</b> providers reflect cultural community <b>V/P:</b> families are respected <b>P:</b> families are equal participants in service processes; services/ providers are accessible; grievance processes in place <b>Surg:</b> progress toward goals <b>Soc:</b> providers don't impose beliefs on families; relationships are built with families; providers work with entire family <b>P/Surg:</b> multidisciplinary approach to service delivery	Clusters: 1, 2, 4 Family perception of interaction; perceptions of equality; grievance procedures in place for families; providers reflect cultural community; services and providers are accessible	Clusters: 1, 2, 3, 6 Family satisfaction; families feel respected; families feel cared about; families feel comfortable requesting services; good service practices/quality; positive measurable progress	Captured through level of importance, demonstration and policy ratings

Table 29. (continued)

<i>Relational Competence Theory</i>					
<i>Model of Practice/ Community Conceptualization</i>	<i>Interpersonal → System Motivation<sup>b</sup>, Knowledge<sup>c</sup>, Skills<sup>d</sup></i>	<i>Group's Combined Contextual Expectations<sup>e</sup></i>	<i>+/- Relational Perceptions of Interaction Quality;<sup>f</sup> Policies/System Barriers/ Targets for Change</i>	<i>Outcomes/Objectives Obtained</i>	<i>Degree of Relational Competence</i>
<i>URB-E</i>	<p>Clusters: 1-6, 8  <b>M:</b> families are respected; individuals are nonjudgmental/empathic; willingness to share cultural knowledge; families comfortable approaching providers  <b>K:</b> knowledge developed between provider and family  <b>K/S:</b> knowledge/ability to provide culturally appropriate care  <b>S:</b> individualized, strengths approach; family-driven/family-empowerment approach; develop relationships of trust &amp; respect; consistent communication between provider and family</p>	<p>Clusters: 1-8  <b>P:</b> equality of services; families are partners in services  <b>V/Surg:</b> communication/language of families/providers; families feel valued and respected  <b>V/Soc:</b> trusting relationships built between families &amp; providers  <b>V/P/Soc:</b> families are empowered by their cultures  <b>Soc:</b> work within culture of families; flexible program services  <b>P/Surg:</b> multidisciplinary approach to service delivery; collaborative processes among service providers</p>	<p>Clusters: 2, 4-8            Family perceptions of interaction (feel understood, valued, respected); non-discriminatory service provision policies; accessible and community-based services</p>	<p>Clusters: 1, 2, 4, 6, 8            Families needs are met; families are satisfied with services and outcomes; families feel comfortable approaching provider; families are empowered by their cultures; services lead to progress</p>	Captured through level of importance, demonstration and policy ratings
<i>RUR-E</i>	<p>Clusters: 1, 3-7  <b>M:</b> (for families) trust and respect b/t provider and family; providers value family culture  <b>K:</b> families can locate resources  <b>S:</b> (for provider) develop mutual trust and respect with family; strengths approach; family empowerment service approach  <b>K/S:</b> communication/language; family culture used as foundation for practice</p>	<p>Clusters: 1-9  <b>P:</b> family empowerment approach; families in charge of own services; alternative service options available  <b>P/V:</b> services are accessible to families  <b>V/Soc:</b> agency practices respond to community culture  <b>Soc:</b> work within family context  <b>Surg:</b> family investment in services; goals/needs are met  <b>P/Surg:</b> collaboration across agencies</p>	<p>Clusters: 2, 4, 6-9            Family perceptions of interaction (listened to/ heard, trust developed, feel comfortable seeking services); service accessibility; service options; provider accountability; agency reflects culture (staff, language); services provided for entire family; funding and policy structures as barriers</p>	<p>Clusters: 2, 4, 5            Family satisfaction; families feel listened to/heard and feel comfortable seeking services; family needs are met; families are consistent in service follow through</p>	Captured through level of importance, demonstration and policy ratings

Table 29. (continued)

<i>Relational Competence Theory</i>					
<i>Model of Practice/ Community Conceptualization</i>	<i>Interpersonal → System Motivation<sup>b</sup>, Knowledge<sup>c</sup>, Skills<sup>d</sup></i>	<i>Group's Combined Contextual Expectations<sup>e</sup></i>	<i>+/- Relational Perceptions of Interaction Quality;<sup>f</sup> Policies/System Barriers/ Targets for Change</i>	<i>Outcomes/Objectives Obtained</i>	<i>Degree of Relational Competence</i>
<i>Aggregate</i>	<p>Clusters: 1-7, 9, 11-15</p> <p><b>M:</b> families/providers willing to ask questions/share about culture; providers are nonjudgmental/affirming of family culture; community ownership of service system</p> <p><b>M/S:</b> providers stay committed to finding resources for families</p> <p><b>K:</b> providers/families understand one another; providers are educated about cultural differences of families, communities, and agencies; knowledge of family resources; cultural competence training provided at all system of care levels</p> <p><b>K/S:</b> provider competencies (relationship building, serving entire family; don't impose self on families or make assumptions, empathy/sympathy, child-centered, allow families to be cultural experts); communication/ language used with families</p> <p><b>S:</b> family-driven service provision/clear roles/family empowerment; family-centered &amp; individualized services; strength-based team approach; relationships developed; families kept informed of child's progress; family's choices respected</p>	<p>Clusters: 1-9, 11-15</p> <p><b>P:</b> families are partners in service processes; service provision is family-driven/empowering of families &amp; their cultures</p> <p><b>V:</b> providers develop trusting relationships with families; services are accessible to families</p> <p><b>V/Soc:</b> communication/ language is responsive to family needs; providers are inclusive, affirming, &amp; nonjudgmental of family's culture; services are flexible &amp; include cultural informal services</p> <p><b>Soc:</b> providers &amp; families learn/work within one another's cultural context; services are family-centered/individualized</p> <p><b>Surg:</b> providers are committed to families; evaluation of services will show progress</p>	<p>Clusters: 2-12, 14, 15</p> <p>Scheduling needs of families are met; parents kept informed of child's progress; inclusive/non-discriminatory services; policies guide non-abusive provider behavior; flexible, non-traditional services options; culturally-appropriate services are ensured; systems/providers reflect community diversity; accessible services (cost; community-based; red tape; language; respecting family time, family grievance process); policies are responsive to family/ community needs (funding, flexible); practitioners involved in systems change; cultural competence training provided; staff policies; involvement of educational systems; family perceptions of services (feel respected, comfortable, listened to, providers care)</p>	<p>Clusters: 4, 5, 10-13, 15</p> <p>Services lead to progress and meeting goals; providers follow through; providers have a credible reputation; educational needs of children are met; families are satisfied with provider treatment; families are empowered; methods to measure achievement</p>	<p>Captured through level of importance, demonstration and policy ratings</p>
		<p><b>P/Surg:</b> agencies collaborate to serve families consistently and over time</p>			

Table 29. (continued)

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*Notes.* Dimensions and Operational Examples: <sup>b</sup>Motivation--Affective/Cognitive Dimensions (social anxiety/apprehension, willingness to communicate, internal locus of control, affinity-seeking competence, social self-esteem, assertiveness/shyness, altercentric interpersonal orientation, loneliness). <sup>c</sup>Knowledge (cognitive and conversational complexity, ontological knowledge, social perceptivity, role taking, problem-solving, social intelligence, knowledge acquisition strategies, intimacy, self-monitoring). <sup>d</sup>Skills Dimensions: Expressiveness (activity, involvement, language), Altercentrism (listening, empathy, immediacy, role-taking, attentiveness), Interaction Management (awkwardness, meshing, synchrony), Social Composure (relaxation, assertiveness, confidence, humor, anxiety). <sup>e</sup>Contextual Expectation Dimensions: Valence (affiliation/sociability; +/- evaluative judgment of environment— inclusion, friendly/hostile, quarrelsome/agreeable; trust/mistrust), Potency (power relations—equality, cooperation; dominance/submissiveness; control), Surgency (activity/intensity; task/goal orientation; autonomy/dependence in interaction; forward/backward movement of interaction), Socialization (social composure; informality/formality, conscientiousness; awareness and interpretation of cultural context and expected rules of conduct). <sup>f</sup>Appropriateness (interaction management, behaviors, overall impression, such as satisfaction, trust, intimacy); Effectiveness (successful interaction, control in interaction [conflict strategies/mutuality of control], goals achievement)

### *Comparison of Assumptions*

The assumptions of each of the four models of practice were placed within cells comprising the eight assumptions of the relational competence theory. A number of cells were left empty after this application. As illustrated, the Cultural Awareness and Cultural Competence models cover more relational competence assumptions than the other two models. In fact, the Ethnic-Sensitive Practice and Process-Stage Approach models are overall very similar to one another in both application to relational competence theory and assumptions. While the models generally do not include emphases that fit neatly into the measurement assumptions, concepts potentially related to the measurement assumptions were identified. The Cultural Competence model is the only one of the four whereby emphases could be placed within all cells of the relational competence model, and is the only model that specifically addresses issues of competence measurement.

There were several concepts within the practice models' assumptions that could not specifically be drawn out of the communities' concept maps. The Ethnic-Sensitive Practice and Process-Stage Approach models both include an emphasis on nonconscious and psychosocial influences on clients. While mental health outcomes would inherently include some type of therapeutic intervention, the only kinds of references to these elements were indirect, such as progress being made or goals being met. Likewise, these same two models focus substantially on the negative experiences of ethnic persons of color and the respective impact on their functioning. Although systems of care communities identified issues of prejudice and discrimination, the references generally

related to accessibility to services and equality in service provision. Participants did not discuss issues of racism at an interpersonal level.

The Process-Stage Approach and Cultural Competence models both include assumptions specifically related to group cultures. Lum's (2000) universal and emic/etic perspective focuses on the patterns and themes across cultures, and working within a somewhat given understanding that all people have had similar experiences. Common patterns related to these experiences can be identified within and across cultures. The communities focused more on understanding and working within individualized family cultures, although knowledge and skills in working with the family's cultural community were identified as important to the service planning process. Cross et al. (1989) specifically include an assumption that dignity of the entire culture of which the family is a member must be preserved through service goals set that also preserve the dignity of the family. While dignity and respect for families were identified as elements in all four communities, there was no specific indication that systems of care recognized the impact their work has on an entire cultural community.

#### *Comparison of Model Elements and Community Conceptualizations*

As evidenced in Table 29, numerous common elements and emphases exist among the models and systems of care conceptualizations. Not one practice model alone covered all of the ideas generated within an individual community. However, nearly all of the ideas generated were covered by at least one of the practice models. There were three themes identified in the community conceptualizations that were not embedded within at least one of the practice models. The two rural communities identified two of

these themes. One issue, identified by both communities, was the need for service systems to make services available to the entire family, not just the child with serious emotional disturbance. This idea was viewed separately from the commonly cited theme of partnering with families in service provision. The second unique issue, identified by one community, was a need to address families' investment and consistent follow-through with services. The third theme, identified by all four communities, was related to families' comfort level in seeking services and approaching service providers. While the practice models may indirectly cover this concept through emphases such as client empowerment or accessibility to services, the related statements generated by all communities specifically used the words "feel comfortable," suggesting a level of focus not differentiated by the practice models.

In contrast, a number of emphases identified in the models were not specifically identified in the community conceptualizations. The most apparent of these missing themes was the focus on provider self-awareness. All four practice models include self-awareness as a key component of their models. None of the communities identified self-awareness, as it is referenced in the models, as a need for cultural competence. There were many references to awareness of the families' cultures, but none to practitioner self-awareness. An argument could be made that they recognized a need for agency self-assessment by virtue of their engagement in this study, but ongoing assessment of cultural competence was not a generated idea.

Following is an account of model emphases not specifically identified in the community conceptualizations:

- **Ethnic-Sensitive Practice:** Self-awareness; knowledge of human behavior; knowledge of the client's sense of identity; using agency resources; knowledge of the impact of client issues on the worker-client relationship; and in-depth knowledge of the client's ethnic reality and social class. While issues of accessibility due to cost and family finances were included, the ideas remained at the practical implications level;
- **Cultural Awareness:** Professional preparedness (self-exploration of meaning of racial/cultural differences); awareness of self-limitations; comparative analysis of differences between self and client; workers achieving a greater depth of involvement with diversity; qualitative process evaluations; and use of empowerment evaluation models to examine relationship between barriers, organizational context, and culturally responsive care;
- **Process-Stage Approach:** Self-awareness; knowledge of cognitive-affective behavioral characteristics; societal dilemmas of people of color/experiences of discrimination and oppression; problem examination at multiple levels; psychosocial assessment; and common and unique experiences of persons across cultures; and
- **Cultural Competence:** Self-awareness/self-assessment; attitudes; commitment to cultural competence; research to improve practice; including families in system processes; continuum of cultural competence.

There were also some prevailing ideas identified across communities that are included in the practice models. The following list identifies the most consistent themes identified among the practice models and the number of communities identifying the themes:

- Mutual respect and trust: four communities; only two communities specifically extended these ideas into building relationships;
- Interest/openness to cultural differences: four communities;
- Knowledge development: four communities;
- Accessibility of services: four communities
- Team/Empowerment service approach: four communities;
- Use of nontraditional/informal services: four communities;
- System policies/accountability: four communities, varying degrees;
- Process/Outcomes Measurement: four communities, varying degrees;
- Collaboration across agencies/multidisciplinary approach, included only in the Cultural Competence model as cross-cultural system interactions and relationships: four communities;
- Programs/agencies reflective of cultural communities: three communities;
- Cross-cultural communication/language: three communities;
- Knowledge of cultural community (mostly related to family culture): three communities;
- Strengths-based practice: three communities; and
- Systems of care values: throughout community conceptualizations.

Overall, a number of elements of each practice model compared were identified across the systems of care community conceptualizations of cultural competence. The extent to which each model's elements were included varied by community. In contrast, a number of each model's elements were not included in the community conceptualizations. A more detailed discussion of these findings is presented in Chapter 5, beginning on page 230. A model comparison was not made with the aggregate map, as the aggregate map was developed from the combined ideas included in the individual community maps. Finally, the group relational competence framework seemed to provide a useful structure within which the comparisons could be made.

## CHAPTER 5

### DISCUSSION AND IMPLICATIONS

Cultural competence is a key philosophical value of social work practice (NASW, 2001) and children's mental health systems of care (Stroul & Friedman, 1986). Yet, assessing cultural competence is a difficult task when the concept under study remains elusive to the researcher. The lack of clarity around the conceptual meaning of cultural competence raises questions about the constructs underlying the practice models advanced and the measurement instruments developed based on these models. Furthermore, the dearth of empirical support for culturally related concepts and practice models raises troubling questions about the foundations upon which social work students are being educated about culturally responsive practice.

This study explored the viability of an innovative approach to examine the construct of cultural competence in children's mental health systems of care and to compare data gathered with current practice models of cultural competence. Although exploratory, the study was grounded in theory and endeavored to generate dialogue about the validity of current conceptualizations and assumptions of the cultural competence construct as applied in children's mental health systems of care and social work practice.

Concept Mapping, as used in this study, generated conceptualizations of cultural competence from the perspectives of adults participating in four different systems of care service communities. The individual systems of care results were then aggregated, reduced to a combined set of data, and used in a second Concept Mapping application to examine conceptualizations of cultural competence across systems of care communities.

The individual and aggregated community conceptualizations were further examined within a relational competence theoretical framework (Spitzberg & Cupach, 1984, 1987; Spitzberg, 1989) for their congruence with assumptions and concepts underlying current practice models and measures of cultural competence.

*Concept Mapping to Conceptualize and Assess Cultural Competence*

Cultural competence was assessed in four children's mental health systems of care communities in one state. Two communities were located in rural areas, and two communities were located in urban areas. The study design was guided by systems of care values that place children, families, and communities at the center of all work. A total of 188 participants across multiple systems of care levels were involved in the study, including family caregivers, family advocates, service providers, administrators, and other systems of care community stakeholders.

Concept Mapping (Trochim, 1989) offered a mixed-method approach that was used to assess cultural competence from multiple perspectives within the four individual systems of care contexts. Mixed-method approaches are suggested for increased understanding of the cultural context of a community (Hernandez et al., 1998). The method was a consumer-friendly applied method that did not require an inordinate time commitment from participants, and the method's implementation process provided immediate feedback to communities. The method brought groups of people together to dialogue about cultural competence, providing a structured way of gathering information while maintaining the group context. Community systems of care participants were included from the beginning planning stages through interpretation of the data. As Cross

et al. (1989) suggest, “new methods of research that involve the community—from planning to dissemination—need to be developed and implemented” (p. 11). Concept Mapping offered a participatory approach to produce meaningful information for purposes of system evaluation and research.

#### *Concept Mapping Research Hypotheses*

Four hypotheses were developed for this study. The two hypotheses specifically related to the Concept Mapping methodology are discussed first. Discussion of the two hypotheses specifically related to the comparison of practice models and community conceptualizations begins on page 230. The first methodological hypothesis (Hypothesis 4) stated:

Findings from the proposed mixed-method, participatory research methodology will indicate the viability of Concept Mapping as a reliable and valid approach to community-based conceptualization and assessment of cultural competence.

Based on the study findings, this researcher concludes that Concept Mapping (Concept Systems, 2001; Trochim, 1989) demonstrated considerable potential for conceptualizing and assessing culturally responsive care within specifically identified cultural contexts. Qualitative and quantitative data were used to produce clear graphical depictions of participant conceptualizations. Moreover, Concept Mapping’s sound statistical component provided a data structure that increased understanding of participants’ perceptions about the interrelatedness of the generated conceptual components of culturally competent interaction. As Green (1999) so aptly states in his discussion of language and meaning,

For the social work investigator, the first response to a word cue is not what we want. Rather, we seek a full, well-elaborated response. We want to know what words the speaker uses to explicate a prototypical cluster and how other clusters are linked to it. The clustering of linked word ideas is an indicator of how the individual is conceptualizing an issue. (p. 127)

While the brainstorming data collection effort gathered words and phrases to describe participant conceptualizations, the sorting and related statistical processes illustrated aggregated perceptions of how these concepts were linked and clustered in a meaningful way by specific groups of participants.

The second methodological hypothesis for the study (Hypothesis 1) stated that: Comparisons between groups of participants will indicate relational differences on cultural competence ratings of importance, frequency of demonstration, and agency policy.

Beyond allowing communities to conceptualize their unique visions of cultural competence, Concept Mapping provided a means for participants to place varying degrees of value on the conceptualized elements generated. Rating scales were used in combination with the generated statements to answer three separate questions. The first question asked participants to indicate how important each idea was for meeting the unique needs of families. The second question asked participants to indicate how often the idea was demonstrated in their system of care. This question specifically related to determining the method's ability to assess concepts of competence at varying degrees of implementation. The final rating question asked Non-Family/Professional participants to

rate to what degree each statement was included in his or her agency's policies. This question generated much discussion among the Professional members as they considered how some of the statements might be applicable to policies. Given the importance of policy in supporting implementation of systems of care values and principles (Stroul & Friedman, 1986), the policy question was of particular import to the State legislated committee responsible for oversight of systems of care implementation as well as to the local system policymakers.

Finally, the pattern match comparisons demonstrated the method's ability to distinguish relational differences of concepts' values within and across groups of participants. As noted earlier in Chapter 2, relational differences in this study were concerned with perceived conceptual relationships among the ratings assigned by participants. While the pattern matches produced a statistical correlation to assess patterns of participant average ratings, the analyses did not include tests of statistical significance. Thus, examination of Hypothesis 1 was based on a qualitative comparison of differences between group ratings and the correlation produced to describe the level of consistency between groups' patterns of average ratings. These pattern match comparisons greatly raised participant consciousness and enhanced understanding about how different cultural groups perceived the relevance of the cultural competence concepts generated. Additionally, critical information was provided to systems of care as they prepared to engage in collaborative work with one another and with families. Differences and similarities were noted within each system of care community and across communities when data were examined in the aggregate phase of the study.

### *Concept Mapping Findings*

*Statement generation.* Concrete and more abstract examples of cultural competence were generated by each system of care. These findings met the relational competence methodological assumption whereby measures of competence should reference behavioral (molecular) and evaluative (molar) impressions (Spitzberg & Cupach, 1987). The URB-N community brainstormed 80 statements; RUR-W brainstormed 76 statements; URB-E brainstormed 82 statements; and RUR-E brainstormed 65 statements. During data reduction for the aggregate phase, a total of 117 individual statements common and unique to communities were identified from the 303 statements originally generated across communities: four statements were common across all communities, 20 were common to three communities, 44 were common to two communities, and 49 statements were unique to individual communities (see Appendix H). The common ideas generated across communities further support the aforementioned relational competence methodological assumption of behavior impressions as well as one of its conceptual assumptions that certain attributes or behaviors are generally viewed as competent across contexts (Spitzberg and Cupach, 1987). These commonalities were also found in the comparisons of the communities' concept map clusters as described below.

*Concept map construction.* Concept maps were produced for each community. Each community chose the cluster map solution that they believed best represented their ideas of cultural competence. One community selected a seven-cluster solution, two communities selected eight-cluster solutions, and one community selected a nine-cluster solution. Based on aggregate participant sorts, fifteen clusters were chosen by the

researcher to construct the aggregate map. Clusters generated in all communities reflected many systems of care and wraparound values and principles.

Four cluster groupings in each community were identified as having similar concepts across all four systems of care. These clusters included examples of relational interaction with regard to respect, trust, communication, and valuing family input in the care process; family empowerment and partnering with families in developing services; issues of service and agency quality (such as, staff and agencies reflecting the diversity of the community, service accessibility, and culturally relevant approaches to service provision); and agency and systems related issues (such as policies, coordinated and collaborative service systems, and provider training). Three communities identified issues related to service providers' genuine interest in, commitment to, and regard for families (individualizing services to the needs and strengths of entire family units and their cultures), and cultural responsiveness of agencies and systems to the persons and communities they serve (keeping services and processes grounded in the needs of communities, understanding organizational cultures and cultures of the community, and responding to differences in cultural language).

While all four communities included statements related to achieving goals or meeting families' needs, two communities developed clusters related specifically to outcomes and accountability. Two systems of care developed clusters that were unique to their specific communities. Clusters generated in the individual maps were embedded in the aggregate map. The researcher's selection of fifteen clusters offered greater detail for map interpretation and representation of the data. The concept maps illustrated different

structural conceptualizations of cultural competence across communities. Although many concepts were common across communities, the data reduction process also revealed many unique concepts specific to each system of care.

*Ratings and Pattern Match Comparisons.* Where the sorting process gives meaning to the statements, the rating data adds value to the statements. The Concept Mapping *pattern match comparisons* used to compare the results from one participant group to another produced graphs showing an overall picture of the differences and similarities in participant ratings. Pattern matches were developed for two specific group comparisons in each individual systems of care assessment: (1) Family and Non-Family participants, and (2) People of Color and White/European participants. Although the researcher had hoped to compare rating differences between and within ethnic groups of color, the sample size limited such comparisons. Thus, all persons of color were placed into one group to gain some sense of rating differences between persons of color and White/European participants. Lum's (2000) assumptions of universality support this type of comparison. Pattern matches were also produced comparing participant ratings of importance and frequency of demonstration, establishing a baseline for ongoing assessment in each community.

Many differences and similarities were detected between groups of participants on the three rating criteria. In general, Family and Non-Family participants were fairly consistent in how they rated importance of the items. This was not the case with the People of Color and White/European comparisons. In two of the three communities where the comparison was available and in the aggregate study, importance ratings by the

People of Color group were higher than those assigned by the White/European group.

This finding held true for the comparison in one community between Mexican American and White/European groups.

Larger differences were noted with regard to participant perceptions of frequency of demonstration ratings, where much more distinct correlations were noted. In two communities the Family/Non-Family demonstration comparison resulted in very little consistency between groups, where contrasting higher and lower cluster ratings were noted. In one community the Non-Family group consistently rated demonstration lower than the Family group, and in the fourth community the Family group consistently rated demonstration higher than the Non-Family group. The aggregate study generally found higher ratings of demonstration assigned by Non-Family members. An interesting finding was the demonstration comparison between People of Color and White/European groups, whereby the People of Color groups consistently assigned higher ratings of demonstration than the White/European groups across communities and in the aggregate study. The higher ratings were magnified in the one Mexican American and White/European comparison. These finding discrepancies in participants' ratings are supported in research conducted by Spitzberg and Cupach (1987) on the relational competence theory.

One [conceptual] assumption supported by relational competence research is the interdependence of competence attributions. The evidence clearly indicates a discrepancy between one's competence as judged by self versus one's competence as judged by others. This underscores the importance of assessing the

perceptions of both members of a dyad to obtain a more complete and systemic view of interpersonal competence (Spitzberg & Cupach, 1987, p. 24), a methodological assumption of the theory. Thus, research on the assumptions of relational competence theory support both the findings from this study and the Concept Mapping method implemented to obtain the results.

The policy rating results were not as remarkable. A scale with a narrower range was used for this rating, and fewer comparisons were made between groups. However, one notable distinction was found in the People of Color and White/European comparisons across communities and in the aggregate study. The consistently higher ratings by the People of Color groups on the policy scale suggested the groups' greater knowledge of statement inclusion in agency policies.

Additional comparisons made from the aggregate data found differences among the urban and rural communities as well. Noting their smaller number of participants, the urban communities rated all clusters as more important. In contrast, participants from the rural communities rated clusters more often demonstrated. Similar findings were found in the individual community reports. Urban Professional participants indicated less statement inclusion in agency policies than Rural Professional participants.

The findings suggest the viability of concept mapping as a method for contextually specific conceptualizations and assessment of cultural competence. The sorting process and multidimensional analysis first produced a relational map structure among the concepts generated and the rating scales enabled the researcher to compare differences among the study participants. In addition to the average ratings themselves, a

correlation coefficient was produced to indicate the pattern of average ratings between groups. With an increased sample size, a larger number of within and across group comparisons could be made, resulting in clearer detection of where system change efforts might be directed.

### *Conceptual Comparisons of Culturally Competent Systems Practice*

The third of three phases of this research study involved a process whereby current models of culturally responsive practice were compared to conceptualizations generated in individual systems of care communities. Four models of culturally competent/diverse practice reviewed in chapter 2 were compared to the four individual and the aggregate systems of care assessments. The four practice models included Ethnic-Sensitive Social Work Practice (Devore & Schlesinger, 1996), Cultural Awareness Help Seeking Behavior (Green, 1999), Process-Stage Approach (Lum, 2000), and Cultural Competence (Cross et al., 1989).

To provide a structured framework for conducting the comparative analysis, the researcher used an expanded group relational competence framework (described in chapter two) adapted from interpersonal relational competence theory (Spitzberg and Cupach, 1984, 1987; Spitzberg, 1989). A matrix comprised of the relational competence theoretical components was used in combination with the practice models to provide a consistent structure for making comparisons. A content analysis (Franklin, 1996; Hinds, et al., 1997; Thorne, 1994) was conducted to identify key elements of each practice model embedded in each concept map produced. Two final hypotheses (Hypotheses 2 and 3) guided this phase of the study:

- (1) Individual community assessments will produce common and unique conceptualizations of cultural competence that are not wholly accounted for in current definitions (assumptions and theoretical conceptualizations) of the construct; and
- (2) Individual community assessments will produce common and unique conceptualizations of cultural competence that are not fully supported by current measures of the construct.

The second hypothesis for this phase is linked to the first, whereby if current models fully comprise the systems of care conceptualizations, then the second hypothesis would be a mute concern since current system level measures have largely been developed using these models as a framework.

The study's findings support, in part, both of these hypotheses. Mixed results were found in the practice model and systems of care conceptual comparisons. While a substantial amount of overlap was identified between the practice models and the community conceptualizations, the comparative analysis indicated that no one model of practice wholly accounted for all of the concepts generated by the systems of care communities. Thus, by association, measures developed using these models as a framework would not adequately capture what may be contextually important to specific systems of care communities. Indeed, in their recent review of cultural competence measures, Boyle and Springer (2001) critically assert that,

All instruments seem to measure global constructs which may or may not apply to the reality of serving clients from specific cultures. In fact, all the instruments

seem to measure exposure to certain concepts about cultural competence as a field of professional literature more than actual knowledge or behavior relevant to any specific cultural group (p. 68).

### *Relational Competence Theoretical Model Assumptions*

As previously described, many aspects of the relational competence assumptions are well embedded in the community's statements of cultural competence. In turn, the specific elements within the theory were identified in every community's conceptualization. Indeed, the emphases of all practice models and community maps appeared to be a good fit within the group relational competence framework. One exception was related to the four measurement assumptions of relational competence theory. Although components of the three social work practice models could be loosely associated with the measurement assumptions, a clear and direct linkage was not evident. In contrast, components of the model advanced by Cross and colleagues (1989) specifically address relational competence methodological assumptions of measurement.

Using the practice model information documented on the matrix, several concepts within the models' assumptions could not be specifically identified within the communities' concept maps. These concepts included an emphasis on nonconscious and psychosocial influences on clients; negative experiences and related impacts on ethnic persons of color; universal patterns across cultures; and preserving dignity of the family's entire culture. Some of these assumptions are critical to the models' practice frameworks and are in part integrated within relational competence assumptions. For example, the assumption of relational competence theory regarding interpersonal judgment asserts that

impressions of competence are based on current and historical contexts of the interactants, which are stored, evaluated, and recalled through one's cognitive schema. Thus, practice model assumptions of the nonconscious and psychosocial influence of one's experiences on current perceptions are congruent with interaction expectation assumptions of relational competence theory. In this study, however, community conceptualizations did not generally include statements reflecting these types of concerns. Although the URB-N community generated two statements related to understanding historical relationships between agencies and between ethnic groups in the community, these particular statements were among the lowest rated statements on all three rating criteria.

The inability to identify seemingly critical assumptions of the models within the systems of care conceptualizations calls for additional exploration to understand these discrepancies. For example, one explanation may be that to get at the level of discourse needed for understanding such complex issues, a more narrative research approach may be needed to dig deeper into the meanings of individual participant responses.

Alternatively, participant perceptions in this study may not have generated ideas quite as abstract as the practice models' assumptions. Or, where the models' assumptions are much more related to cognitive processes, the indicators generated by the Concept Mapping process implemented were more behavioral. While the absence of these assumptions in the data might lead the reader to conclude that the related hypotheses were clearly realized, such a conclusion would be much too premature given the limitations of this exploratory study.

*Practice Model Elements, Community Conceptualizations and Relational Competence Components*

Numerous common elements and emphases were identified among all four of the practice models and systems of care conceptualizations. Although not one practice model alone covered all of the ideas generated within an individual community, nearly all of the ideas generated were covered by at least one of the practice models. There were two themes identified in the rural community conceptualizations that were not specifically identified as part of any practice model emphases. These issues included needs for service systems to include the entire family in receiving services and a need to address families' investment and consistent follow-through with services. A third theme, identified by all four communities, related to families feeling comfortable seeking services and approaching service providers. While the practice models may suggest these concepts are covered through emphases such as client empowerment or accessibility to services, the statements generated by all communities specifically referred to families "feeling comfortable," suggesting a slightly different level of focus.

Considering these three issues within the relational competence framework offers a potential alternative for understanding the discrepancies between the practice models and the community conceptualizations. Relational competence theory suggests that outcomes of an interaction should result in interactant satisfaction and perceptual congruence with the interactants' desired expectations (Spitzberg & Cupach, 1984; 1987). Research indicates that "feeling good" is "conceptually and empirically related to communication satisfaction" (Spitzberg & Cupach, 1987, p. 18). Thus, it can be further

argued that “feeling comfortable,” “feeling respected and valued,” and “feeling listened to and heard,” as conceptualized by systems of care participants, would result in a greater level of interaction satisfaction thereby increasing one’s motivation to engage in continued interaction. As opposed to viewing satisfaction as a secondary outcome of limited value, as is often the case in evaluative studies, this line of thinking gives consumer satisfaction a central role in understanding the interaction of consumer and system perceptions of cultural competence.

In contrast to the above findings, a number of practice model emphases were not specifically identified in the community conceptualizations. The most apparent of these missing themes was the focus on provider self-awareness, where none of the communities identified self-awareness, as intended in the practice models, as part of their conceptualizations. Cross and colleagues (1989) include an additional component further linking issues of self-awareness to “dynamics of difference,” whereby interactants must understand the histories of their individual or systems’ cultures in relationship to those with whom they are interacting. Within the group relational competence framework, these individual and system histories interact to form the group’s relational expectations, a key component for understanding relationships.

Similar to the assumptions discussion above, with an emphasis on self-awareness or dynamics of difference seemingly critical to all models of culturally diverse practice, what is to be made of its exclusion from all four communities’ conceptualizations? Is this concept inherent but not clearly indicated in the ideas generated; is it a supposition made by academic theorists without empirical support; did participants in all four systems of

care lack the cultural maturity to recognize the importance of self-awareness; does this finding suggest a need for professional staff training; did the study not obtain a diverse enough sample to capture the range of concepts necessary? Answers to these questions are not easily attained, and certainly cannot be clarified from the data in this study. Yet the findings raise concerns that would require a much closer examination to get at a deeper understanding of the issues.

Many other model emphases identified in chapter 4 were not specifically identified in the community conceptualizations, such as knowledge of human behavior and cognitive-affective behavioral characteristics; knowledge of the client's sense of identity; qualitative process evaluations and use of empowerment evaluation models to examine relationships between barriers, organizational context, and culturally responsive care; commitment to cultural competence; and research to improve practice. If all the models' components are ultimately determined to be essential to a basic understanding of cultural competence, findings from this study would suggest that Concept Mapping may be used as a diagnostic tool for identifying missing links. In effect, not only are a system's observed areas of need identified through the statement generation process, but by noting critical concepts that are not produced, hidden areas of need are also identified.

Some prevailing ideas identified across communities were included in the practice models. Some of the most consistent themes were mutual respect and trust; relationship building; interest/openness to cultural knowledge development; accessibility of services; team/empowerment/strengths approach; use of nontraditional/informal services; system policies/accountability; process and outcomes measurement; programs/agencies reflective

of cultural communities; and cross-cultural communication/language. Inter-agency collaboration, identified across community conceptualizations, was clearly identified only in the Cultural Competence (Cross et al., 1989) practice model.

In summary, the systems of care community conceptualizations of cultural competence included elements of each practice model compared but the amount of each model's elements included varied by community. Similarly, a number of each model's elements were not included in the individual community conceptualizations but a number of the models' elements were identified across communities. Thus, measurement models developed within current model frameworks are questionable in their applicability across varied systems of care. They are not flexibly designed to allow the emergence of contextual conceptualizations and identification of specific uniquenesses within individual systems of care. As such, they are not able to dynamically capture differences in priorities and demonstrative perceptions within and across participant groups.

Relational Competence theory assumes a requirement for event-specific measures of competence (Spitzberg & Cupach, 1987). Even Lum (2000), whose practice model focuses primarily on the experiences of people of color, contends that "culturally diverse social work practice must reexamine the nature and meaning of culture, moving from a static, fixed notion to a fluid, flexible meaning" (p. 330). Overall, the group relational competence framework provided a useful structure within which the conceptual comparisons could be made.

### *Limitations*

Concept Mapping is viewed by the researcher as a promising method for understanding the cultures of individuals and systems within the communities' systems of care. However, there are also potential limitations in using the method that warrant further exploration in its present and further application.

#### *Participant Sample*

The first potential limitation of the method relates to the participant sample. Selection of participants for a study using Concept Mapping is a critical factor in the underlying foundations of the data. Careful attention must be given to selection of sorting participants, as the sorting process structures and gives meaning to the data. It is imperative to have an adequate number of sorters to obtain a valid statistical analysis. If structural comparisons are desired among participant groups, the sample must be large enough to include at least 10 sorters in each group. It is just as important to recruit sorters who understand the context within which the research is taking place and who have the knowledge necessary for making meaning of the information.

In this study, including appropriate sorters was not determined to be an issue since the study sought to gather a broad range of conceptual understandings of the data generated. However, the overall participant sample limited the application of pattern match comparisons, thus limiting the number of within and across group comparisons that could be obtained. In two communities ethnic groups of color were vastly underrepresented. Thus, the sample may have been a contributing factor in the finding that specific concepts were missing from practice model elements.

Furthermore, the conceptualizations of cultural competence constructed in this study are limited to the actual study participants. The findings are not generalizable beyond the study groups, although they do offer a sense of how systems of care participants perceive issues of cultural competence within their respective systems. Likewise, findings from the aggregate study are specific to the total aggregate participants across the four systems. It was determined, however, that an aggregate examination of data across systems was a necessary step in assessing the potential for future theoretical and measurement development.

Finally, the literacy level of participants impacts their ability to participate in the sorting and rating phases of Concept Mapping. Concern for this issue is heightened when the first language of the participants differs from that of the language used in the Concept Mapping process. These issues are of particular concern when the researcher is unaware of participants' inability to read the sort cards and rating sheets. In this study there were four people on the research team available to observe participants and make inquiries to ascertain difficulties. In the couple of cases where participants could not read in their primary language they were accompanied by another participant who assisted them in the process. In one community several participants' first language was Spanish, and they could not read English. In this instance one of the research team's bilingual facilitators translated the statements from English to Spanish orally, allowing participants time to select their ratings. While accommodations were made for persons who could not read, the impact of these accommodations cannot be known for certain.

### *Focus Statement*

The development of a focus statement from which the data are initially generated is another critical step in the Concept Mapping process. Like formulating any other research question, great discernment must be given to the specific question asked in relation to the kind of data desired. This study presented three variations of the focus statement to which participants could respond. Although some may question the reliability and validity of using three different data prompts, this researcher believes that the variations likely increased the clarity of the type of information desired, thus increasing the reliability across respondents and validity of statement content.

### *Rating and Likert Scaling*

Rating scales developed for Concept Mapping are limited by the scale range developed, assigned scale anchors, and statements generated. In consideration of the rating values obtained, a retrospective examination of the rating scales used in this study indicated that the highest and lowest anchors used may have limited variation of importance ratings obtained. Rather than a definitive all or nothing anchor a little more flexibility in the anchoring may have increased the range of ratings.

A limitation to the policy rating question may have been that it is sometimes difficult to assign a rating to the inclusion of such specific examples in agency policies. Since systems of care often require change at the policy level, the intent of the question was to gather information about overall participant knowledge of cultural competence policies across their respective agencies. Including an optional response of *I don't know*,

may have balanced the difficulty in answering the question, as across assessments, between 6.5% and 15% of all participant responses were *I don't know*.

Issues of social desirability bias, or Likert scaling in general for different ethnic groups of participants, may have contributed to some of the findings. It is believed that the implementation of the rating process minimized potential social desirability bias, as participants worked individually to rate the scales and no individual ratings were shared with the systems of care communities. However, some research indicates that Likert scaling may not be as reliable or appropriate for some ethnic groups of color as they are for white persons. Land and Hudson (1999) reported that Latinos often have difficulty accurately completing Likert scales. Bachman and O'Malley (1984a; 1984b) reported that African Americans are more likely than whites to use the extreme ends, especially the positive end, of the scale continuum. The implementation measures taken with regard to Spanish translations were an effort to address potential problems with Latino participants. It cannot be known for certain the impact Likert-scaling procedures had on the results obtained from the Mexican American and African American participants in the study. This is another area for future research focus in use of the Concept Mapping method.

### *Breadth versus Depth*

As already indicated, depending on the implementation of Concept Mapping processes, the information gathered does not generally get at the deeper level meanings behind the statements generated. Rather, the process allows the researcher to gather a wide scope of information on a particular idea of interest. While the information gathered

is contextually based, it does not engage participants in lengthy in-depth discussions. The process could be used in combination with other methods, such as using the initial data generated to identify issues for more in-depth study through interview or narrative methods.

Finally, Concept Mapping alone cannot provide findings of cause and effect. However, the maps generated from the multidimensional scaling analyses provide a clearer understanding of how closely participants perceive the relationships among data elements. These identified relationships can provide a basis for further relational or theoretical research.

#### *Implications and Potential Applications for Social Work*

##### *Education and Practice, Policy and Research*

Implications resulting from this study were noted for social work education, practice, policy, and research. All of these implications are interrelated with regard to the conceptualizations of cultural competence. While discussion of the study's findings must be tempered with caution due to limitations of its nonprobability sample, many important issues emerged from the findings. Given the exploratory purposes of the study, this section raises critical questions and suggests relevant applications that may warrant additional inquiry.

##### *Education and Practice*

The common and unique conceptualizations of cultural competence within four children's mental health systems of care suggest that cultural competence must be examined contextually. Relational Competence theory (Spitzberg & Cupach, 1984, 1987)

supports this finding. The theory includes a specific contextual component for understanding relational interactions. The knowledge component of the theory includes an element of performance procedures whereby interactants must possess knowledge of the behaviors appropriate in different contexts, and the skills component suggests that one's social composure impacts perceptions of competence. Any single model of culturally responsive practice must be flexible in its application across multiple cultural contexts. The study further suggests that current models of social work practice with culturally diverse populations may be applicable in varying degrees across diverse populations. Models exclusive to persons of color may not reflect emphases necessary for working with other diverse groups, such as those in differing geographic areas or persons with disabilities.

A specific focus on issues related to family culture when working within a systems of care framework was clearly delineated across all four communities' statements. While family culture may be woven into the three practice models reviewed specific to social work, the models do not give this concept primary emphasis. In contrast to the practice models, social work's Educational Policy and Accreditation Standards (EPAS, CSWE, 2001) identifies "family structure" as a specific cultural grouping with which students must be prepared to practice "without discrimination, with respect, and with knowledge and skills" (p. 7).

Expanding upon this implication, comparisons of the assumptions and emphases among the four practice models reviewed, the four systems of care conceptualizations, and the relational competence theory suggest potential disconnects between social work

education and practice needs. An examination of the profession's standards will help elucidate this point.

Examples of the four social work ethical principles outlined in Chapter 2 (Social Justice, Dignity and Worth of the Person, Importance of Human Relationships, and Competence [NASW, 1996]) were found across all of the community conceptualizations and models of practice. The related ethical standards include social worker responsibilities for knowledge of diversity, cultural respect, accountability for self and to profession, engagement in research, and advocacy (NASW, 1996). All standards except accountability to the profession and engagement of research were noted among the community conceptualizations and practice models. Two practice models do not include any type of accountability among their primary emphases. All ten of the NASW Standards for Cultural Competence in Social Work Practice (2001) were captured in some way within the community conceptualizations and to a large extent are considered within the practice models. Finally, the Council on Social Work Education's EPAS (2001) includes specific emphases on preparing students to work competently in diverse environments and cites specific diverse groups to which competence policies apply.

The disconnect between education and practice emerges when knowledge of stated models, standards and policy are thought to be transferred into practice. Social work education often prepares social workers with a knowledge base of history, experiences, and general characteristics of diverse groups of people. However, knowledge is but one aspect of culturally responsive practice. This knowledge is not always transferred to developing actual skills. At some point knowledge and context must

intersect requiring the worker to step out of the generalized knowledge base and engage in appropriate behavior responses. Furthermore, within the relational competence theoretical framework, motivation plays a critical role in interpersonal and group competence. Social work gives much attention to the ethics and values of the profession, but learning about these values does not translate into internalization of the values. Social work students who do not possess the motivation to enact these values in preparation for culturally diverse practice within an organization will likely become one of those group members perpetuating negative perceptual relations within the organization. Social work education must address issues of motivation if its group contextual expectations include production of culturally competent practitioners engaged at all levels of social work practice.

Combining the NASW Code of Ethics (1996) with the recently developed NASW Standards for Cultural Competence (2001) and recently revised CSWE EPAS (2001), implications are suggested for individuals and institutions found to be culturally incompetent. As noted earlier, the ethical and cultural competence standards both suggest social worker accountability for participating in efforts to ensure culturally relevant interaction at both practice and service system levels. The ethics and standards require social workers to address incompetence among its professional membership and to pursue the rectification of incompetence according to appropriate chains of command. Social work's educational accreditation standards require ongoing assessment and improvement of educational programs. These assessments examine the actualization of objectives written to comply with educational policies, including those pertaining to

issues of diversity and cultural competence. Indeed, CSWE recently endorsed the NASW Standards for Cultural Competence, a move that is expected to add increased emphasis on the standards (Cultural Competence Standards, 2003).

The social work practice and educational ethics, policies, and standards clearly distinguish cultural competence as a key focus of professional responsibility for social work practitioners, educators and institutions alike. Yet the profession continues to struggle with how to actualize and assess this vital concept. Can and will social work hold itself accountable to its stated standards and commitment to culturally competent education and practice? Who or which professional organization is assuming primary responsibility for setting and implementing sanctions to individuals and educational programs for noncompliance of cultural competence expectations? If social work truly took stock of its cultural competence today using the profession's standards, what might be the impact on professional social workers, educators, and educational programs? What types of measures would social work use to assess the cultural competence of persons, programs and institutions? On what theoretical basis are these measures grounded? The profession must carefully consider its responses to such questions to move social work forward in its cultural responsiveness and to be seriously considered as a model for other professions.

Although this study did not set out to place relational competence theory at the center of the study, the expansion to group relational competence was so useful in the analyses and in understanding the data that the theory became a predominant feature of the study. The intent for using the theory was to provide a common structure for

comparing the practice models and community conceptualizations of cultural competence. The applicability of the theory went beyond the expectations of the researcher and provided fertile ground for contemplating critical issues and for future research.

Perhaps the most relevant implications are related to the empirical validity of current models of culturally diverse practice. Much effort has no doubt been dedicated to the development and improvement of the models over the past two decades yet questions remain as to their actual impact and applicability with multicultural populations. The models generally do not provide a relational theory to depict how their respective assumptions and components fit together. In contrast, the Interpersonal and Group Relational Competence theoretical frameworks do provide a sense of how components interact to effect degrees of outcome and relational competence. Fitting the practice models and community conceptualizations within the group relational competence theoretical framework elicited questions beyond identifying common and unique elements across all of the models. The study's findings provide a preliminary basis for inquiring about the empirical validity of the models currently advanced in social work education. This is not to say that the models would not hold up under such testing rather that there appears to be a gap in our knowledge base related to their contextual and empirical validity.

### *Policy*

All of the implications reviewed thus far are directly associated with issues of policy. Systems of care policies impacting children's mental health were a primary

concern in this study. The study was grounded in systems of care philosophy and was undertaken in an effort to influence state and local mental health policies related to culturally competent care for children and families. The community-based research approach coupled with state expectations for the participating state-funded systems of care generated important information for decision-making at two governmental levels. Family members and agency professionals are using the community information gathered to advocate for resources in response to their individual community assessments. The state legislated oversight committee is expected to use the findings to advocate for and support communities by guiding policy development and the legislative agenda around the state's children's mental health systems of care.

Developing contextual conceptualizations and essentially a local vision of culturally competent care prepares the systems of care to plan and implement related policies. The participatory process used in Concept Mapping allowed participants to define and describe from their unique perspectives how a complex construct could be deconstructed and conceptualized for practical application. The consumer perspectives did not often reflect those of the provider system. These findings suggest the importance for state level policymakers of mental health services to recognize and respond to the needs of their state's communities.

As state budgets for mental health services increasingly diminish it becomes more critical to design programs and services in ways that most efficiently and effectively produce the desired results. Combining participant perceptions with evidence-based research would seemingly provide the most accurate method for determining and setting

policies that support the interests of consumers, providers, and policymakers. The Concept Mapping results in this study produced concrete information for setting individual community and state goals and establishing systems of care baselines for measuring the ongoing development of culturally competent practice and policy across public service systems. Concept Mapping demonstrated its ability to inform systems' understanding of a complex concept. The method's participatory processes suggest considerable application for gathering multiple stakeholder perspectives that can inform a wide range of state policy initiatives.

These policy implications can be more broadly extended to mental health and health care policy in general. As noted in Chapter 2, managed care is greatly involved in identifying indicators and developing measures of cultural competence for behavioral, mental and physical health care organizations. However, the methods currently used for generating these indicators are not based in empirical theoretical study. As lists of indicators are developed they will likely be used to set policies for cultural competence in managed health care organizations, with related theoretical validation to be implemented at a later time. Findings from this study present social work with some ideas that could potentially inform development of behavioral and mental health care models of cultural competence and contribute to efforts toward theoretical development. In his review of managed health care and issues of cultural competence, K. Davis (2001) suggests,

Equitable health care for people of color as a national policy goal...will require unprecedented visionary leadership and agreement across political ideologies about the desired direction of national health care policy and the acceptable role

of government. Of equal importance in the possible transformation of American health care policy is the need to find a culturally relevant conceptual framework for services. (p. 56)

Social work needs to be a contributing participant in leading the mental health and health care fields toward policy development based on empirical validation of a cultural competence framework.

Findings from this study suggest that the group relational competence model offers a potential avenue for developing a comprehensive model of cultural competence as applied in a system context. As outlined in Chapter 2, the expanded relational competence model views group expectations as having critical influence on the policies developed around cultural competence. For example, in terms of political economy (Austin, 1988), based on the perceived legitimation of a state's mental health system by its internal and external legitimators (e.g., consumers, political decisionmakers, and program staff), system policymakers may or may not be compelled to develop culturally responsive policies. If the system is perceived by key legitimators as ineffective with regard to responding to the needs of diverse groups of people, barriers to positive relational perceptions of the system will be identified. Examination of these barriers prompts development of new policies in an effort to influence the internal expectations of the mental health system. Thus, development and validation of a culturally competent model of care may be imperative to ensuring critical policy reform at any level.

## *Research*

*Theoretical Validation.* As discussed above, to address the culturally related gaps in social work education, practice, and policy, theoretical models guiding practice must undergo empirical validation (Boyle & Springer, 2001). Although this study was not an empirical test of relational competence theory, its application to group relational competence offers a framework within which constructs of cultural competence across similar service contexts, i.e., systems of care communities, can be compared and contrasted. As such, the theory provides a structure for designing research studies.

The interpersonal relational competence model has undergone some extensive empirical research that has supported the construct validity of the theoretical model (Spitzberg & Cupach, 1987). As a part of the validation process a number of interpersonal measures of competence have been developed in an effort to further operationalize the model's constructs. As suggested in chapter 3, the interpersonal relational competence model can be applied within a group relational competence context to develop a measurement structure for "changing patterns of perceptions" within an organization. It further offers a theoretical foundation from which to begin identifying the relationships among concepts of competence. Such theoretical development is necessary to ground social work models of culturally competent practice and assessment.

### *Concept Mapping: Cultural Competence Assessment and Scale Development.*

Cultural competence is understood as a developmental process (Cross et al., 1989), and there is no particular reference point in time by which a system of care should be expected to have fully achieved cultural competence, if ever. Since the study process

developed was intended to serve as both a current and ongoing measure of the systems' levels of cultural competence, there needs to be a method for assessing incremental achievements and changes in the systems' development over time. Concept Mapping is noted for its utility in instrument development (e.g., van Nieuwenhuizen, Schene, Koeter, & Huxley, 2001). Its methods are consistent with processes generally outlined for scale development (Crocker & Algina, 1986; DeVellis, 1991; Springer, Abell, & Hudson, 2002). The Concept Mapping approach, however, allows communities to define the cultural competence construct for themselves. With the continued development of individual community conceptualizations of cultural competence, the results can be examined for identification of possible elements to be included on a measurement instrument that can at a minimum assess concepts found to be common across systems of care communities.

Asking participants to rate the indicators on importance provides a potential mechanism for assigning weights to indicators. This weighting process would be useful in designing an instrument that is sensitive to change over time. As data are collected and compared across systems of care and groups within and across the systems, consistencies in weightings (i.e., importance ratings) can assist in the development of a more contextually dynamic instrument. In their own research efforts to empirically test the relational competence model, Spitzberg & Cupach (1987) suggest that when assessing competence, people generally reliably use the entire range of a scale when it is constructed with continuous, equal intervals. Although participants in this study did not use the entire range of the scales, this was assessed, in part, as a limitation of the anchors

assigned to the rating scales developed. As the researcher explores additional approaches to Likert scale development, an increased variation in responses is anticipated.

*Concept Mapping bridges quantitative and qualitative research paradigms.*

Concept Mapping is a true mixed-method approach to evaluation and research. As such it provides a bridge between quantitative and qualitative research paradigms. Contextual and numerical data are collected and used with sound statistical techniques to produce a vast amount of information that can be analyzed in multiple ways beyond even that embedded within the Concept Systems (2001) software. In addition to the numerical results computed from data collected, the software produces graphics that provide clear visual depictions of the data for dissemination of information back to participants and organizations. In social work's continued search for research approaches that appeal to practitioners, organizational systems, and researchers alike, Concept Mapping offers an innovative method that has applicability across a wide range of research questions.

Conceptualization of cultural competence in children's mental health systems of care requires individualization at the family, organizational, and community levels. The Concept Mapping methodology offered an innovative way of gathering and analyzing data from many individuals across multiple levels of systems of care within specific contextual environments. By examining discrepancies between groups of participants, the results of the study helped existing mental health systems of care develop training plans to meet their unique needs, establish a baseline to monitor progress in developing their communities' conceptualizations of cultural competence, and gather information to assist in policy development. While there remains much to learn about the vast potential

application of the Concept Mapping methodology, its application in this study suggests its viability as an additional tool for conceptualizing and assessing constructs of culturally responsive practices in mental health systems of care for children and families.

The underlying assumptions and emphases of current culturally related practice models and competence measures in social work do not appear adequate to capture the intersect of complex contextual issues at multiple system levels. The relational competence theory as expanded to a group relational competence framework provided not only a useful structure for comparing culturally diverse practice models and systems of care conceptualizations but also emerged as a potentially promising framework for the development of a comprehensive relational theory of cultural competence for social work and children's mental health systems of care. The numerous questions raised in this exploratory study provide multiple levels for future inquiry of cultural competence in social work education and practice, policy, and research. Such inquiry must continue if mental health systems are to improve their service performance and meet the needs of all persons reflecting the diversity of our nation.

APPENDIX A

# Respecting Family Differences

Are We Going the Right Direction?



## We would like to hear what you think!

**When:**

**Where:** (Map attached)

**Who:** All Families involved with \_\_\_\_\_

**Details: Childcare will be available (Please call \_\_\_\_\_ at \_\_\_\_\_ to make arrangements)**

**Transportation available (Please call \_\_\_\_\_ at \_\_\_\_\_ to make arrangements)**

**Food will be provided**

**We will provide compensation to Parents and kids 11 years or older who participate**

# Respetando las Diferencias Familiares



## ¡Queremos escuchar su opinión!

**Cuando:**

**Donde:** (Adjunto un mapa)

**Quien:** Todas las familias que reciben servicios de \_\_\_\_\_

**Detalles:** Habrá cuidado para niños (Favor de llamar a \_\_\_\_\_, para hacer arreglos)

Habrá transportación si es necesario (Favor de llamar a \_\_\_\_\_, para hacer arreglos)

**Habrá comida**

**Se proveerá compensación para padres y madres, e hijos(as) mayores de 11 años por su participación**

**System of Care - Cultural Competence Assessment**  
**Adult Participant Sign-In Sheet**  
**June \_\_\_\_, 2002**

As part of the ongoing development of the \_\_\_\_\_ system of care, we are asking that caregivers, youth, service providers, and other involved community members participate in this assessment. The information gathered will be used to help us understand how we can best provide services to children and families. Through your participation a picture of care will be created for our community that we can use to monitor our progress and identify areas where we can improve. Your participation is voluntary, and your signature on this sign-in sheet indicates that you have read and understand the above statement and have decided to participate. *If you brought a child 11 years of age or older for whom you have custodial authority, your signature also tells us that you give permission for the identified child to participate.* Thank you.

<b>Name (please print)</b>	<b>Sign Name</b>	<b>Name of Child/Youth (if applicable) (please print)</b>

This assessment is being conducted by the Center for Social Work Research, University of Texas at Austin. If you have any questions about this assessment, please call \_\_\_\_ at \_\_\_\_ or \_\_\_\_ at \_\_\_\_.

**System of Care - Cultural Competence Assessment**  
**Youth Participant Sign-In Sheet**  
**June \_\_\_\_, 2002**

As part of the ongoing development of the \_\_\_\_\_ system of care, we are asking that caregivers, youth, service providers, and other involved community members participate in this assessment. The information gathered will be used to help us understand how we can best provide services to children and families. Through your participation a picture of care will be created for our community that we can use to monitor our progress and identify areas where we can improve. Your participation is voluntary, and your signature on this sign-in sheet indicates that you have read and understand the above statement and have decided to participate. Thank you.

Name <i>(please print)</i>	Sign Name

***This assessment is being conducted by the Center for Social Work Research, University of Texas at Austin. If you have any questions about this assessment, please call call \_\_\_\_ at \_\_\_\_ or \_\_\_\_ at \_\_\_\_.***

Registro de Firmas para el Grupo de Discusión  
**Martes 22 de Abril del 2001**

Como parte del proceso del programa de evaluación del Consorcio de Niños, les hemos pedido a las personas encargadas del cuidado de los niños que participan en el Consorcio que asistan a este grupo de discusión. La información recogida en el grupo de discusión será utilizada en los informes sobre el programa y en los pedidos adicionales de apoyo financiero. Los resultados nos proveerán retroalimentación acerca de la efectividad general del programa ni serán utilizados para evaluar el desempeño de participantes individuales. Su firma en esta hoja de registro indica que Ud. ha leído y comprendido lo arriba expresado y ha decidido participar.

Le agradecemos por su apoyo.

<b>NOMBRE EN LETRAS DE IMPRENTA</b>	<b>FIRMA</b>

**TEXAS INTEGRATED FUNDING INITIATIVE EVALUATION**  
**CONSENT TO PARTICIPATE IN RESEARCH STUDY**  
**Caregiver Version**

You are invited to participate in a study exploring the effectiveness of an integrated service system with children and families receiving community-based mental health services. This study is part of a state grant that was awarded to **insert name of county** in order to develop and evaluate a community-based mental health service system for children and families. We, **name of project**, are asking you to be a participant in this study because your child received mental health services. We are asking all children enrolled in the **name of project** and their families to participate in this study. We anticipate that between 6 and 10 families will be eligible to participate in the evaluation this year.

If you decide to participate, you will be asked questions about how you and your child are doing and feeling. You will be asked questions about your family and your experiences with the services your child and you have received, including mental health and substance use services. You and your child will be asked to provide such information at the initial interview and again every three months. You will be asked to continue participation in the evaluation even if you stop receiving services from the **name of project**. Each interview with you will take approximately one hour and fifteen minutes to complete. Each interview with your child will take approximately ten minutes to complete.

As part of the project, we would like your permission to make use of your child's school records including disciplinary, attendance, and transfer records; juvenile court records; records from the department of human services and child protection; and mental health records related to your child's care. Your agreement to participate in this project and your signature on this form will provide your permission for release of any of these records for a period of one year from the time of your first interview. If you continue in the study beyond that time, we will ask you to allow us to continue such access to your child's records for the remainder of the study.

*To the extent allowed by law*, everything that you and your child talk about will be kept confidential. Your information will be kept in a locked place at **name of project and any other location where information will be stored** and the University of Texas at Austin. A code number is being used so your names will not be associated with the information that is shared with the University of Texas at Austin. We will only report summarized results looking at the youth and families as a group, so your identities will not be known. To the extent allowed by law, we will not disclose any information that can be identified with you or your child, nor connect you or your child to any information we present.

Your decision to participate or allow your child to participate will not affect any services either of you now receive or might receive in the future. Your decision will not affect or jeopardize you or your child's future relations with the **insert name of project**, social services in **service area**, or the University of Texas at Austin. If you decide to participate,

you are free to discontinue participation at any time. Further, your child will be free to refuse to participate at any time in any or all interviews as well.

If you have any questions, please feel free to ask. If you have any questions later, you may contact the individual who is supervising this evaluation study: **insert name, title and telephone number of appropriate person.**

Your signature indicates that you have read the information above and have decided to participate. You may withdraw your participation and discontinue your child's participation at any time without consequences after signing this form. You may keep a copy of this form.

If you agree to participate you will be given **insert compensation** for each interview as compensation for your time and effort.

SAMPLE ONLY

\_\_\_\_\_  
Signature of Parent or  
Legal Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Interviewer

\_\_\_\_\_  
Date

**TEXAS INTEGRATED FUNDING INITIATIVE EVALUATION**  
**PARENTAL GUARDIAN CONSENT FOR CHILD TO PARTICIPATE IN**  
**RESEARCH STUDY**  
(version for caregivers of youth 11 and older)

Your child is being invited to participate in a study exploring the effectiveness of an integrated service system with children in need of mental health services. This study is part of a state grant that was awarded to **name of project** in order to develop and evaluate community-based mental health services for children and families. We, **name of project**, are asking you to allow your child to be a participant in this study because he/she has received mental health services. We are asking all children enrolled in the **name of project** to participate in this study. We anticipate that between 6 and 10 children will be eligible to participate in the study this year.

If you decide to allow your child to participate, he/she will be asked questions about how satisfied he/she was with the services he/she received. Your child will be asked to provide such information 3 months after the beginning of services and again every three months. Each interview with your child will take approximately ten minutes to complete.

Your child's information will be kept in a locked place at **name of project and any other designated location** and the University of Texas at Austin. A code number is being used so your child's name will not be associated with the information shared with the University of Texas at Austin. We will only report summarized results looking at the youth as a group, so his/her identity will not be known. *To the extent allowed by law*, we will not disclose any information that can be identified with him/her, or connect him/her to any information we present.

Your decision whether or not to allow your child to participate will not affect any services he/she now receives or might receive in the future. Your decision will not affect or jeopardize you or your child's future relations with the **insert name of your project**, any social services in **service area**, or the University of Texas at Austin. If you decide to allow your child to participate, you are free to discontinue participation at any time. Further, your child will be free to refuse to participate in any or all interviews as well.

If you have any questions, please feel free to ask. If you have any questions later, you may contact the individuals who are supervising this evaluation study: **insert name, title and phone numbers of appropriate person**.

Your signature indicates that you have read the information above and have decided to allow your child to participate. You may withdraw your permission and discontinue your child's participation at any time without consequences after signing this form. You may keep a copy of this form.

If you and your child agree to allow him/her to participate, your child will receive **insert compensation** for every interview.

\_\_\_\_\_  
Child's Name

\_\_\_\_\_  
Signature of Parent or Legal Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Interviewer

\_\_\_\_\_  
Date





**URB-E**  
**Cultural Competence Assessment**  
**Participant Information Sheet**

CSID _____ (Evaluator Use only)
------------------------------------

Name: \_\_\_\_\_

<div style="border: 1px solid black; padding: 5px; margin-bottom: 10px;"> <b>1</b> </div> <p><b>What is your role with URB-E?</b></p> <p><i>(please choose either A, B, or C, and answer all questions in that section)</i></p>	<p><b>A. Family Member</b></p> <p><i>Check one:</i></p> <p><input type="checkbox"/> Caregiver</p> <p><input type="checkbox"/> Advocate</p> <p><input type="checkbox"/> Other Family Member: _____</p> <p style="text-align: center;"><i>(please specify)</i></p> <p><b>What is the primary agency that provides your family with services?</b></p> <hr/> <p><i>Check one:</i></p> <p><input type="checkbox"/> Steering Committee Member</p> <p><input type="checkbox"/> Non-Steering Comm Member</p>
	<p><b>B. HIFI Agency Member</b></p> <p><i>Check one:</i></p> <p><input type="checkbox"/> Direct Service Provider</p> <p><input type="checkbox"/> Administrator</p> <p><input type="checkbox"/> Other: _____</p> <p style="text-align: center;"><i>(please specify)</i></p> <p><b>What agency do you represent?</b></p> <hr/> <p><i>Check one:</i></p> <p><input type="checkbox"/> Steering Committee Member</p> <p><input type="checkbox"/> Non-Steering Comm Member</p>
	<p><b>C. <input type="checkbox"/> Other _____ (please specify)</b></p> <p><i>Check one:</i></p> <p><input type="checkbox"/> Steering Committee Memb</p> <p><input type="checkbox"/> Non-Steering Comm Member</p>
<div style="border: 1px solid black; padding: 5px; margin-bottom: 10px;"> <b>2</b> </div> <p><b>How long have you been involved with this project?</b></p>	<p><input type="checkbox"/> More than 2 years</p> <p><input type="checkbox"/> 1-2 years</p> <p><input type="checkbox"/> 4-11 months</p> <p><input type="checkbox"/> Less than 3 months</p>
<div style="border: 1px solid black; padding: 5px; margin-bottom: 10px;"> <b>3</b> </div> <p><b>How many cultural competence trainings/wrkshops have you attended in the last two years?</b></p>	
<div style="border: 1px solid black; padding: 5px; margin-bottom: 10px;"> <b>4</b> </div> <p><b>Demographic Information</b> <i>(Please check only one for each section.)</i></p>	
Gender	<input type="checkbox"/> Female <input type="checkbox"/> Male
Race/Ethnicity	<input type="checkbox"/> White/European American <input type="checkbox"/> Mexican American <input type="checkbox"/> Black/African American <input type="checkbox"/> Asian American <input type="checkbox"/> Biracial <input type="checkbox"/> Other group not listed <i>If other group, please specify: _____</i>
Sexual Orientation	<input type="checkbox"/> Heterosexual (Straight) <input type="checkbox"/> Homosexual (Gay/Lesbian/Bisexual)
Household Income	<input type="checkbox"/> 0 - 15,000 <input type="checkbox"/> 25,001 - 35,000 <input type="checkbox"/> Above 50,000 <input type="checkbox"/> 15,001 - 25,000 <input type="checkbox"/> 35,001 - 50,000
Do you belong to a religious group?	<input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, please specify: _____</i>
Age	<i>(Please indicate your age in years.)</i>
Do you have any type of a disability?	<input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, please specify: _____</i>
<div style="border: 1px solid black; padding: 5px; margin-bottom: 10px;"> <b>5</b> </div> <p><b>Please identify anything else that you consider unique about your family.</b></p>	

**RUR-E**  
**Cultural Competence Assessment**  
**Participant Information Sheet**

CSID _____ (Evaluator Use only)
------------------------------------

**NAME:** \_\_\_\_\_

<div style="border: 1px solid black; padding: 5px; width: 30px; margin: 0 auto; text-align: center; font-weight: bold;">1</div> <p><b>What is your role with RUR-E?</b></p> <p><i>(please choose either A, B, or C, and answer all questions in that section)</i></p>	<p><b>I. A. Family Member</b></p> <p><i>Check one:</i></p> <p><input type="checkbox"/> Caregiver</p> <p><input type="checkbox"/> Advocate</p> <p><input type="checkbox"/> Other Family Member: _____</p> <p style="text-align: center;"><i>(please specify)</i></p> <p><b>What is the primary agency that provides your family with services?</b></p> <hr/> <p><i>Check one:</i></p> <p><input type="checkbox"/> Community Advisory Board Member</p> <p><input type="checkbox"/> Non Community Advisory Board Member</p>
	<p><b>B. Tri-County Agency Member</b></p> <p><i>Check one:</i></p> <p><input type="checkbox"/> Work Directly with Youth/Families</p> <p><input type="checkbox"/> Administrator</p> <p><input type="checkbox"/> Other: _____</p> <p style="text-align: center;"><i>(please specify)</i></p>
	<p><b>II. What agency do you represent?</b></p> <p><i>Check one:</i></p> <p><input type="checkbox"/> Community Advisory Board Member</p> <p><input type="checkbox"/> Non Community Advisory Board Member</p>
	<p><b>D. <input type="checkbox"/> Other _____</b></p> <p style="text-align: center;"><i>(please specify)</i></p> <p><i>Check one:</i></p> <p><input type="checkbox"/> Community Advisory Board Member</p> <p><input type="checkbox"/> Non Community Advisory Board Member</p>
<div style="border: 1px solid black; padding: 5px; width: 30px; margin: 0 auto; text-align: center; font-weight: bold;">2</div> <p><b>How long have you been involved with this project?</b></p>	<p><input type="checkbox"/> More than 2 years</p> <p><input type="checkbox"/> 1-2 years</p> <p><input type="checkbox"/> 4-11 months</p> <p><input type="checkbox"/> Less than 3 months</p>
<div style="border: 1px solid black; padding: 5px; width: 30px; margin: 0 auto; text-align: center; font-weight: bold;">3</div> <p><b>How many cultural competence trainings/wkshops have you attended in the last two years?</b></p>	
<div style="border: 1px solid black; padding: 5px; width: 30px; margin: 0 auto; text-align: center; font-weight: bold;">4</div> <p><b>Demographic Information <i>(Please check only one for each section.)</i></b></p>	
Gender	<input type="checkbox"/> Female <input type="checkbox"/> Male
Race/Ethnicity	<input type="checkbox"/> White/European American <input type="checkbox"/> Mexican American <input type="checkbox"/> Black/African American <input type="checkbox"/> Asian American <input type="checkbox"/> Biracial <input type="checkbox"/> Other group not listed <i>If other group, please specify: _____</i>
Sexual Orientation	<input type="checkbox"/> Heterosexual (Straight) <input type="checkbox"/> Homosexual (Gay/Lesbian/Bisexual)
Household Income	<input type="checkbox"/> 0 - 15,000 <input type="checkbox"/> 25,001 - 35,000 <input type="checkbox"/> Above 50,000 <input type="checkbox"/> 15,001 - 25,000 <input type="checkbox"/> 35,001 - 50,000
Do you belong to a religious group?	<input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, please specify: _____</i>
Age	_____ <i>(Please indicate your age in years.)</i>
Do you have any type of a disability?	<input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, please specify: -</i> _____
<div style="border: 1px solid black; padding: 5px; width: 30px; margin: 0 auto; text-align: center; font-weight: bold;">5</div> <p><b>Please identify anything else that you consider unique about your family.</b></p>	

Febrero 6, 2003

Estimado Miembro de la Comunidad:

¡Saludos otra vez! El verano pasado Ud. participó en una evaluación de la competencia cultural del sistema de cuidado para salud mental de niños en su comunidad. Luego en el otoño pasado les pedimos a los participantes que nos ayudaran a examinar información de cuatro diferentes comunidades en Texas. Usando la información que recibimos, se preparó un reporte de resumen para el *State Consortium* de familias y profesionales que apoyan el desarrollo de los sistemas de cuidado en Texas. El reporte fue distribuido a los líderes de sus sistemas de cuidado locales y esa información ayudará para apoyar la asistencia técnica y los planes de entrenamiento sobre la competencia cultural en cada comunidad.

Aunque lo que recibimos se pudo usar para preparar el reporte, fueron muy pocos los que respondieron en cada comunidad. Nuestro equipo de evaluación ha continuado con su interés de ver la cuestión de el impacto de la cultura en los servicios de salud mental para niños y creemos que es muy importante explorar esta cuestión para el cuidado adecuado de los niños y sus familias. Por esta razón una vez mas les pedimos su ayuda para poder tener mejor entendimiento de la información que recibimos cuando estuvimos en su comunidad. Combinamos todos los enunciados que recibimos en cada comunidad en una lista y le pedimos que compare cada enunciado con los otros enunciados en la lista. Hemos traducido las listas a español para que respondan en la idioma que se les haga mas fácil. Hay una lista que clasifica las declaraciones basado en lo importante y otra lista que clasifica de acuerdo a como cada declaración es demostrada en su comunidad. Le mandamos tambien tarjetas para surtir y declaraciones en inglés por si gusta participar en esa idioma.

Cada miembro adulto de la familia que participe en este proyecto y regrese este paquete recibirá un tarjeta de \$25 para uso en *Wal-Mart*. Cuando recibamos su paquete nosotros le mandaremos su tarjeta. Hemos incluido un sobre con timbre para que nos mande el paquete. **Es importante que nos mande el paquete lo mas tarde el lunes, Febrero 24, 2003.**

Muchas gracias por su apoyo en esta evaluación. Nosotros todavía nos acordamos de el buen tiempo que tuvimos en cada comunidad. Si Ud gusta una copia de el reporte de su comunidad, cada oficina local del proyecto de sistema de cuidado tiene copias del reporte. Si tiene alguna pregunta sobre este proyecto por favor, llame al (512) 232-7903. Esperamos que pueda participar en este proyecto.

Sinceramente,

Tamara S. Davis, MSSW  
Systems of Care Evaluation Team

## Instrucciones

**Este paquete tiene dos formularios de evaluación. El primer formulario evalúa cuales declaraciones son más o menos importante. El segundo formulario evalúa cuales declaraciones son más o menos demostradas por su sistema de cuidado local.**

1. Compare cada declaración con todas las otras declaraciones en la lista.
2. Por favor trate de usar la clasificación completa del 1 al 5 de posibles categorías en sus resultados.

### Recordatorio

Las siguientes declaraciones fueron usadas para producir ejemplos de la competencia cultural que usamos en los formularios.

Yo se que los servicios a familias son culturalmente competentes cuando

---

Yo se que los servicios a familias son respetuosos cuando

---

Yo se que los servicios a familias son culturalmente sensible cuando

---

## Evaluación de Competencia Cultural: Resumen de Cuatro Comunidades

### *Información de el Participante*

**Nombre:** \_\_\_\_\_ **Teléfono:** \_\_\_\_\_

**Dirección:** \_\_\_\_\_

<b>¿Qué comunidad (sistema de cuidado) representa?</b>	
<input type="checkbox"/> Floydada/Plainview (Family Connections) <input type="checkbox"/> Harris County (HIFI) <input type="checkbox"/> Tarrant County (Mental Health Connection) <input type="checkbox"/> Tri-County (T-CIFI)	
<b>¿Qué agencia sirve a su familia?</b>	
<b>¿Cuántos entrenamientos or clases de competencia cultural ha asistido en los ultimos dos años?</b>	
<b>Información Demográfica</b>	
Género	<input type="checkbox"/> Femenina <input type="checkbox"/> Masculino
Raza/ étnica	<input type="checkbox"/> Méjico Americano <input type="checkbox"/> Otro grupo (indique cuál): _____
Orientación Sexual	<input type="checkbox"/> Heterosexual <input type="checkbox"/> Homosexual <input type="checkbox"/> Otro: _____
Ingresos del Hogar	<input type="checkbox"/> 0-15,000 <input type="checkbox"/> 15,001-25,000 <input type="checkbox"/> 25,001-35,000 <input type="checkbox"/> 35,001-50,000 <input type="checkbox"/> ↑ 50,000
¿Pertenece a una Religión?	<input type="checkbox"/> Si <input type="checkbox"/> No (Indique cuál): _____
Edad	_____ (Su edad en años)
¿Tiene alguna desabilidad?	<input type="checkbox"/> Si <input type="checkbox"/> No (Indique cuál): _____

## Spanish Translation of Statements - Aggregate Study

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- 1 Los proveedores dedican tiempo para conocer y establecer armonía con los niños y familias que sirven.
- 2 El entendimiento de el gobierno sobre las necesidades de servicios de la comunidad se mantienen mediante estructuras apropiadas de distribución de fondos.
- 3 Los proveedores de servicio en verdad apoyan, valoran y conservan las culturas individuales de las familias.
- 4 Los servicios incluyen a todas las personas sin discriminar.
  
- 5 Los planes de servicio se ratifican por escrito, por lo que cada quien puede considerarse responsable.
- 6 Los multiples trámites de el sistema no son una barrera para que las familias adquieran servicios.
- 7 Un continuo de servicios y proveedores coordinados permite servicios de transición ininterrumpidos para las familias.
- 8 Los servicios se basan en las necesidades especificas de las familias.
  
- 9 Los proveedores piensan mas allá de su posición de trabajo y se esfuerzan al servir a las familias.
- 10 Las familias se fortalecen con la solidez y las diferencias de su cultura.
- 11 El proveedor de servicio aprueba la participación de un defensor objetivo de la familia.
- 12 Los proveedores de servicio y las familias pueden usar humour en su relación.
- 13 Se proporcionan servicios a las familias utilizando un acercamiento multidisciplinario.
- 14 Las familias participan políticamente al abogar por el cambio en las políticas gubernamentales.
- 15 Las personas que toman las decisiones cambian los servicios para sustentar las necesidades de la comunidad.
- 16 Los sistemas de servicio apoyan los esfuerzos para ampliar servicios más alla de la disposición de servicio "tradicional".
- 17 La política (legislada y de agencia) permite a los proveedores la flexibilidad de hacer lo necesario por las familias.
- 18 Los servicios para las familias permanecen consistentes a través de los partidos políticos.
  
- 19 Los patrones apoyan a los empleados que tienen miembros en la familia con necesidades especiales.
- 20 Se logra un progreso notable en los resultados de los niños.
  
- 21 Los servicios guían para mejorar el progreso de las familias en relación al cumplimiento de sus metas.
- 22 Las agencias trabajan juntas (combinan recursos, información y esfuerzos) para cumplir las metas de las familias.
- 23 La gente sabe como responder apropiadamente en situaciones de crisis.
  
- 24 El sistema educativo esta preparado para participar positivamente.

- 25 Hay igualdad de oportunidad de servicios para todos los individuos.
- 26 Los chicos están contentos con si mismos.
- 27 A los niños se les permite ser niños.
- 28 Se establecen relaciones de confianza entre los proveedores y familias.
- 29 Las familias entienden como usar procedimientos de queja imparcial.
- 30 Se cumplen las necesidades de la familia.
- 31 Mejora la comunicación entre padres y sus hijos.
- 32 Las familias están satisfechas con los servicios que reciben.
- 33 En el proceso del servicio a cada quien se le trata igual.
- 34 Las familias están activas en todos los aspectos de los servicios.
- 35 Los proveedores de servicio y sus familias en verdad trabajan como un equipo.
- 36 Las familias se comprometen a la participación en el proceso de servicio.
- 37 Las organizaciones proporcionan entrenamiento cultural específico-comunitario competente a los empleados en todos los niveles.
- 38 Las familias se instruyen acerca de las culturas y mandatos de las organizaciones.
- 39 La flexibilidad se establece en el sistema de servicio para proporcionar servicios únicos/no tradicionales para cumplir las necesidades de las familias.
- 40 Hay una continuidad de cuidado de familias a través del largo trayecto.
- 41 En la agencia hay un entendimiento cultural e histórico.
- 42 Los proveedores de servicio tienen una reputación positiva de servir a familias.
- 43 Las necesidades educativas de todos los niños se cumplen y se apoyan.
- 44 Las familias tienen muchas opciones de servicios.
- 45 Los miembros de la comunidad apoyados por los proveedores de servicio, valoran la propiedad de los servicios de la comunidad.
- 46 Las familias ven apoyo y motivación en los proveedores de servicio, en los que elaboran las políticas y en los administradores de la agencia.
- 47 Los proveedores valoran y honran las opiniones de todos los miembros de la familia.
- 48 Las instituciones de educación superior conocen a sus comunidades y pueden instruir a los estudiantes en cuanto a tipos de alternativas y referencias.
- 49 La voz de la familia y su preferencias son prioritarias.

- 50 A las familias se les da el tiempo y consideración de lo que su situación merece.
- 51 Los servicios mejoran la vida familiar.
- 52 A los trabajadores se les procesa de manera debida e inmediata por las acusaciones de los consumidores.
- 53 Las políticas de las agencias permiten a los empleados tener tiempo de recuperación cuando tienen casos difíciles.
- 54 Los profesionales y los empleados que trabajan directamente con las familias reciben pago justo.
- 55 Se contrata a empleados que tienen experiencia con enfermedades de salud mental.
- 56 Los servicios están disponibles para necesidades de diagnóstico dual, retraso mental/salud mental.
- 57 No hay listas de espera.
- 58 No hay una sobre-representación de niños en educación alternativa.
- 59 Educación continua se ofrece tanto a familias como a profesionales.
- 60 Las personas no se insultan entre si al tartar de ser muy atentas en cuanto a la cultura.
- 61 Consumidores no son sometidos a trabajadores abusivos (abuso verbal, manejo físico, limitaciones ambientales).
- 62 La gente no escucha a profesionales hacer comentarios basados en los orígenes étnicos.
- 63 Los servicios y los sistemas no son competitivos.
- 64 Se valora a los de edad avanzada.
- 65 Los practicantes pueden efectuar cambios en el sistema de cuidado.
- 66 No existe animosidad entre los sistemas y las familias.
- 67 Existen formas de medir el logro.
- 68 Las familias reciben respuesta cuando la solicitan.
- 69 Los proveedores no asumen que la familia no entiende lo que sucede con la situación familiar.
- 70 Las familias tienen muchas opciones disponibles al escoger a los proveedores de servicio.
- 71 Las familias están felices de ver a los proveedores.
- 72 Hay consistencia en cuanto a quien proporciona los servicios a las familias.
- 73 Las funciones de cada persona involucrada en los servicios son claras (padres, consejero, niño).
- 74 Las familias y los proveedores de servicio no se juzgan.

- 75 El cuidado es apropiado al desarrollos del niño y el diagnóstico no lo dirige.
- 76 Los padres son informados del tratamiento y progreso de su hijo.
- 77 A las familias se les refiere como personas y no se sienten etiquetadas o marcadas al recibir servicios.
- 78 Existen oportunidades para la familias para apoyarse y compartir información.
- 79 Los proveedores de servicio en verdad entienden lo que es importante para las familias.
- 80 Las familias sienten que se les trata con dignidad y respeto.
- 81 Los proveedores de servicio saben cuando ofrecer apoyo empatetico y/o simpatetico a las familias.
- 82 Existe una comunicación de respeto entre los niños y los proveedores de servicio.
- 83 Los niños empiezan a tomar responsabilidad por su propia conducta.
- 84 Las familias reconocen que los proveedores de servicio se interesan por ellos.
- 85 Los servicios y programas procuran las necesidades de horario de la familia.
- 86 El tiempo de las familias se respeta.
- 87 Las familias sienten que los proveedores de servicio las escuchan.
- 88 Se trata con respeto en forma individual a los padres y a los niños.
- 89 Los proveedores de servicio realizan cada cual esfuerzo para encontrar ayuda para familias sin pasar la responsabilidad a otra agencia.
- 90 Los servicios son individualizados (no a todos se les ofrecen los mismos servicios de la misma manera).
- 91 Los servicios están centrados en los niños y permiten que estos se expresen de los sevicios que reciben.
- 92 Los proveedores en efecto realizan lo que dicen que haran.
- 93 Los proveedores trabajan con y proveen de servicios a toda la familia más que solo al nino identificado.
- 94 Las familias estan informadas con precisión de los servicios y recursos que están a su disposición.
- 95 Los proveedores de servicio pueden admitir que no tienen la comprensión necesaria para trabajar con una familia.
- 96 Los proveedores de servicio no imponen sus propios valores y creencias sobre las familias.
- 97 Los proveedores de servicio se instruyen sobre las diferencias culturales de las familias a las que sirven.
- 98 Los servicios para las familias no juzgan pero afirman las culturas y origenes de las familias.
- 99 Las familias y los proveedores de servicio quieren compartir entre ellos sus culturas y creencias.

- 100 Los proveedores quieren preguntar y permitir que las familias sean expertos de sus propias culturas.
- 101 Los servicios culturalmente apropiados aseguran el cumplimiento de las necesidades de las familias.
- 102 Los proveedores de servicios consideran la cultura de la persona en su totalidad (espiritual, física, financiera, mental, familia).
- 103 Las demografías culturales de aquellos a quienes se les sirve reflejan la población de la comunidad.
- 104 Los sistemas y los proveedores de servicio reflejan (asemejan) las diversas culturas en su comunidad.
- 105 La provisión de servicios incluye el entendimiento mutuo entre el proveedor y las familias.
- 106 La línea de comunicación siempre está abierta.
- 107 Los servicios se proporcionan dentro de las comunidades propias de las familias.
- 108 Los servicios están disponibles para las familias sin importar los recursos financieros de estas.
- 109 Las formas y documentos de la agencia se imprimen en el idioma cultural de las familias.
- 110 Las familias pueden obtener acceso a servicios y proveedores sin barreras (transporte, lenguaje, educación, costo).
- 111 Los proveedores de servicio usan un lenguaje familiar-amigable libre de términos técnicos.
- 112 Las familias pueden comunicarse en su propio idioma con los proveedores de servicios.
- 113 Las familias dirigen los servicios (estas se encargan de sus propios servicios).
- 114 Cuando los proveedores de servicios respetan las elecciones de los padres sin juzgar.
- 115 Las familias se sienten cómodas al obtener servicios y hacer preguntas a los proveedores de servicio.
- 116 Los servicios y apoyos son capacidades basadas y elaboradas en los recursos existentes de las familias.
- 117 Las familias pueden por su parte encontrar recursos y usar nuevos recursos para ayudarse.

## APPENDIX B

### Structured Youth Focus Groups

In communities where youth participate in the cultural competence assessment, separate focus groups will be conducted to gather information specifically from a youth perspective. The youth groups will not use the Concept Mapping methodology. Instead, a focus group data collection process combined with a modified Nominal Group prioritization process will be used. The discussion will be modeled after that which begins the Concept Mapping Idea Generation with the adult groups. Following are the methodological steps for the youth focus groups:

1. Sign-in/Consent Form: Have youth sign in and explain that their signature also means that they understand the purpose of their participation, that their participation is voluntary, and that their signature means they have agreed to participate.
2. Youth will be offered food and beverage.
3. Welcome group participants and introductions.
4. Focus Group Discussion: (*approx. 45 minutes*)
  - Explain purpose of the group meeting: *to gather information from their points of view about some specific ways they want people to work with them*
  - Move to a discussion around the meaning of culture. Ideas generated will be recorded on flip chart sheets that will remain displayed throughout the meeting
  - Group dialogue will move to a discussion about the meaning of respect. Ideas generated will be recorded on flip chart sheets that will remain displayed throughout the meeting
  - Group discussion will then move to putting the concepts of culture and respect together. This discussion can focus on “cultural respect” from people in general
  - Once the group appears to understand how these concepts fit together, move the discussion to “cultural respect” from people who work with the youth and family. Have youth briefly name the kinds of people working with them and their families. Give them a couple of examples, like a counselor or juvenile probation officer
  - Move the discussion to specific Idea Generation based on the focus statement:
    - *Complete the following statement with specific examples:  
I know that people working with me and my family respect us when*
  - If youth do not understand the statement, it can be rephrased as:

- *I know that people working with me and my family treat us fairly when \_\_\_\_\_*
    - Record statements on a flip chart with enough margins on both sides for later use in the dot voting process. Hang statements up on the wall as they are generated
5. Statement Prioritization:
- Explain the prioritization process with dots – one question at a time. The first vote is for importance: ***Pick the top five examples that you think are the most important for you and your family***
  - Have participants decide on their top five priorities ***before*** they go up to place their dots on the **left** side of the statements. This is to avoid as much peer pressure as possible. Then have them vote by placing their dots next to statements, with 1 being their top priority and 5 being their 5<sup>th</sup> priority
  - Cover the dots with a blank sheet of flip chart paper
  - Now tell the youth you want them to vote on something else. The second vote is for demonstration: ***Pick the top five examples that you think people working with you actually do the most often***
  - Have participants decide on their top five examples ***before*** they go up to place their dots on the **right** side of the statements. Again, this is to avoid as much peer pressure as possible. Then have them vote by placing their dots next to statements, with 1 being the example that happens most often and 5 being their 5<sup>th</sup> most often example
  - Results/Feedback to the group:
    - With the youth watching, add the total number of points up for both importance and demonstration
    - Share the results back with the youth
    - If time permits, ask the youth if they are surprised by any of the results
6. Thank youth for their participation and adjourn when you see the adult group breaking up

## APPENDIX C

### Group Cultural/Competence Brainstorm

CULTURE			
URB-N	RUR-W	URB-E	RUR-E
<ul style="list-style-type: none"> <li>-Man-made</li> <li>-Environment</li> <li>-Values</li> <li>-Traditions</li> <li>-Diversity</li> <li>-Interaction</li> <li>-Way of life</li> <li>-Belief system</li> <li>-Heritage</li> <li>-Nationality</li> <li>-Educational background</li> <li>-Expression and creativity</li> <li>-Norms and behavioral expectations</li> <li>-Science and medicine</li> <li>-Food</li> <li>-Physical characteristics</li> <li>-Language and communication</li> <li>-Child-rearing practices</li> <li>-Expectations (relationships)</li> <li>-Religious beliefs and practices</li> <li>-Mores and folkways</li> <li>-Music</li> <li>-Family Hierarchy</li> <li>-Clothing</li> <li>-Work (how people approach work/ incorporate into life)</li> <li>-Ethics</li> <li>-Time (how people regulate time)</li> <li>-Hierarchy (societal)</li> <li>-Politics</li> <li>-Leisure</li> <li>-Money and finance</li> <li>-Identity (how we see ourselves from others inside/ outside culture)</li> <li>-Taboos and biases</li> <li>-Prejudices</li> <li>-Community involvement/ community relationships</li> <li>-Sexual orientation</li> <li>-Festivals</li> <li>-Holidays</li> <li>-Death Rituals</li> <li>-Other Rituals</li> <li>-Signs and symbols</li> <li>-How we view illness</li> <li>-Expectations from others within culture</li> <li>-Attitude toward disability</li> <li>-Views of government – entities of authority</li> <li>-Shared humor</li> </ul>	<ul style="list-style-type: none"> <li>-Beliefs</li> <li>-Norms</li> <li>-Values</li> <li>-Behaviors</li> <li>-Communication</li> <li>-Traditions</li> <li>-Ethnicity</li> <li>-Needs</li> <li>-Religion</li> <li>-Diversity</li> <li>-Language</li> <li>-Attitudes</li> <li>-Habits</li> <li>-Socio-economic status</li> <li>-Dress</li> <li>-Areas of Residence</li> <li>-Nationality</li> <li>-Food</li> <li>-Rules</li> <li>-Roles</li> <li>-Family hierarchies</li> <li>-Music</li> <li>-Art</li> <li>-Literature</li> <li>-Age of community residents – lifespan</li> <li>-Family</li> <li>-Lifestyle</li> <li>-Generations</li> <li>-Urban/Rural</li> <li>-Belonging to a subset – specialized cross-section of society</li> </ul> <hr/> <p style="text-align: center;"><b><i>Continued from URB-N</i></b></p> <ul style="list-style-type: none"> <li>-Mythology</li> <li>-Healthcare choices</li> <li>-Cross-cultural adaptation</li> <li>-Housing</li> <li>-Entertainment</li> <li>-Emotional response</li> <li>-Transportation</li> <li>-Employment</li> <li>-Economics</li> <li>-Parental involvement</li> <li>-Family values</li> </ul>	<ul style="list-style-type: none"> <li>-Values</li> <li>-Traditions</li> <li>-Environment</li> <li>-Community</li> <li>-Ethnic backgrounds</li> <li>-Family</li> <li>-Language</li> <li>-Religion</li> <li>-Economics</li> <li>-Society</li> <li>-Rituals</li> <li>-Humanness</li> <li>-Mores – unwritten norms</li> <li>-Sexual orientation</li> <li>-Beliefs</li> <li>-Communication styles</li> <li>-Groups</li> <li>-Health</li> <li>-Behaviors</li> <li>-Geography</li> <li>-Prejudices</li> <li>-Nutrition</li> <li>-Biases</li> <li>-Attitudes</li> <li>-Dress</li> <li>-Emotions</li> <li>-Food</li> <li>-Music</li> <li>-Age</li> <li>-Housing</li> <li>-Gender roles</li> <li>-Laws</li> <li>-Celebrations</li> <li>-Education</li> <li>-Learning styles</li> <li>-Cultures are shaped by their own history</li> <li>-Lifestyle</li> <li>-Race</li> <li>-Support</li> <li>-Relationships</li> <li>-Care</li> <li>-Heritage</li> <li>-Child rearing practices</li> <li>-Spirituality</li> <li>-Recreation</li> <li>-Roles</li> <li>-Problem-solving</li> </ul>	<ul style="list-style-type: none"> <li>-Background</li> <li>-Values</li> <li>-Behaviors and beliefs similar to one group/community</li> <li>-Traditions</li> <li>-Motivation for behaviors/things that people do</li> <li>-Race</li> <li>-Ethnicity</li> <li>-Demographics</li> <li>-Norms</li> <li>-Socio-economics</li> <li>-Separation from other types of cultures – each culture is unique</li> <li>-Religion</li> <li>-Diversity</li> <li>-Gender</li> <li>-Mont. Cty – different in every direction</li> <li>-Different societal pressures</li> <li>-Education</li> <li>-Environment</li> <li>-Urban/rural cultures</li> <li>-Services/resources provided are different in each community</li> <li>-Standards of living</li> <li>-Histories</li> <li>-Populations within an area</li> <li>-Reproduction/continuation of the individual cultures is maintained</li> <li>-Food</li> <li>-The way people live and dress</li> <li>- clothing</li> <li>-Financial background</li> <li>-Language</li> <li>-Family background</li> <li>-Work – different jobs</li> <li>-Urban/suburban/country – geographic areas</li> <li>-Attitudes</li> <li>-Customs</li> <li>-Children - discipline</li> <li>-How you present yourself</li> <li>-Elderly</li> <li>-The way we look at the world</li> <li>- how you perceive things around you</li> </ul>

<ul style="list-style-type: none"> <li>-Culturally specific mental illnesses</li> <li>-Penal system</li> <li>-Cowboy</li> <li>-Practices</li> <li>-Behaviors</li> <li>-Beliefs specific to a group of people</li> <li>-Lifestyles of people</li> <li>-Attitudes</li> <li>-Ethnicity</li> <li>-Education</li> <li>-Social habits</li> </ul>	<ul style="list-style-type: none"> <li>-Organizational structure</li> <li>-Preconceptions of others' cultures</li> <li>-Worldview</li> <li>-Law enforcement</li> <li>-Social status</li> <li>-Financial status</li> <li>-Penal beliefs and practices</li> <li>-Marriage and Divorce</li> <li>-Courting practice</li> </ul>		<ul style="list-style-type: none"> <li>-Special needs children – gifted/talented; kids' labels</li> <li>-Government as part of culture</li> <li>-Medical structure</li> <li>-Rules</li> <li>-Rights</li> <li>-Community and individual standards</li> <li>-Respect from peers</li> <li>-How you earn respect</li> <li>-Rights of equality</li> <li>-Gender rights</li> <li>-Sexual orientation</li> <li>-Perceptions of others on you</li> <li>-</li> <li>how others see you and vice versa</li> <li>-Military expectancies</li> <li>-Respect toward others</li> </ul>
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<b>COMPETENCE</b>			
<b>URB-N</b>	<b>RUR-W</b>	<b>URB-E</b>	<b>RUR-E</b>
<ul style="list-style-type: none"> <li>-Inclusion and collaboration</li> <li>-Knowledge</li> <li>-Approach to education – patients and families</li> <li>-Understanding</li> <li>-Outcomes</li> <li>-Choices</li> <li>-Nonjudgmental</li> <li>-Skills</li> <li>-Responsible for educating staff</li> <li>-Sensitivity</li> <li>-Professional - Ethical</li> <li>-Credibility</li> <li>-Accountability</li> <li>-Efficiency</li> <li>-Flexibility</li> <li>-Management style</li> <li>-Communication</li> <li>-Integrity</li> <li>-Street skills</li> <li>-Honesty and trust</li> <li>-Dependability</li> <li>-Consistency</li> <li>-Fairness</li> <li>-Respect</li> <li>-Equality</li> <li>-Openness – open to situation</li> <li>-Affirmation of differences</li> <li>-Willingness to learn new skills</li> <li>-Acceptance of differences</li> <li>-Asking questions when you don't know the answers</li> <li>-Cooperation</li> <li>-Empathy – meeting the client where they are</li> <li>-Understanding others' perspectives – and validating</li> <li>-Non-patronizing</li> </ul>	<ul style="list-style-type: none"> <li>-Respect others' differences</li> <li>-Open-minded</li> <li>-Ability</li> <li>-Capability</li> <li>-Responsibility</li> <li>-Knowledge</li> <li>-Flexibility</li> <li>-Proficiency</li> <li>-Fluency in putting ideas into practice</li> <li>-Not imposing your ideas on someone else</li> <li>-Acceptance</li> <li>-Paperwork</li> <li>-Empathy</li> <li>-Tenaciousness</li> <li>-Adaptability</li> <li>-Function effectively in context of person's culture</li> <li>-Multi-faceted/multi-focused</li> <li>-Understanding</li> <li>-Agree to disagree (even though you don't like something)</li> <li>-Looking at big picture</li> <li>-Stepping outside the box</li> <li>-Trustworthy</li> <li>-Accept who we are without being ashamed of who we are</li> <li>-Ability to complete a task</li> <li>-Ability to express your feelings</li> <li>-Attitude</li> <li>-Compliance</li> <li>-Respect</li> <li>-Ability to work without a lot of supervision</li> <li>-Staying up-to-date educationally</li> </ul>	<ul style="list-style-type: none"> <li>-Ability</li> <li>-Having knowledge of</li> <li>-Skills</li> <li>-Talent</li> <li>-Experience</li> <li>-Appropriate</li> <li>-Measuring up</li> <li>-Trustworthy</li> <li>-Confidence</li> <li>-Reliable</li> <li>-Self-esteem</li> <li>-Having the knowledge and ability to understand a given situation or task</li> <li>-Be aware</li> <li>-Sure of self</li> <li>-Capable</li> <li>-Using good judgment</li> <li>-Problem-solving</li> </ul>	<ul style="list-style-type: none"> <li>-Proficiency</li> <li>-Knowledge</li> <li>-Ability to apply knowledge</li> <li>-Understanding/interpreting</li> <li>-Dialoging</li> <li>-Capability</li> <li>-Accountability</li> <li>-Skills</li> <li>-Awareness</li> <li>-Insight</li> <li>-Physical and mental competency</li> <li>-Reliability</li> <li>-Stability</li> <li>-How well you function in society</li> <li>-How well you fit in society or other group</li> <li>-Responsibility</li> <li>-Ability</li> <li>-Handicap/disability – expectations</li> <li>-Learning</li> <li>-Financial situation</li> <li>-Self-advocate</li> <li>-Acceptance</li> <li>-Speaking the language needed with others</li> </ul>

<ul style="list-style-type: none"> <li>-Connections between service providers and families</li> <li>-Connections between various providers</li> <li>-Ability</li> <li>-Capability</li> <li>-Educational background</li> <li>-Self-confidence</li> <li>-Commitment</li> <li>-Sincerity</li> <li>-Follow-through</li> <li>-Experience (professional experience)</li> <li>-Life experience</li> <li>-Financial support</li> <li>-Knowledge of Resources in the community</li> <li>-Knowledge of model programs in US and World</li> <li>-Cost-effectiveness</li> <li>-Quality-effectiveness</li> <li>-Responsibility to outcome -- ownership</li> <li>-Political Ideology</li> <li>-Passion</li> <li>-Work balance – healthy boundaries</li> <li>-Sharing power</li> <li>-Parents as professionals</li> <li>-Show of parity</li> <li>-Sharing valid information</li> <li>-Consumer-friendly forms</li> <li>-Consumer-friendly employees</li> </ul>	<ul style="list-style-type: none"> <li>-Able to talk to any person/deal with any person</li> <li>-Being culturally aware</li> </ul> <hr/> <p><b><i>Continued from URB-N</i></b></p> <ul style="list-style-type: none"> <li>-Community involvement and responses</li> <li>-Patience with people from cultures different from yours</li> <li>-Volunteerism</li> <li>-Advocacy</li> <li>-Confidentiality</li> <li>-Public relations</li> <li>-Working environments are organized</li> </ul>		
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CULTURAL COMPETENCE			
URB-N	RUR-W	URB-E	RUR-E
<ul style="list-style-type: none"> <li>-Uniformity – Consistency in working with clients</li> <li>-Flexibility to adapt to individual/family needs</li> <li>-Consumer oriented, rather than system oriented</li> <li>-Staff represent population being served</li> <li>-Inclusive</li> <li>-Training on cultural competence</li> <li>-Capabilities versus disabilities – strengths vs. weaknesses – Strengths --</li> <li>-Perspective preferred vs. deficiencies</li> <li>-Training – feedback</li> <li>-Integrate → service learning → scientist-practitioner approach</li> <li>-Access to system of care (transportation, child care, etc.)</li> <li>-Respect family unit and value system</li> </ul>	<ul style="list-style-type: none"> <li>-Respect of differences</li> <li>-Nonjudgmental acceptance of differences</li> <li>-Understand what the differences are</li> <li>-Willingness to learn</li> <li>-Willingness to understand</li> <li>-Function effectively within pattern of behaviors</li> <li>-Being able to work with different cultures without trying to become a part of that culture</li> <li>-A lack of competence destroys – gives one the ability to destroy everything around them</li> <li>-Working together</li> <li>-Making yourself aware of cultural differences and learning how to work with those differences</li> <li>-Accepting and respecting other people’s cultural differences</li> </ul>	<ul style="list-style-type: none"> <li>-Ability to individualize and accept mores</li> <li>-Willing to accept and understand one’s choices in life</li> <li>-Ability to understand and appreciate the differences in human groups</li> <li>-Knowledge to accept and respect one another’s belief systems</li> <li>-Ability to integrate differences and similarities between different groups</li> <li>-Ability to understand, accept, and appreciate the diversity of the families that make up our community</li> <li>-Understanding your own cultural views</li> <li>-Having a working knowledge of different cultural groups</li> <li>-Parts of a whole--Family culture/youth culture may</li> </ul>	<ul style="list-style-type: none"> <li>-Tolerance and acceptance of the uniqueness of each group</li> <li>-Awareness and understanding of the things that make people and families unique</li> <li>-Provide educational resources to families so they can use them efficiently and effectively</li> <li>-Knowledge and insight into the behaviors and beliefs of a group or community</li> <li>-Goes beyond awareness and understanding -- Demonstration of performance</li> <li>-Dialogue and interaction necessary</li> <li>-Being able to understand differences</li> </ul>

<ul style="list-style-type: none"> <li>-No one is turned away because of type of disability /system doesn't give up</li> <li>-Family preservation</li> <li>-Services are available where they are most needed in community</li> <li>-Outreach to new developing demographics</li> <li>-Competence needs to be system-wide → administration as well as provider</li> <li>-Enough money to pay for it all</li> <li>-Culture-specific materials</li> <li>-Wraparound for all eligible children</li> <li>-Coordination of services, i.e., medical, school, social services, community services, family services</li> <li>-Front-line Workers who have been on the job for more than 2 years</li> <li>-Consistency</li> <li>-No one gets turned away that needs services</li> <li>-Intake workers who listen patiently and in an understanding way to individual needs</li> <li>-All intake calls are monitored for outcome with any group who receives state or federal funding</li> <li>-Populace or citizenry that is enlightened regarding mental illness/mental health</li> <li>Monitoring of educational adaptation to family needs</li> <li>-Respecting people regardless of ethnicity, religion, faith</li> <li>-Provide services according to what family needs, educating self when knowledge is needed</li> <li>-Being sensitive to needs of consumers</li> <li>-Treat all people with dignity</li> <li>-Recognition of children with mental health needs</li> </ul>	<ul style="list-style-type: none"> <li>-Willingness to asking people about things you need to know</li> <li>-Setting examples – being a role model for people in your own culture</li> <li>-Ability to transcend cultures</li> <li>-Avoid stereotypes</li> <li>-Doing away with racism – all the “isms”</li> <li>-Being able to live in society without prejudice</li> <li>-Understanding other people</li> <li>-Don't participate when other people are engaging in hurtful activities toward other people -- “micro aggressions”</li> </ul>	<ul style="list-style-type: none"> <li>be different than the societal culture</li> <li>-Recognizing individual and unique differences within all groups</li> <li>-Knowledge and awareness of the unique differences of families or groups or individuals</li> <li>-Being sensitive to families or individuals</li> <li>-Respectful</li> <li>-Not looking at things in a “cookie-cutter” way – looking outside the box</li> <li>-Versatile</li> <li>-Willing to work in interdependence with people – in partnership with people</li> <li>-2-way flow of information/ communication</li> <li>-Good listening skills</li> <li>-Accepting and appreciating people just as they are</li> </ul>	<ul style="list-style-type: none"> <li>-Being open-minded</li> <li>-Being able to accept differences</li> <li>-Ability to understand</li> <li>-Ability to foster and accept change</li> <li>-Finding similarities</li> <li>-Admitting when you're wrong</li> <li>-Accepting constructive criticism</li> <li>-Don't judge people by the way they are different</li> <li>-Be objective, not subjective or judgmental</li> <li>-Getting involved</li> </ul>
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## APPENDIX D

### Instructions for Sorting and Rating

This packet contains instructions and data collection forms for two key tasks of the concept mapping process:

- Task 1: Sorting the statements into groups and labeling the groups
- Task 2: Rating each individual statement on a numerical scale

In addition to these instructions, the following materials are included in your packet:

- A set of sort cards
- Rating forms (two forms for family members; three forms for professional members)
- Rubber bands

Please follow the instructions below very carefully. Even a few small errors can influence the final results.

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#### Task 1 – Instructions for Sorting and Labeling Statements

**Step 1 → Sorting the Statement Cards:** Enclosed in your package is a set of cards. Each card has a statement and a statement ID number. *Group the statements into piles in a way that makes sense to you, following these guidelines:*

- Group the statements for how *similar in meaning* they are to one another. Do not group the statements according to how important they are, how high a priority they have, etc. This will be covered in another part of the process.
- There is no right or wrong way to group the statements. You will probably find that you could group the statements in several sensible ways. Pick the arrangement that feels best to you.
- You cannot put one statement into two piles at the same time. Each statement must be put into only one pile.
- People differ on how many piles they wind up with.
- A statement may be put alone as its own pile if you think it is unrelated to the other statements or it stands alone as a unique idea.
- Make sure that *every* statement is put somewhere. Do not leave any statements out.
- Do not create any piles that are “miscellaneous” or “junk” piles. If you have statements left over that you can’t place, put each statement in its own pile.

## **Step 2→Labeling the piles:**

- Pick up one of your piles, quickly scan the statements in that pile, and make up a *short phrase* or *title* that describes the contents of the pile.
  - Place a rubber band around the pile to secure the grouping.
  - Turn the pile over and write your pile label on the back card. Please write legibly.
  - Continue this process until all piles are secured and labeled.
- 

## **Task 2 – Instructions for Rating Statements**

In Task 2, you will rate each statement on two or three criteria. Family members will rate the statements on importance and how often the statement is demonstrated in your system of care. Professional members will rate the statements on importance, how often the statement is demonstrated in your system of care, and whether or not the statement is covered under the professional's agency policies.

Each rating form has its own written instructions. Please follow carefully the instructions on each of the rating forms. Two key instructions for all forms are:

1. Before you assign a rating to a statement, compare how you want to rate that statement to how you would rate all other statements in the list
  2. Try to use the entire range of the scale in your ratings. This will help your community get maximum benefit from the assessment.
- 

When you are finished with the sorting and rating, place all materials back into your envelope and hand it to someone on the UT evaluation team to look over before you leave.

If you are willing to sort and/or rate statements generated by the other TIFI communities, please indicate this by giving us your contact information on the sheet provided as you leave.

***THANK YOU FOR YOUR PARTICIPATION!***

Cultural Competence Assessment  
**Importance** Rating Sheet

**Rating Question:** *How important is this example for meeting the unique needs of families?*

**Instructions:** Compare each statement to all other statements in the list. Then rate each statement by **circling a number** from 1-5 based on the following scale:  
5=Extremely important; 4=Very important; 3=Fairly important; 2=A little important; 1=Not important. **Please try to use the entire 1-5 range of possible ratings in your scoring.**

	<i>How important is this example for meeting the unique needs of families?</i>	<i>Extremely Important</i>	<i>Very Important</i>	<i>Fairly Important</i>	<i>Important</i>	<i>Not Important</i>
#	Example	5	4	3	2	1
1		5	4	3	2	1
2		5	4	3	2	1
3		5	4	3	2	1
4		5	4	3	2	1
5		5	4	3	2	1
6		5	4	3	2	1
7		5	4	3	2	1
8		5	4	3	2	1
9		5	4	3	2	1
10		5	4	3	2	1
11		5	4	3	2	1
12		5	4	3	2	1
13		5	4	3	2	1
14		5	4	3	2	1
15		5	4	3	2	1
16		5	4	3	2	1

Cultural Competence Assessment  
**Frequency of Demonstration** Rating Sheet

**Rating Question:** *How often is this example demonstrated in your community's system of care?*

**Instructions:** Compare each statement to all other statements in the list. Then rate each statement by **circling a number** from 1-5 based on the following scale: 5=Always demonstrated; 4=Usually demonstrated; 3=Sometimes demonstrated; 2=Rarely demonstrated; 1=Never demonstrated. Please try to use the entire 1-5 range of possible ratings in your scoring.

	<i>How often is this example demonstrated in your community's system of care?</i>	<i>Always Demonstrated</i>	<i>Demonstrated</i>	<i>Sometimes Demonstrated</i>	<i>Rarely Demonstrated</i>	<i>Never Demonstrated</i>
#	Example	5	4	3	2	1
1		5	4	3	2	1
2		5	4	3	2	1
3		5	4	3	2	1
4		5	4	3	2	1
5		5	4	3	2	1
6		5	4	3	2	1
7		5	4	3	2	1
8		5	4	3	2	1
9		5	4	3	2	1
10		5	4	3	2	1
11		5	4	3	2	1
12		5	4	3	2	1
13		5	4	3	2	1
14		5	4	3	2	1

Cultural Competence Assessment  
**Policy** Rating Sheet

My level of knowledge about our **system of care** policies on cultural competence is:

**(please check one)**

No Knowledge \_\_\_\_\_      A little Knowledge \_\_\_\_\_      A lot of Knowledge \_\_\_\_\_      Extensive Knowledge \_\_\_\_\_

**Instructions:** Compare each statement to all other statements in the list. Then read the following question and rate each statement by **circling a number** from 1-3 based on the following scale: 3=Fully Covered; 2=Somewhat Covered; 1=Not Covered; 0=I don't know. **Please try to use the entire 1-3 range of possible ratings in your scoring.**

**Rating Question:** *To what extent is this statement covered under your agency's policies?*

	<i>To what extent is this statement covered under your agency's policies?</i>	<i>Fully Covered</i>	<i>Somewhat Covered</i>	<i>Not Covered</i>	<i>I Don't Know</i>
#	<b>Example</b>	<b>3</b>	<b>2</b>	<b>1</b>	<b>0</b>
1		3	2	1	0
2		3	2	1	0
3		3	2	1	0
4		3	2	1	0
5		3	2	1	0
6		3	2	1	0
7		3	2	1	0
8		3	2	1	0
9		3	2	1	0
10		3	2	1	0
11		3	2	1	0
12		3	2	1	0
13		3	2	1	0

Relational Competence Theory Assumptions <sup>a</sup>								
<i>Model of Practice/ Community Conceptualization</i>	<i>Competence is an interpersonal judgment (Impression)</i>	<i>Competence inferences evolve from an interdependent process</i>	<i>Competence inferences are continuous judgments</i>	<i>Personal attributes increase perceptions of competence</i>	<i>Measures of competence reference behavioral &amp; evaluative impressions</i>	<i>Measures of competence relate to functional outcomes</i>	<i>Measures of competence are event- specific</i>	<i>Measures of competence permit self and other assessment</i>
<i>Ethnic-Sensitive Practice</i>								
<i>Cultural Awareness</i>								
<i>Process-Stage Approach</i>								
<i>Cultural Competence</i>								

APPENDIX E

Note: Concepts in matrix adapted from Relational Competence Theory (Spitzberg & Cupach, 1984, 1987; Spitzberg, 1989), and culturally diverse/competent practice Cross et al. (1989), Devore & Schlesinger (1996), Green (1999), and Lum (2000).

<sup>a</sup>Assumption comparisons are primarily based on specifically postulated assumptions of models' authors. Lum (2000) cites no specific assumptions rather the model is based on the identified premises.

<i>Relational Competence Theory</i>					
<i>Model of Practice/ Community Conceptualization</i>	<i>Interpersonal → System Motivation<sup>b</sup>, Knowledge<sup>c</sup>, Skills<sup>d</sup></i>	<i>Group's Combined Contextual Expectations<sup>e</sup></i>	<i>+/- Relational Perceptions of Interaction Quality;<sup>f</sup> Policies/System Barriers/ Targets for Change</i>	<i>Outcomes/Objectives Obtained</i>	<i>Degree of Relational Competence</i>
<b>Ethnic-Sensitive Practice Cultural Awareness Process-Stage Approach Cultural Competence URB-N  RUR-W  URB-E  RUR-E</b>					

Notes. Dimensions and Operational Examples: <sup>b</sup>Motivation--Affective/Cognitive Dimensions (social anxiety/apprehension, willingness to communicate, internal locus of control, affinity-seeking competence, social self-esteem, assertiveness/shyness, altercentric interpersonal orientation, loneliness). <sup>c</sup>Knowledge (cognitive and conversational complexity, ontological knowledge, social perceptivity, role taking, problem-solving, social intelligence, knowledge acquisition strategies, intimacy, self-monitoring). <sup>d</sup>Skills Dimensions: Expressiveness (activity, involvement, language), Altercentrism (listening, empathy, immediacy, role-taking, attentiveness), Interaction Management (awkwardness, meshing, synchrony), Social Composure (relaxation, assertiveness, confidence, humor, anxiety). <sup>e</sup>Contextual Expectation Dimensions: Valence (affiliation/sociability; +/- evaluative judgment of environment— inclusion, friendly/hostile, quarrelsome/agreeable; trust/mistrust), Potency (power relations—equality, cooperation; dominance/submissiveness; control), Surgency (activity/intensity; task/goal orientation; autonomy/dependence in interaction; forward/backward movement of interaction), Socialization (social composure; informality/formality, conscientiousness; awareness and interpretation of cultural context and expected rules of conduct). <sup>f</sup>Appropriateness (interaction management, behaviors, overall impression, such as satisfaction, trust, intimacy); Effectiveness (successful interaction, control in interaction [conflict strategies/mutuality of control], goals achievement

## APPENDIX F

### RUR-W

#### Focus Groups with Youth Participants

A separate process was conducted with youth to gather information specifically from a youth perspective. The Concept Mapping methodology was not used with the youth group. Instead, the youth participated in a focus group to generate ideas about cultural competence and then prioritized the ideas they generated. The discussion with youth was modeled after that used for Brainstorming with the adults. Youth dialogue centered on the meaning of cultural respect and specific ways youth want people to work with them and their families. The specific focus statement used with youth to generate their list of ideas was:

*Complete the following statement with specific examples: I know that people working with me and my family respect us when*

After the statements were generated, youth were then asked to individually decide which five statements were the most important for them and their families. Then youth were asked to individually decide which five statements the people working with them demonstrated most often. Points were assigned whereby each youth's most important and most demonstrated statements received the most points. The points were totaled and shared back with the youth.

#### *Youth Participants*

A total of 21 youth participated in the assessment. Their ages ranged from 10–16 years, with the average age being 13 years. The gender of participants included 10 females and 11 males. The race/ethnicity of participants included 56% Mexican American, 29% White/European, 10% Black/African American, and 5% Biracial.

#### *Findings from Youth Assessment*

The youth generated 13 statements to indicate how they believe people working with them show respect of their families' cultures. Clear ideas emerged as what they perceived to be the most important and the most demonstrated of all the ideas. Table F-1 lists the statements and the top ten rank order on importance and demonstration. Rankings are listed in ascending order where "1" indicates the highest ranking and "10" indicates the lowest ranking.

Statement two "when someone listens to your suggestions" was ranked as the most important example of cultural respect as well as the most demonstrated. Beyond this comparison the rank order of many examples appears to be inconsistent between importance and demonstration. For example, statements six and four are rated as the second and fourth most important, but neither made the top ten on the ranking of

demonstration. In contrast, statements three and ten were ranked low on importance but ranked second and third on demonstration.

There were three general themes that came from the youth focus group discussion and prioritization process. The first was related to the importance for youth to feel they are listened to and respected. This is reflected in statements one, two and three. The second theme centered on the youths' desire for adults to respond to their behavior in ways that do not reflect anger and are not punitive in nature. This theme is reflected in statements four, six and eight. The final theme emerging from the discussion involved youth having a voice on matters of importance. Statements two, five, seven, and ten reflect this theme in a variety of situations.

**Table F-1. Youth Statements with Rankings of Importance and Demonstration**

<b>Focus Statement Response</b>	<b>Importance Ranking</b>	<b>Demonstration Ranking</b>
1. when they look at my eyes and I know that they're listening	8/9	4
2. when someone listens to your suggestions	1	1
3. when people are quiet and listen	8/9	2
4. when people talk to us without cussing	4	
5. when your teacher asks you what you think	5/6	9
6. when people talk calmly when they are mad	2	
7. when people give you choices instead of telling you what to do	10/11	10
8. when people won't hit you to get out of the way	5/6	5/6
9. when people apologize to you when they do something wrong	3	5/6
10. when people make you feel responsible	10/11	3
11. when people provide a service that you need; help others	7	7
12. when they have manners		8
13. when people make you feel good		

In comparing the youth statements and rankings to those of the adult Family members, key consistencies are noted. Most of the youth statements are also reflected within the 20 statements rated most important by adult Family members. Table F-2 notes the specific statements rated highest by adult Family members. It is evident that respect for youth and families is of highest importance for both adult and youth Family participants. Adult statements resembling the youth statements and themes noted above are highlighted in Table F-2. Clearly, youth and family voice in the service process and responsive providers are two of the most important issues for Family participants. Statement #73 is highlighted because it reflects a similar youth theme, but from an opposite perspective. Youth expressed a desire for adults to respond to them without anger, while adults expressed a desire for youth to respond to adults without anger.

Table F-2. Top Twenty Adult Family Member Importance Ratings in Descending Order

#	Statement	Rating
40	there is improvement in meeting goals.	4.64
74	parents learn to listen to their children.	4.62
47	the needs of the family are met.	4.59
24	you see progress with child and family outcomes.	4.57
62		4.57
73	kids learn to express their feelings with words instead of with anger.	4.54
2	families have a voice and choice about what's going on.	4.51
39	everyone is treated equally.	4.49
60	providers care.	4.49
72	children communicate better with parents.	4.46
22	trust is built between providers and families.	4.43
59	providers listen.	4.43
69	providers value family's input.	4.43
44	the line of communication is always open.	4.41
63	providers keep parents informed of their kids' progress.	4.41
66	there is noticeable change in the child/youth.	4.41
52	families are treated with respect.	4.38
53	providers ask families for their input and don't just tell families what to do.	4.38
67	families can tell there is change/growth in themselves.	4.36
56	families are treated equally.	4.35

The youth themes are again reflected in the adult ratings of demonstration. Table F-3 provides a sample of how the adult ratings and youth rankings correspond. The eight statements rated as most demonstrated and the fifteen statements rated least demonstrated by adult Family members are included. Again, statements resembling those from the youth are highlighted. "Providers listen" is rated as highly demonstrated and statements related to voice and choice in services are rated as least demonstrated by both adult and youth participants. The contrasting issues related to expression of anger are rated among the lowest on demonstration by both the adult and youth groups. Indeed, youth did not even rank this theme as being demonstrated.

Table F-3. Selected Adult Family Member Demonstration Ratings in Descending Order

<b>Top 8 Rated Adult Statements</b>		
<b>#</b>	<b>Statement</b>	<b>Rating</b>
62	not only parents are treated with respect, but so are the kids.	4.20
70	providers bond with the children.	4.14
71	providers have good communication with the children.	4.14
52	families are treated with respect.	4.11
74	parents learn to listen to their children.	4.06
12	families feel free to be as open as they want to be about their beliefs.	4.03
59	providers listen.	4.03
60	providers care.	4.03
<b>Bottom 15 Rated Adult Statements</b>		
<b>#</b>	<b>Statement</b>	<b>Rating</b>
73	kids learn to express their feelings with words instead of with anger.	3.52
28	there are a lot of options for services.	3.51
39	everyone is treated equally.	3.49
18	there is a lightness in the provider-family relationship - don't get hung up on political correctness.	3.46
35	providers don't assume families won't understand what's going on with the family/situation.	3.43
54	providers can admit when they are wrong.	3.43
1	families report back that they feel respected.	3.40
14	providers can step back and allow other community members to take a leadership role.	3.38
7	providers don't impose their own beliefs on families.	3.37
8	providers don't impose their own values on families.	3.37
15	there is a lot of diversity within the provider group.	3.36
5	providers allow families to be experts on their own cultures.	3.33
2	families have a voice and choice about what's going on.	3.29
9	providers don't impose their own solutions on families.	3.09

## URB-E

### Focus Groups with Youth Participants

A separate process was conducted with youth to gather information specifically from a youth perspective. The Concept Mapping methodology was not used with the youth group. Instead, the youth participated in a focus group where they generated ideas about cultural competence and then prioritized their ideas. The discussion that occurred with youth was modeled after that used for Brainstorming with the adults. Youth dialogue centered on the meaning of cultural respect and specific ways youth wanted people to work with them and their families. The specific focus statement used with youth to generate their list of ideas was:

*Complete the following statement with specific examples: I know that people working with me and my family respect us when*

After the statements were generated, youth were asked to individually decide which five statements were the most important for them and their families. Then youth were asked to individually decide which five statements the people working with them demonstrated most often. Points were assigned whereby each youth's most important and most demonstrated statements received the most points. The points were totaled and shared back with the youth.

### *Youth Participants*

A total of seven youth participated in the HIFI assessment. Their ages ranged from 14–18 years. The gender of participants included three females and four males. The race/ethnicity of youth participants included three Black/African American youths, three Latino/Latina youths, and one White/European youth.

### *Findings from Youth Assessment*

The youth generated 20 statements to indicate how they believe people working with them show respect of their families' cultures. Clear ideas emerged around what they perceived to be the most important and the most demonstrated of all the ideas. Table F-4 lists the youth statements and the top five rank order on importance and demonstration. Rankings are numbered in ascending order where "1" indicates the highest ranking and "5" indicates the lowest ranking.

**Table F-4. Youth Statements with Rankings of Importance and Demonstration**

<b>Focus Statement Response</b>	<b>Importance Ranking</b>	<b>Demonstration Ranking</b>
1) they listen to me	<b>1</b>	<b>1</b>
2) they say what you want to hear		
3) they make sure that you're in a good environment (referring to probation)		
4) they talk to us like we're adults	<b>2</b>	<b>3</b>
5) they show me the respect that I give to them		<b>4/5</b>
6) by not filling up my system with medication	<b>4</b>	
7) they do not try to force something out of you		
8) they're glad you came to the meeting (e.g., genuinely glad to see you)		
9) they only ask appropriate questions		<b>4/5</b>
10) they don't mess with your mind by using words you don't understand	<b>5</b>	
11) they don't accuse you of things you "might" have done	<b>5</b>	
12) they listen to how I feel	<b>5</b>	
13) they respect your way of life, especially religion		<b>2</b>
14) they ask for my opinion		
15) they truly care about what you say and don't just pretend to care		
16) they respect your financial status (don't set you apart because of income)		
17) they don't take away my allowance		
18) they punish me only when I have done something wrong and reward me when I have done something right		
19) the punishment fits the crime	<b>3</b>	
20) they allow me to get my ears pierced		

Statement two, "they listen to me," was ranked as the most important example of cultural respect as well as the most demonstrated. Statement four " they talk to us like we're adults" was ranked second in importance and third in demonstration. Beyond this comparison the rank order of many examples appears to be inconsistent between importance and demonstration. Statements listed as the next highest in importance did not make the top five on the ranking of demonstration.

Issues related to providers listening and communicating with youth and demonstrating respect of youth and their families are the primary themes that emerged from the group. The statements generated by the youth are also reflected in the ideas brainstormed by the adult participants. In comparing the youth statements and rankings to those of the

adult Family members, some consistencies are noted. Many of the youth statements generated are also reflected within the 20 statements rated most important by adult Family members. Table F-5 notes the specific statements rated highest on importance by adult Family members. Respect for youth and families and, being heard, and care that is appropriately matched to the family's situation is of highest importance for both adult and youth Family participants. Adult statements resembling the youth statements and themes noted above are highlighted.

Table F-5. Top Twenty *Adult* Family Member Importance Ratings in Descending Order

#	Statement	Rating
1	they are individualized.	4.88
23	the family feels comfortable to approach the service provider regarding need for change.	4.88
26	communication is open.	4.88
35	families are respected.	4.88
36	services lead to progress.	4.88
48	families are informed of services and resources that are available.	4.88
24	the family feels comfortable to approach the service provider with questions.	4.75
58	all the agencies working with a family communicates and works toward the same goals.	4.75
59	there is continuity of care as youth transition into adulthood ("age-out").	4.75
61	there is continuity of care for people across developmental stages.	4.75
56	families are satisfied with outcomes.	4.71
2	the families feel understood.	4.63
4	families' specific needs are met.	4.63
12	family strengths are highlighted and utilized.	4.63
14	they enhance family life.	4.63
34	the families feel the community providers work together.	4.63
42	services are child-centered.	4.63
46	services include everyone with mental illness and their families.	4.63
49	accurate and relevant information about services is given to families.	4.63
75	families and providers are able to develop relationships that foster mutual trust and respect.	4.63
78	care is appropriate.	4.63

The youth themes are again reflected in the adult Family ratings of demonstration. Table F-6 provides a sample of how the adult ratings and youth rankings correspond. The top 19 statements rated most demonstrated by adult Family members are included. Again, statements resembling those from the youth are highlighted. In general, youth and adult Family statements that are related to being heard and respected are also noted by both groups as most often demonstrated.

Table F-6. Selected Adult Family Member Demonstration Ratings in Descending Order

<b>Top 19 Rated Adult Family Statements - Demonstration</b>		
<b>#</b>	<b>Statement</b>	<b>Rating</b>
19	the values of the provider are not projected on the family.	4.50
	communication is open.	4.43
20	the language is in that of the family.	4.25
24	the family feels comfortable to approach the service provider with questions.	4.25
1	they are individualized.	4.13
5	families' opinions are recognized.	4.13
15	services are targeted to more than one cultural group.	4.00
21	the communication is in the terminology of the family	4.00
23	the family feels comfortable to approach the service provider regarding need for change.	4.00
25	the family is able to reject services without judgment from the provider.	4.00
71	services and supports are strengths-based	4.00
72	the service provider takes the time to know about the person with whom they are interacting.	4.00
35	families are respected.	3.88
37	services are developmentally appropriate.	3.88
40	services are provided without provider making assumptions about family.	3.88
42	services are child-centered.	3.88
68	service providers and families work as a team.	3.88
77	people can laugh together.	3.88
78	care is appropriate.	3.88

## RUR-E

### Focus Groups with Youth Participants

A separate process was conducted with youth to gather information specifically from a youth perspective. The Concept Mapping methodology was not used with the youth group. Instead, the youth participated in a focus group to generate ideas about cultural competence and then prioritized the ideas they generated. The discussion with youth was modeled after that used for brainstorming with the adults. Youth dialogue centered on the meaning of cultural respect and specific ways youth want people to work with them and their families. The specific focus statement used with youth to generate their list of ideas was:

*Complete the following statement with specific examples: I know that people working with me and my family are culturally competent when ..*

After the statements were generated, youth were asked to individually decide which statements were the most important for them and their families. Points were assigned whereby each youth's most important statements received the most points. The points were totaled and shared back with the youth.

### *Youth Participants*

A total of six youth participated in the TCIFI assessment. Their ages ranged from 13–16 years. The gender of participants included one female and five males. The race/ethnicity of youth participants included one Mexican American youth and five White/European youth.

### *Findings from Youth Assessment*

The youth generated 11 statements to indicate how they believe people working with them should show cultural competence to their families. Clear ideas emerged around what they perceived to be the most important of all the ideas. Table F-7 lists the statements and the top five rank order on importance. Rankings are numbered in ascending order where "1" indicates the highest ranking and "5" indicates the lowest ranking.

**Table F-7. Youth Statements with Rankings of Importance**

Focus Statement Response	Importance Ranking
21) they're nice to us	1
22) they're helping us	4
23) they're listening	2
24) they're helping our elders	3
25) they provide employment or other services	5
26) they help you treat others nice	5
27) you're cured	11
28) you're making better grades	5
29) you don't automatically get put in jail	5
30) you don't automatically go to boot camp or probation	10
31) you don't automatically get sent to a mental hospital	5

Statement one, "they're nice to us," ranked as the most important example of cultural respect. Statement three " they're listening" ranked second in importance. Statement four "they're helping our elders" ranked third in importance. The themes that surfaced most often in the group's discussion were related to service resources, out-of-home care, and youth not feeling heard. Youth expressed a specific need for their families to gain access to resources. They felt that the service systems were too willing to remove youth from their homes and place them in facilities like detention centers, boot camps and psychiatric hospitals without first considering other alternatives. Finally, the youth felt the adults in their lives do not listen to them. When youth were asked to decide which statements the people working with them demonstrated most often, youth were unclear about who was specifically working with their families. Collectively the youth expressed feelings that none of the agencies working with them consistently demonstrated the activities listed in their brainstormed list.

The statements generated by the youth are also reflected in the ideas brainstormed by the adult participants. In comparing the youth statements and rankings to those of the adult Family members, consistencies are noted. Many of the youth statements generated are also reflected within the 18 statements rated most important by adult Family members. Table F-8 notes the specific statements rated highest on importance by adult Family members contrasted to adult Family member average demonstration ratings. The importance ratings for Family participants ranged from 2.22 to 4.90 across all 65 statements. The demonstration ratings for Family participants ranged from 1.33 to 3.60 across all 65 statements.

The adult statements resembling the youth statements and themes noted above are highlighted. Several of the adult statements relate to families' access to services and alternative supports, and the discrepancies in ratings for these statements are notable. Statement #22 echoes the youth statement reflecting the importance of families being heard. Finally, the adult statement related to satisfaction with services (#1) is related to youth statements about how they feel treated by providers.

Table F-8. Eighteen Statements Rated Most Important by Adult Family Members Compared to Family Member Demonstration Ratings

#	Statement	Importance Rating	Demonstration Rating
62	the educational needs of all children are met and supported.	4.90	2.20
40	services are available for families even when they don't have financial resources.	4.80	3.30
41	services are advertised and families know about them.	4.80	1.80
14	families are consistent in following through with services.	4.78	3.40
22	families feel listened to and heard.	4.70	3.00
42	there is assistance to families to cut the red tape to access services.	4.70	2.40
63	agencies pull their resources and information together to serve families.	4.70	2.00
65	children are allowed to be children.	4.70	2.70
1	families are satisfied with the service.	4.60	3.10
21	families don't feel labeled.	4.60	3.60
49	the government develops funding structures that meet the needs of all communities.	4.60	1.78
6	providers do what they actually say they are going to do.	4.50	2.30
26	families do not feel their lack of money will limit the services they can receive.	4.50	3.30
37	families have alternatives for services/treatment/interventions.	4.50	2.50
38	people respect the individual as a person.	4.50	3.10
50	families in communities are willing to get involved in advocating for changes in government policies.	4.50	2.80
59	parents receive support for the challenges that come in their jobs due to the special needs of a family member.	4.50	1.78
39	all of the families' needs have been met.	4.44	2.70

## APPENDIX G

### URB-N

#### Statements by Cluster with Average Ratings

		Average Rating		
		Importance	Demonstration	Policy
<b>Cluster 1: Respect &amp; Dignity of Client &amp; Family</b>		<b>4.58</b>	<b>3.21</b>	<b>2.47</b>
1	they are strength-based, family-driven.	4.68	3.23	2.29
4	all families feel comfortable accessing care.	4.59	2.86	2.21
13	families' and clients' rights and ideas are respected.	4.68	3.67	2.73
14	there is mutual respect between families and the system.	4.45	3.24	2.40
15	the dignity of the family is respected.	4.82	3.68	2.73
21	it is not embarrassing for children and families to receive services.	4.23	3.29	2.20
27	services and programs are offered at family-friendly times.	4.40	2.57	2.00
29	family differences are valued.	4.32	3.18	2.67
49	services are accessible regardless of families' financial resources.	4.86	2.90	2.53
51	services to families are nonjudgmental and affirming.	4.64	3.36	2.60
56	families don't need to have power, pull, or education to get services.	4.55	3.10	2.67
60	the majority of those served feel they are respected.	4.68	3.45	2.64
		<b>Average Rating</b>		
		Importance	Demonstration	Policy
<b>Cluster 2: Family-Driven Service Delivery System</b>		<b>4.37</b>	<b>3.18</b>	<b>2.23</b>
3	they understand what's important to me.	4.27	3.09	2.07
5	they are inclusive of all persons.	4.82	3.19	2.40
6	parents are kept informed of their child's treatment.	4.36	3.67	2.71
9	animosity is not present.	4.27	3.00	1.69
24	kids are happy with themselves.	4.59	2.91	1.64
30	the elderly are valued.	4.45	2.76	2.21
36	the system and provider do not impose their personal values on families.	4.50	3.57	2.43
39	client self-help is encouraged and supported.	4.43	3.41	2.67
50	when professionals respect parents' choices.	4.23	3.57	2.67
52	family advocate doesn't receive calls saying family can't get anywhere with services.	3.82	2.67	1.77
		<b>Average Rating</b>		
		Importance	Demonstration	Policy
<b>Cluster 3: Quality Assurance of System of Care Reform</b>		<b>4.05</b>	<b>2.99</b>	<b>2.04</b>
12	people get better.	4.91	3.35	2.43
20	children start to take responsibility for their own healthcare.	3.19	2.29	1.64
22	motivation is encouraged rather than isolating people.	4.05	3.25	2.36
37	self-presentation of service providers is credible to the family.	4.05	3.32	2.42

46	employers are more supportive in job/employment opportunities for adult individuals needing a less stressful work environment.	3.71	2.19	1.42
55	plans are put in writing so everyone can be accountable.	4.32	3.40	2.47
57	the person who is giving the services accepts the help of a family advocate.	3.95	3.25	2.17
64	person don't insult one another in an effort to be polite.	3.65	2.89	2.00
66	families don't prematurely give up on the provider.	4.18	2.90	1.62
67	there are not an over-representation of children in alternative education.	3.86	2.29	1.38
79	consumers are not submitted to abusive workers (verbal abuse, physical management, environmental constraints).	4.73	3.75	2.54

		<b>Average Rating</b>		
<b>Cluster 4: Characteristics of Effective Agencies</b>		<b>Importance</b>	<b>Demonstration</b>	<b>Policy</b>
		<b>3.98</b>	<b>2.83</b>	<b>1.97</b>
2	benefits stated are actually provided.	4.59	3.36	2.43
7	the ratios of different ethnic groups among the families and staff reflect the ratios of these groups in the community.	3.30	2.81	1.80
16	the same level of service is available to everyone.	4.64	2.82	2.20
19	the system has the flexibility to provide unique/non-traditional services to families.	4.09	2.55	1.80
25	staff look like the people they are working with (language, race, ethnicity, etc.).	3.18	2.95	1.86
26	the demographics of those served reflect the community's population.	3.43	2.82	1.93
33	crisis situations are immediately dealt with.	4.73	3.27	2.43
43	individual staff providing services achieve a level of cultural competence.	4.18	3.18	2.00
48	we practice what we preach about individual and community acceptance.	3.45	2.52	1.77
68	there are no more waiting lists.	4.59	1.90	1.75
71	staffing ratios represent ethnic composition of clientele served.	3.55	2.90	1.69

		<b>Average Rating</b>		
<b>Cluster 5: Responsive Resource Allocation Policies</b>		<b>Importance</b>	<b>Demonstration</b>	<b>Policy</b>
		<b>4.27</b>	<b>2.36</b>	<b>1.57</b>
10	legislators understand the programs they are funding.	4.32	2.24	1.50
11	public policy permits flexibility.	4.23	2.24	1.64
40	legislators are sensitive to the needs of families.	4.32	2.27	1.50
70	our legislators realize that more money is needed to be spent on services.	4.64	2.50	1.79
73	representatives are elected by enlightened citizens and voters.	3.86	2.37	1.33
77	there is proper allocation of money for evidenced-based services.	4.29	2.52	1.69

		<b>Average Rating</b>		
		<b>Importance</b>	<b>Demonstration</b>	<b>Policy</b>
<b>Cluster 6: Changes in System Services with Needs of Consumers</b>		<b>3.82</b>	<b>2.62</b>	<b>1.82</b>
17	the agency has a good reputation across neighborhoods.	4.00	3.23	2.20
31	services and systems are non-competitive.	3.77	2.59	1.69
34	there are systems in place that help us look at broad changes in the provision of services.	3.48	2.77	2.00
35	there are checks and balances in service provision.	3.76	2.95	1.85
38	training is provided to help the system understand the cultures of the community.	3.77	2.86	2.00
41	all decision-making bodies reflect the community.	3.55	2.09	1.67
42	all decision-making bodies are sensitive to the needs of the community.	4.32	2.45	1.92
44	relationships and history of ethnic groups in [this] County are understood.	3.32	2.38	1.40
45	relationships and history of agencies in [this] County are understood.	3.09	2.33	1.67
63	when services to families don't change just because the political party changes.	4.14	2.85	1.83
69	services are available for mental health/mental retardation dual diagnoses needs.	4.64	2.76	2.00
75	the society in which we live changes its value system to prioritize the health of its citizens.	4.05	2.15	1.67
		<b>Average Rating</b>		
		<b>Importance</b>	<b>Demonstration</b>	<b>Policy</b>
<b>Cluster 7: Cultural Competence: Staff &amp; Training</b>		<b>3.92</b>	<b>2.82</b>	<b>2.12</b>
32	organizations insist on providing cultural competence training at least annually at all levels.	3.64	2.71	2.17
59	you don't hear professionals make remarks based on ethnic origins.	4.73	3.64	2.79
61	individual staff make efforts to educate themselves about countries and religions of people different from them.	3.91	2.52	2.00
62	educational opportunities about cultural diversity are made available to staff.	4.09	2.95	2.14
72	staff are hired who have experienced mental health illnesses.	3.23	2.26	1.50
		<b>Average Rating</b>		
		<b>Importance</b>	<b>Demonstration</b>	<b>Policy</b>
<b>Cluster 8: Local Service Policy Implications</b>		<b>3.95</b>	<b>2.71</b>	<b>1.82</b>
8	practitioners can actually impact changes in the system of care.	3.67	2.95	1.85
18	all the agencies work together.	4.27	2.77	1.73
23	human service organizations combine resources and efforts to meet the needs of the community.	4.32	2.86	2.08
28	services change with the changing needs of the community.	4.23	2.82	2.20
47	law enforcement officials are better trained about how to respond to crises for children with mental health disabilities.	4.23	2.71	1.71

53	each provider knows what the other providers are doing with a specific family.	3.95	2.67	1.54
54	a professional is relieved of their duties when not following the ARD.	3.35	2.44	1.50
58	educational institutions know their communities and can teach students methods of referral.	3.68	2.43	1.46
65	continuing education involves families and professionals.	3.95	2.52	1.86
74	professional and direct care staff receive equitable pay.	3.95	2.45	1.75
76	agency policies allow employees to have case-related grief time.	3.38	2.57	1.82
78	workers are given rapid due process for accusations made by consumers.	3.95	3.24	2.18
80	educational system is prepared to be positive participants.	4.36	2.79	2.00

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**RUR-W**  
**Statements by Cluster with Average Ratings**

		Average Rating		
		Importance	Demonstration	Policy
<b>Cluster 1: Families as Partners</b>		<b>4.18</b>	<b>3.63</b>	<b>2.18</b>
1	families report back that they feel respected.	4.26	3.46	1.94
2	families have a voice and choice about what's going on.	4.63	3.40	2.47
12	families feel free to be as open as they want to be about their beliefs.	4.09	3.70	2.40
13	families know the providers care.	4.35	3.67	2.43
16	families are happy to see providers.	3.60	3.57	1.80
19	families are active in all aspects of services.	4.15	3.46	2.44
20	families think of providers as helpful rather than a hindrance.	4.13	3.71	1.87
23	families are not in denial of the need for services.	4.13	3.51	1.57
26	families are willing to allow providers to educate them about the provider agency.	3.89	3.56	1.71
31	families feel comfortable calling on providers for help, not just because they are calling out of desperation.	3.87	3.65	2.07
43	you get a response when making a request.	4.23	3.62	2.00
50	the family's problem is addressed with specifics.	4.20	3.63	2.24
51	I know I am part of the team.	4.19	3.63	2.40
52	families are treated with respect.	4.54	4.12	2.65
56	families are treated equally.	4.44	3.73	2.71
		Average Rating		
		Importance	Demonstration	Policy
<b>Cluster 2: Good Service Practices</b>		<b>4.22</b>	<b>3.70</b>	<b>2.27</b>
3	family programs fit the scheduling needs of the family.	4.33	3.65	2.44
10	service provision is a two-way street of understanding between provider and families.	4.26	3.60	2.13
18	there is a lightness in the provider-family relationship - don't get hung up on political correctness.	3.58	3.33	1.67
27	there is easy accessibility for families to providers.	4.09	3.80	2.56
38	everyone is on the same page.	4.09	3.49	2.07
39	everyone is treated equally.	4.52	3.62	2.35
44	the line of communication is always open.	4.44	3.79	2.31
45	all avenues are covered in order to help.	4.15	3.71	2.13
46	appointments are kept on time.	4.13	3.81	2.24
62	not only parents are treated with respect, but so are the kids.	4.63	4.22	2.81
		Average Rating		
		Importance	Demonstration	Policy
<b>Cluster 3: Positive Measurable Progress</b>		<b>4.48</b>	<b>3.68</b>	<b>2.27</b>
24	you see progress with child and family outcomes.	4.56	3.82	2.47
40	there is improvement in meeting goals.	4.60	3.94	2.47
47	the needs of the family are met.	4.63	3.71	2.28
65	there are ways to measure achievement.	4.09	3.75	2.69

66	there is noticeable change in the child/youth.	4.39	3.62	2.25
67	families can tell there is change/growth in themselves.	4.38	3.69	2.13
72	children communicate better with parents.	4.46	3.39	1.92
73	kids learn to express their feelings with words instead of with anger.	4.57	3.43	2.21
74	parents learn to listen to their children.	4.61	3.76	2.00

**Average Rating**

		<b>Importance</b>	<b>Demonstration</b>	<b>Policy</b>
<b>Cluster 4: Culturally Responsive Services</b>		<b>3.75</b>	<b>3.51</b>	<b>2.29</b>

11	there is inter-agency cultural understanding.	3.61	3.42	2.00
15	there is a lot of diversity within the provider group.	3.38	3.30	2.29
28	there are a lot of options for services.	3.98	3.35	2.25
29	there are a lot of options for service providers.	3.89	3.35	2.13
30	services are provided in different languages.	3.78	3.75	2.29
37	employees are representative of the population.	3.39	3.54	1.94
57	there are fair and impartial grievance procedures.	4.04	3.72	2.75
58	grievance procedures are explained about how they work.	3.91	3.66	2.69

**Average Rating**

		<b>Importance</b>	<b>Demonstration</b>	<b>Policy</b>
<b>Cluster 5: Positive Inter-Agency Interaction</b>		<b>4.01</b>	<b>3.60</b>	<b>2.14</b>

4	providers are educated to cultural differences.	4.06	3.33	1.82
14	providers can step back and allow other community members to take a leadership role.	3.62	3.29	2.00
34	providers acknowledge when they are not able to/should not empathize, but need to just sympathize.	3.62	3.63	1.62
48	providers don't pass the buck from one organization to another.	4.19	3.63	2.07
55	providers can look for an answer if they don't know it.	4.17	3.78	2.57
61	providers make every effort to find someone who can handle problems they can't handle themselves.	4.39	3.82	2.47
75	providers use a multi-disciplinary approach.	4.02	3.71	2.43

**Average Rating**

		<b>Importance</b>	<b>Demonstration</b>	<b>Policy</b>
<b>Cluster 6: Responsive to Family Uniqueness</b>		<b>4.11</b>	<b>3.65</b>	<b>2.13</b>

5	providers allow families to be experts on their own cultures.	3.96	3.36	1.82
6	providers are willing to ask questions to learn about families' cultures.	4.07	3.49	1.75
7	providers don't impose their own beliefs on families.	3.96	3.41	2.12
8	providers don't impose their own values on families.	4.04	3.44	2.18
9	providers don't impose their own solutions on families.	3.79	3.14	2.18
25	providers are willing to do more than what their job description says.	4.09	3.94	2.06
32	providers are able to empathize with families - walk a mile in families' shoes.	3.74	3.60	1.80
33	providers refer to families as people instead of just cases.	4.21	3.75	2.13
35	providers don't assume families won't understand what's going on with the family/situation.	3.81	3.48	1.73
36	providers explain things in terms families can understand.	4.31	3.92	2.41

42	providers take time to get to know the people they are servicing.	4.24	3.87	2.13
54	providers can admit when they are wrong.	4.15	3.52	2.27
59	providers listen.	4.50	3.94	2.56
60	providers care.	4.48	4.04	2.44
68	providers work with the entire family rather than only the child.	4.20	3.73	2.33
76	providers don't look down on caregivers because they don't have the same level of education or knowledge.	4.19	3.69	2.19

		<b>Average Rating</b>		
		<b>Importance</b>	<b>Demonstration</b>	<b>Policy</b>
<b>Cluster 7: Provider-Family Respect/Rapport</b>		<b>4.22</b>	<b>3.81</b>	<b>2.32</b>
17	providers and families are able to use humor in their relationships.	3.48	3.52	1.53
21	providers are able to build strong rapport with families.	4.19	3.65	2.31
22	trust is built between providers and families.	4.48	3.71	2.25
41	providers are able to look at the true issues of the family.	4.30	3.73	2.13
49	providers are supportive of family needs.	4.28	3.82	2.35
53	providers ask families for their input and don't just tell families what to do.	4.48	3.81	2.59
63	providers keep parents informed of their kids' progress.	4.43	3.86	2.81
64	providers provide families with specific information about their kids.	4.20	3.82	2.50
69	providers value family's input.	4.48	3.92	2.50
70	providers bond with the children.	3.91	4.02	2.07
71	providers have good communication with the children.	4.19	4.10	2.53

**URB-E**  
**Statements by Cluster with Average Ratings**

		<b>Average Rating</b>		
		<b>Importance</b>	<b>Demonstration</b>	<b>Policy</b>
<b>Cluster 1: Family-Focused Services</b>		<b>4.39</b>	<b>3.63</b>	<b>2.34</b>
1	they are individualized.	4.73	3.88	2.56
3	the families help plan the services.	4.27	3.58	2.47
4	families' specific needs are met.	4.65	3.54	2.50
12	family strengths are highlighted and utilized.	4.62	3.46	2.33
14	they enhance family life.	4.50	3.69	2.56
17	they are family-driven (family makes the decisions).	3.85	3.31	2.00
20	the language is in that of the family.	4.35	3.88	2.12
21	the communication is in the terminology of the family.	4.19	3.73	2.18
		<b>Average Rating</b>		
		<b>Importance</b>	<b>Demonstration</b>	<b>Policy</b>
<b>Cluster 2: Empowering &amp; Respecting Families</b>		<b>4.19</b>	<b>3.56</b>	<b>2.34</b>
2	the families feel understood.	4.46	3.62	2.24
5	families' opinions are recognized.	4.46	3.77	2.44
6	families' opinions are acted upon.	3.92	3.46	2.25
7	families' opinions are honored.	4.24	3.42	2.44
10	families are able to maintain their dignity while receiving services.	4.46	3.81	2.75
11	family voice and choice are prioritized.	4.08	3.31	2.31
16	the existing culture of the family is preserved.	4.08	3.73	2.25
27	families walk away feeling empowered by their culture.	3.69	3.12	1.75
28	everyone in the family has a voice.	3.96	3.42	2.18
32	the family recommends the services they receive to someone else.	3.73	3.27	2.07
33	the families feel cared about.	4.54	3.73	2.65
35	families are respected.	4.77	3.96	2.63
45	families are empowered by and accepting of the strengths and differences of their culture (independent of the service provider).	3.69	3.32	2.29
50	families are given the time and consideration their situation deserves.	4.46	3.85	2.50
51	families' time is respected.	4.12	3.69	2.35
56	families are satisfied with outcomes.	4.42	3.46	2.33
		<b>Average Rating</b>		
		<b>Importance</b>	<b>Demonstration</b>	<b>Policy</b>
<b>Cluster 3: Developing Positive/Trusting Relationships</b>		<b>4.17</b>	<b>3.69</b>	<b>2.22</b>
19	the values of the provider are not projected on the family.	3.92	3.96	2.39
26	communication is open.	4.77	3.96	2.56
55	families and service providers don't stereotype or make assumptions about the other.	4.25	3.38	2.00
62	there is mutual understanding between families and service providers.	4.15	3.65	2.60
67	individuals are empathic.	4.25	3.72	2.25

70	people are willing to share their cultures with each other.	3.62	3.42	1.71
75	families and providers are able to develop relationships that foster mutual trust and respect.	4.38	3.73	2.38
77	people can laugh together.	4.19	3.68	1.87

**Average Rating**

<b>Cluster 4: Family/Provider Partnerships</b>	<b>Importance</b>	<b>Demonstration</b>	<b>Policy</b>
	<b>3.93</b>	<b>3.47</b>	<b>2.24</b>

23	the family feels comfortable to approach the service provider regarding need for change.	4.56	3.77	2.47
24	the family feels comfortable to approach the service provider with questions.	4.62	3.92	2.71
25	the family is able to reject services without judgment from the provider.	4.27	3.73	2.35
31	the provider is "invited back to dinner" (when trust is developed).	2.54	2.62	1.56
34	the families feel the community providers work together.	4.04	3.31	2.27
47	everyone feels equal in the service process.	4.00	3.65	2.33
54	families are nonjudgmental of service providers.	3.48	3.31	2.00

**Average Rating**

<b>Cluster 5: Individualized Services</b>	<b>Importance</b>	<b>Demonstration</b>	<b>Policy</b>
	<b>4.31</b>	<b>3.70</b>	<b>2.54</b>

8	not everyone is offered the exact same services in the exact same way.	3.96	3.62	2.59
9	flexibility is built into the program to address a variety of needs.	4.27	3.46	2.59
43	there is equal opportunity for services for all individuals.	4.38	3.65	2.71
46	services include everyone with mental illness and their families.	4.12	3.54	2.35
71	services and supports are strengths-based.	4.27	3.81	2.47
78	care is appropriate.	4.69	4.04	2.63
79	there is a culturally appropriate way to meet the needs of culturally and racially diverse groups.	4.12	3.54	2.25
81	services are ensured for families without regard to race, culture or ethnicity.	4.69	3.96	2.75

**Average Rating**

<b>Cluster 6: Characteristics of Quality Services</b>	<b>Importance</b>	<b>Demonstration</b>	<b>Policy</b>
	<b>4.09</b>	<b>3.62</b>	<b>2.37</b>

13	some culturally-based services are provided.	3.69	3.31	2.33
15	services are targeted to more than one cultural group.	4.04	4.04	2.76
18	they are economically sensitive.	4.19	3.73	2.35
29	services lack technical jargon.	3.76	3.62	2.31
30	services are within the neighborhood.	3.85	3.27	2.06
36	services lead to progress.	4.73	3.62	2.41
37	services are developmentally appropriate.	4.38	3.81	2.61
39	services are non-judgmental.	4.12	3.80	2.44
40	services are provided without provider making assumptions about family.	3.96	3.62	2.35
41	needs-based services are provided.	4.58	3.92	2.50
42	services are child-centered.	4.27	4.12	2.56

44	services are not diagnosis driven.	3.85	3.35	2.18
64	services are easily accessible and convenient.	4.04	3.24	2.17
65	services are provided close to families' homes.	3.58	3.12	1.93
76	services are personalized.	4.38	3.73	2.53
		<b>Average Rating</b>		
<b>Cluster 7: Continuity of Care</b>		<b>Importance</b>	<b>Demonstration</b>	<b>Policy</b>
		<b>4.25</b>	<b>3.36</b>	<b>2.22</b>
22	they are multi-disciplinary.	3.77	3.69	2.31
57	one agency shouldn't be responsible for everything.	3.77	3.31	2.20
58	all the agencies working with a family communicates and works toward the same goals.	4.56	3.31	2.06
59	there is continuity of care as youth transition into adulthood ("age-out").	4.58	3.12	2.19
60	there is a continuum of services.	4.54	3.31	2.22
61	there is continuity of care for people across developmental stages.	4.54	3.58	2.27
63	there is coordination among service providers and families.	4.15	3.64	2.50
66	issues of confidentiality do not become a barrier to obtaining or accessing services.	4.31	3.38	2.27
73	information follows families from one provider to another so families don't have to start from scratch.	4.27	2.88	1.86
74	there is consistency in who provides services to families.	4.00	3.35	2.33
		<b>Average Rating</b>		
<b>Cluster 8: The Role of the Service Provider</b>		<b>Importance</b>	<b>Demonstration</b>	<b>Policy</b>
		<b>4.19</b>	<b>3.62</b>	<b>2.37</b>
38	the provider goes out of her/his means to help the family.	3.69	3.35	2.12
48	families are informed of services and resources that are available.	4.73	3.88	2.83
49	accurate and relevant information about services is given to families.	4.62	3.85	2.72
52	needs are identified and met within families' own communities.	3.85	3.19	2.18
53	service providers are nonjudgmental.	4.40	3.81	2.65
68	service providers and families work as a team.	4.38	3.69	2.41
69	someone who is objective can intervene on behalf of families.	3.60	3.36	2.06
72	the service provider takes the time to know about the person with whom they are interacting.	4.42	3.88	2.29
80	providers, policy-makers and administrators of public and private child-serving agencies are helpful.	4.12	3.68	2.06
82	there is productive cross-cultural intervention.	4.08	3.56	2.33

**RUR-E**  
**Statements by Cluster with Average Ratings**

		<b>Average Rating</b>		
		<b>Importance</b>	<b>Demonstration</b>	<b>Policy</b>
<b>Cluster 1: Family Follow-Through &amp; Empowerment</b>		<b>3.83</b>	<b>2.86</b>	<b>1.82</b>
1	families are satisfied with the service.	4.33	3.04	1.91
13	families know there is consistency in services being provided over the long haul.	4.14	2.61	1.91
17	families are invested in the process because they know they have something to gain.	3.74	3.13	1.75
18	families are able to help themselves.	3.58	3.00	1.90
36	families are in charge of their own services (when working with providers).	3.38	2.52	1.64
		<b>Average Rating</b>		
		<b>Importance</b>	<b>Demonstration</b>	<b>Policy</b>
<b>Cluster 2: Mutual Trust &amp; Respect</b>		<b>4.24</b>	<b>2.96</b>	<b>1.73</b>
2	families feel they are treated with dignity and respect.	4.38	3.48	2.33
11	families trust the providers.	4.13	2.74	1.27
12	families feel comfortable seeking services.	3.96	2.78	1.58
20	families don't feel stigma associated with receiving services.	4.13	2.83	1.50
21	families don't feel labeled.	4.29	3.17	1.73
22	families feel listened to and heard.	4.65	3.04	2.00
39	all of the families' needs have been met.	4.13	2.65	1.70
		<b>Average Rating</b>		
		<b>Importance</b>	<b>Demonstration</b>	<b>Policy</b>
<b>Cluster 3: Meeting Individual Family Needs</b>		<b>3.97</b>	<b>2.87</b>	<b>1.85</b>
16	the families don't say, "Yes, but..." (provider hasn't hit on what family is wanting).	3.39	2.70	1.20
19	families are offered and they accept new tools for solving their own problems.	4.00	2.87	2.00
38	people respect the individual as a person.	4.29	3.48	2.46
47	families are able to communicate in their own language.	4.13	3.04	1.91
57	there is a support system for single parents and families who feel isolated.	4.04	2.27	1.70
		<b>Average Rating</b>		
		<b>Importance</b>	<b>Demonstration</b>	<b>Policy</b>
<b>Cluster 4: Family Barriers</b>		<b>4.04</b>	<b>2.70</b>	<b>1.80</b>
14	families are consistent in following through with services.	4.35	3.04	1.58
26	families do not feel their lack of money will limit the services they can receive.	4.13	2.96	2.09
32	families can access the services with no barriers (transportation, language, education, cost).	4.33	2.57	1.75
35	families can find their own resources.	3.38	2.70	1.83
37	families have alternatives for services/treatment/interventions.	3.92	2.87	2.27

46	families communicate with different families to support and educate one another about services available.	3.83	2.78	1.70
50	families in communities are willing to get involved in advocating for changes in government policies.	4.29	2.43	1.56
59	parents receive support for the challenges that come in their jobs due to the special needs of a family member.	4.13	2.27	1.60

		<b>Average Rating</b>		
		<b>Importance</b>	<b>Demonstration</b>	<b>Policy</b>
<b>Cluster 5: Children's Rights</b>		<b>4.15</b>	<b>2.83</b>	<b>1.96</b>
52	children have a voice in what services they receive.	3.63	2.59	1.44
53	there is two-way respectful communication between children and agency providers.	4.25	3.00	2.08
62	the educational needs of all children are met and supported.	4.54	2.65	2.23
65	children are allowed to be children.	4.17	3.09	2.08

		<b>Average Rating</b>		
		<b>Importance</b>	<b>Demonstration</b>	<b>Policy</b>
<b>Cluster 6: Providers Embrace Family Culture</b>		<b>3.91</b>	<b>2.77</b>	<b>1.95</b>
3	providers draw on the resources that families currently have.	3.46	3.04	1.92
4	providers draw on families' existing strengths.	4.29	2.91	2.00
5	providers truly support and value the individual cultures of the families.	3.92	2.73	2.18
6	providers do what they actually say they are going to do.	4.42	2.78	2.00
7	providers seek to understand and inform themselves of knowledge about the cultures of families with whom they are interacting.	3.74	2.57	1.70
8	providers can admit they do not have the level of understanding necessary for working with a family.	4.00	2.17	1.44
9	providers are open to letting families educate them about the family's culture.	3.70	2.65	1.80
10	providers educate families about the organizations' cultures and mandates.	3.22	2.74	2.20
15	providers demonstrate caring of families.	4.00	3.17	2.00
23	providers ask families about their culture.	3.25	2.13	1.50
24	providers are not judgmental of families' culture.	4.33	3.05	2.18
25	providers meet families where they are.	3.83	2.78	1.75
27	providers and agencies use family-friendly language.	3.92	3.48	2.25
29	providers think outside the box and extend themselves in serving/advocating for families.	4.29	2.65	1.90
54	providers can consider the whole person (spiritual, physical, financial, mental, family unit).	3.96	2.83	2.00
55	providers include the entire family structure in services.	4.25	2.65	2.33

		<b>Average Rating</b>		
		<b>Importance</b>	<b>Demonstration</b>	<b>Policy</b>
<b>Cluster 7: To Prevent Cultural Barriers</b>		<b>3.73</b>	<b>2.69</b>	<b>1.94</b>
28	agencies/systems reflect ("look like") the cultures in their community.	2.91	2.74	1.64
33	forms/documents are translated into the cultural language of families.	4.22	3.14	2.08

45	agency literature is printed in everyone's languages.	3.67	2.82	1.91
56	services offer opportunities to other members of the family, especially the other children.	4.08	2.43	1.92
58	agencies provide opportunities for families to share information with one another.	3.63	2.52	2.11
61	services meet the needs of the whole community (church, schools, families, work, employers, friends, etc.).	3.88	2.50	2.00

		<b>Average Rating</b>		
		<b>Importance</b>	<b>Demonstration</b>	<b>Policy</b>
<b>Cluster 8: Service Accessibility</b>		<b>4.14</b>	<b>2.51</b>	<b>1.94</b>
40	agencies pull their resources and information together to serve families.	4.71	3.30	2.38
41	the government develops funding structures that meet the needs of all communities.	4.04	2.22	2.00
42	county agencies work together to meet the needs of families.	4.50	2.52	1.70
51	policy-makers (legislative and agency) change policies to allow providers to do what they need to do for families.	3.67	2.23	1.71
60	agencies cut down on the amount of red tape families and providers have to go through for services.	4.00	1.82	1.50
64	agency/policy-makers support direct workers' efforts to move beyond "traditional" ways to implement services.	3.92	3.00	2.36

		<b>Average Rating</b>		
		<b>Importance</b>	<b>Demonstration</b>	<b>Policy</b>
<b>Cluster 9: Enhancing Policy to Facilitate Collaboration</b>		<b>4.28</b>	<b>2.48</b>	<b>1.84</b>
30	agency/policy-makers support direct workers' efforts to move beyond "traditional" ways to implement services.	4.21	2.74	2.00
31	policy-makers (legislative and agency) change policies to allow providers to do what they need to do for families.	4.42	2.36	1.56
34	agencies cut down on the amount of red tape families and providers have to go through for services.	4.29	2.35	1.45
43	county agencies work together to meet the needs of families.	4.46	2.77	2.08
44	agencies work together to help families transition from one county to another.	3.67	2.32	1.78
48	agencies have a resource where families can look up what services and family resources are available.	4.13	2.65	2.23
49	the government develops funding structures that meet the needs of all communities.	4.50	1.95	1.60
63	agencies pull their resources and information together to serve families.	4.54	2.65	2.00

**Aggregate Study**  
**Statements by Cluster with Average Ratings**

		Average Rating		
		Importance	Demonstration	Policy
<b>Cluster 1: Service Provider Competencies</b>		<b>3.79</b>	<b>3.35</b>	<b>2.24</b>
1	providers take the time to get to know and build rapport with the children and families they are serving.	4.44	3.70	2.28
11	the service provider welcomes the involvement of an objective family advocate.	3.38	3.14	2.29
69	providers don't assume families won't understand what's going on with the family/situation.	3.82	3.30	2.12
81	service providers know when to offer empathetic and/or sympathetic support to families.	3.58	3.41	2.27
91	services are child-centered and allow children to have a voice in what services they receive.	3.58	3.32	2.12
93	providers work with and provide services to the entire family rather than only the identified child.	4.00	3.11	2.38
96	service providers don't impose their own values and beliefs on families.	4.00	3.39	2.27
100	providers are willing to ask questions and allow families to be experts on their own cultures.	3.51	3.43	2.24

		Average Rating		
		Importance	Demonstration	Policy
<b>Cluster 2: Family-Centered Services</b>		<b>3.87</b>	<b>3.36</b>	<b>2.21</b>
8	the services provided are based on the specific needs of families.	4.27	3.65	2.33
73	the roles of each person involved in services are clear (parent, counselor, child).	4.02	3.41	2.35
79	service providers truly understand what's important to families.	3.98	3.36	2.06
85	services and programs meet the scheduling needs of the family.	3.96	3.36	2.29
98	services to families are nonjudgmental and affirming of families' cultures and backgrounds.	3.67	3.45	2.12
10 5	service provision involves mutual understanding between provider and families.	3.78	3.36	2.24
11 3	services are family-driven (families are in charge of their own services).	3.40	2.93	2.06

		Average Rating		
		Importance	Demonstration	Policy
<b>Cluster 3: Provider-Family Interaction</b>		<b>3.96</b>	<b>3.34</b>	<b>2.22</b>
3	service providers truly support, value, and preserve the individual cultures of the families.	3.91	3.30	2.18
12	service providers and families are able to use humor in their relationships.	3.24	3.23	2.06
28	trusting relationships are built between providers and families.	4.11	3.41	2.39
35	service providers and families truly work as a team.	4.20	3.27	2.29

47	providers value and honor input from the whole family.	4.04	3.36	2.06
74	families and service providers are not judgmental about one another.	3.93	3.18	2.19
76	parents are kept informed of their child's treatment and progress.	4.49	3.64	2.50
11	service providers use family-friendly language that is free of technical jargon.	3.89	3.52	2.06
11	when service providers respect parents' choices without being judgmental.	3.82	3.18	2.29

		<b>Average Rating</b>		
		<b>Importance</b>	<b>Demonstration</b>	<b>Policy</b>
<b>Cluster 4: Culturally Accountable System Policies</b>		<b>3.90</b>	<b>3.30</b>	<b>2.26</b>
4	services are inclusive of all persons without discrimination.	4.44	3.50	2.61
7	a continuum of coordinated services and providers enable smooth service transitions for families.	3.89	3.07	2.22
16	the service systems support efforts to broaden services beyond "traditional" service provision.	3.53	2.95	2.19
21	services lead to improving families' progress toward meeting their goals.	4.33	3.52	2.39
22	agencies work together (combine resources, information, and efforts) to meet the goals of families.	4.31	3.45	2.12
25	there is equal opportunity for services for all individuals.	4.22	3.20	2.53
61	consumers are not submitted to abusive workers (verbal abuse, physical mgmt, environmental constraints).	4.29	3.55	2.41
97	service providers are educated about the cultural differences of families they are serving.	3.80	3.34	2.12
10	culturally appropriate services are ensured to meet the needs of families.	3.49	3.25	2.12
10	)systems and service providers reflect ("look like") the diverse cultures in their community.	2.73	3.11	1.93

		<b>Average Rating</b>		
		<b>Importance</b>	<b>Demonstration</b>	<b>Policy</b>
<b>Cluster 5: Provider Accountability to Families</b>		<b>3.99</b>	<b>3.30</b>	<b>2.28</b>
5	service plans are put in writing so everyone can be held accountable.	3.93	3.93	2.65
9	providers think outside the box of their job description and extend themselves in serving families.	3.96	3.09	2.29
42	service providers have a credible reputation for serving families.	4.09	3.50	2.24
56	services are available for mental health/mental retardation dual diagnoses needs.	3.78	3.10	2.27
75	care is developmentally appropriate and not diagnosis driven.	3.80	3.14	2.06
89	service providers make every effort to find help for families without passing the buck to another agency.	4.00	3.25	2.25
92	providers actually do what they say they are going to do.	4.49	3.55	2.41
95	service providers can admit they do not have the understanding necessary for working with a family.	4.07	2.84	2.20
102	service providers consider the culture of the whole person (spiritual, physical, financial, mental, family unit).	3.82	3.32	2.20

		<b>Average Rating</b>		
		<b>Importance</b>	<b>Demonstration</b>	<b>Policy</b>
<b>Cluster 6: Culturally Appropriate Services</b>		<b>3.87</b>	<b>3.28</b>	<b>2.31</b>
13	services to families are provided using a multi-disciplinary approach	3.43	3.16	2.50
39	flexibility is built into the service system to provide unique/non-traditional services to meet family needs.	3.69	2.93	2.13
72	there is consistency in who provides services to families.	3.96	3.23	2.13
90	services are individualized (not everyone is offered the exact same services in the exact same way).	3.98	3.27	2.47
107	services are provided within families' own communities.	3.89	3.64	2.47
108	services are available to families regardless of families' financial resources.	4.33	3.55	2.31
116	services and supports are strengths-based and draw on the existing resources of families.	3.80	3.18	2.19
		<b>Average Rating</b>		
		<b>Importance</b>	<b>Demonstration</b>	<b>Policy</b>
<b>Cluster 7: Gov't/Agency Community Involvement</b>		<b>3.49</b>	<b>2.96</b>	<b>1.93</b>
2	government's understanding of the community's service needs are supported through appropriate funding allocation structures.	4.07	2.84	2.06
15	decision-making bodies change services to meet the needs of the whole community.	3.60	2.74	1.94
17	policy (legislated and agency) permits providers the flexibility to do what is needed for families.	4.04	2.82	1.94
37	organizations provide community-specific cultural competence training to employees at all levels.	3.43	2.83	2.06
41	there is inter-agency cultural and historical understanding.	3.02	2.98	1.87
45	community ownership of services is valued by community members and supported by service providers.	3.33	3.05	1.93
65	practitioners can actually impact changes in the system of care.	3.60	3.18	1.80
103	the cultural demographics of those served reflect the community's population.	2.82	3.25	1.88
		<b>Average Rating</b>		
		<b>Importance</b>	<b>Demonstration</b>	<b>Policy</b>
<b>Cluster 8: Agency Policies</b>		<b>3.21</b>	<b>2.98</b>	<b>1.97</b>
5 2	workers are given rapid due process for accusations made by consumers.	3.50	3.20	2.14
5 3	agency policies allow employees to have case-related grief time.	3.07	2.74	1.79
5 4	professional and direct care staff receive equitable pay	3.18	2.81	1.86
5 5	staff are hired who have experienced mental health illnesses.	2.80	2.76	1.93
6 3	services and systems are non-competitive.	3.52	3.37	2.14

		Average Rating		
		Importance	Demonstration	Policy
<b>Cluster 9: Removing Restrictions to Access</b>		<b>3.44</b>	<b>3.15</b>	<b>2.05</b>
6	"red tape" is not a barrier to families accessing services.	3.89	2.93	2.06
18	when services to families remain consistent across political parties.	3.44	3.11	1.93
19	employers are supportive of employees who have family members with special needs.	3.80	3.12	1.76
40	there is continuity of care for families over the long haul.	3.91	2.95	2.24
57	there are no more waiting lists.	3.64	2.48	1.93
62	people don't hear professionals make remarks based on ethnic origins.	3.96	3.77	2.35
10	agency forms and documents are printed in the cultural language of families.	3.73	3.66	2.06
9				
		Average Rating		
		Importance	Demonstration	Policy
<b>Cluster 10: Education Involvement/Expectations</b>		<b>3.68</b>	<b>2.87</b>	<b>1.91</b>
24	educational system is prepared to be positive participants.	3.84	3.02	2.00
43	the educational needs of all children are met and supported.	4.29	3.09	2.31
48	)higher education institutions know their communities and can teach students about alternative types of referrals.	3.27	2.45	1.73
58	there is not an over-representation of children in alternative education.	3.33	2.69	1.79
59	continuing education is offered to both families and professionals.	3.69	3.07	1.73
		Average Rating		
		Importance	Demonstration	Policy
<b>Cluster 11: Family Empowerment</b>		<b>3.91</b>	<b>3.25</b>	<b>2.21</b>
10	families are empowered by the strengths and differences of their culture.	3.47	2.93	2.13
34	families are active in all aspects of services.	3.93	3.20	2.29
36	families are invested in the service process.	3.89	3.27	2.25
44	families have a lot of options for services.	3.71	2.77	2.06
46	families view service providers, policy-makers and agency administrators as helpful and motivating.	3.56	3.00	1.93
49	family voice and choice are prioritized.	3.98	3.16	2.29
50	families are given the time and consideration their situation deserves.	4.29	3.25	2.41
78	opportunities are available for families to support and share information with one another.	3.72	3.23	2.06
80	families feel they are treated with dignity and respect.	4.53	3.34	2.24
84	families know the service providers care.	3.91	3.50	2.41
87	families feel listened to and heard by service providers.	4.13	3.41	2.19
11	families are able to communicate in their own language with service providers.	3.78	3.73	2.19
2				
11	families feel comfortable accessing services and asking questions of service providers.	3.98	3.47	2.29
5				

		<b>Average Rating</b>		
		<b>Importance</b>	<b>Demonstration</b>	<b>Policy</b>
<b>Cluster 12: Respectful Responsiveness to Families</b>		<b>3.88</b>	<b>3.28</b>	<b>2.19</b>
68	families get a response when they make a request.	4.31	3.36	2.35
70	families have a lot of options available when choosing serviceproviders.	3.58	2.84	2.00
71	families are happy to see providers.	3.51	3.25	2.00
77	families are referred to as people and don't feel labeled or stigma associated with receiving services.	4.20	3.43	2.22
86	families' time is respected.	3.84	3.52	2.31
94	families are accurately informed of services and resources that arE available to them.	4.11	3.16	2.53
99	families and service providers are willing to share their cultures and beliefs with each other.	3.33	3.32	2.00
110	)families can access services and providers with no barriers (transportation, language, education, cost).	4.16	3.39	2.12
		<b>Average Rating</b>		
		<b>Importance</b>	<b>Demonstration</b>	<b>Policy</b>
<b>Cluster 13: Outcomes &amp; Accomplishments</b>		<b>4.08</b>	<b>3.26</b>	<b>2.14</b>
14	families get politically involved in advocating for change in government policies.	3.23	2.50	1.50
20	noticeable progress is made in child outcomes.	4.44	3.50	2.53
26	kids are happy with themselves.	4.33	3.32	1.93
27	children are allowed to be children.	4.30	3.41	2.25
31	communication between parents and their children improves.	4.34	3.41	2.19
64	the elderly are valued.	4.04	3.42	2.00
67	there are ways to measure achievement.	3.76	3.37	2.75
83	kids begin taking responsibility for their own behavior.	4.18	3.18	2.00
		<b>Average Rating</b>		
		<b>Importance</b>	<b>Demonstration</b>	<b>Policy</b>
<b>Cluster 14: Positive Family/Provider Regard</b>		<b>3.86</b>	<b>3.36</b>	<b>2.33</b>
23	people know how to appropriately respond to crisis situations.	4.16	3.30	2.39
33	everyone is treated equally in the service process.	4.13	3.50	2.29
51	services enhance family life.	4.04	3.30	2.29
60	persons don't insult one another by trying to be too culturally polite.	3.09	3.52	2.24
66	animosity is not present between systems and families.	3.89	3.20	2.27

		Average Rating		
		Importance	Demonstration	Policy
<b>Cluster 15: Responsive Family/Provider Communication</b>		<b>3.99</b>	<b>3.27</b>	<b>2.25</b>
29	families understand how to use impartial grievance procedures.	3.71	2.98	2.29
30	the needs of families are met.	4.38	3.30	2.19
32	families are satisfied with the services they receive.	4.02	3.23	2.44
38	families are educated about the organizations' cultures and mandates.	3.32	2.75	1.93
82	there is two-way respectful communication between children and service providers.	4.09	3.77	2.18
88	parents and children are individually treated with respect.	4.18	3.80	2.39
106	the line of communication is always open.	4.49	3.43	2.53
117	families are able to find resources on their own and use new resources to help themselves.	3.71	2.91	2.06

***TIFI Cultural Competence Assessment  
Aggregate Statement Reduction***

<b><i>Pile Number</i></b>	<b>1</b> providers take the time to get to know and build rapport with the children and families they are serving.	<b><u><i>Community</i></u></b>
<b><i>Stmt #</i></b>	121 providers are able to build strong rapport with families.	RUR-W
<b><i>Stmt #</i></b>	142 providers take time to get to know the people they are servicing.	RUR-W
<b><i>Stmt #</i></b>	170 providers bond with the children.	RUR-W
<b><i>Stmt #</i></b>	472 the service provider takes the time to know about the person with whom they are interacting.	URB-E
<b><i>Pile Number</i></b>	<b>2</b> government's understanding of the community's service needs are supported through appropriate funding allocation structures.	<b><u><i>Community</i></u></b>
<b><i>Stmt #</i></b>	210 legislators understand the programs they are funding.	URB-N
<b><i>Stmt #</i></b>	270 our legislators realize that more money is needed to be spent on services.	URB-N
<b><i>Stmt #</i></b>	277 there is proper allocation of money for evidenced-based services.	URB-N
<b><i>Stmt #</i></b>	349 the government develops funding structures that meet the needs of all communities.	RUR-E
<b><i>Pile Number</i></b>	<b>3</b> service providers truly support, value, and preserve the individual cultures of the families.	<b><u><i>Community</i></u></b>
<b><i>Stmt #</i></b>	229 family differences are valued.	URB-N
<b><i>Stmt #</i></b>	305 providers truly support and value the individual cultures of the families.	RUR-E
<b><i>Stmt #</i></b>	416 the existing culture of the family is preserved.	URB-E
<b><i>Pile Number</i></b>	<b>4</b> services are inclusive of all persons without discrimination.	<b><u><i>Community</i></u></b>
<b><i>Stmt #</i></b>	205 they are inclusive of all persons.	URB-N
<b><i>Stmt #</i></b>	248 we practice what we preach about individual and community acceptance.	URB-N
<b><i>Pile Number</i></b>	<b>5</b> service plans are put in writing so everyone can be held accountable.	<b><u><i>Community</i></u></b>
<b><i>Stmt #</i></b>	235 there are checks and balances in service provision.	URB-N
<b><i>Stmt #</i></b>	255 plans are put in writing so everyone can be accountable.	URB-N
<b><i>Pile Number</i></b>	<b>6</b> "red tape" is not a barrier to families accessing services.	<b><u><i>Community</i></u></b>
<b><i>Stmt #</i></b>	334 agencies cut down on the amount of red tape families and providers have to go through for services.	RUR-E
<b><i>Stmt #</i></b>	342 there is assistance to families to cut the red tape to access services.	RUR-E

<b>Pile Number</b>	<b>7</b> <u>a continuum of coordinated services and providers enable smooth service.</u>	<b><u>Community</u></b>
<b>Stmt #</b>	344 agencies work together to help families transition from one county to another.	RUR-E
<b>Stmt #</b>	460 there is a continuum of services.	URB-E
<b>Stmt #</b>	466 issues of confidentiality do not become a barrier to obtaining or accessing services.	URB-E
<b>Stmt #</b>	473 information follows families from one provider to another so families don't have to start from scratch.	URB-E
<b>Pile Number</b>	<b>8</b> <u>the services provided are based on the specific needs of families.</u>	<b><u>Community</u></b>
<b>Stmt #</b>	150 the family's problem is addressed with specifics.	RUR-W
<b>Stmt #</b>	252 family advocate doesn't receive calls saying family can't get anywhere with services.	URB-N
<b>Stmt #</b>	404 families' specific needs are met.	URB-E
<b>Stmt #</b>	441 needs-based services are provided.	URB-E
<b>Pile Number</b>	<b>9</b> <u>providers think outside the box of their job description and extend themselves in serving families.</u>	<b><u>Community</u></b>
<b>Stmt #</b>	125 providers are willing to do more than what their job description says.	RUR-W
<b>Stmt #</b>	329 providers think outside the box and extend themselves in serving/advocating for families.	RUR-E
<b>Stmt #</b>	438 the provider goes out of her/his means to help the family.	URB-E
<b>Pile Number</b>	<b>10</b> <u>families are empowered by the strengths and differences of their culture.</u>	<b><u>Community</u></b>
<b>Stmt #</b>	427 families walk away feeling empowered by their culture.	URB-E
<b>Stmt #</b>	445 families are empowered by and accepting of the strengths and differences of their culture (independent of the service provider).	URB-E
<b>Pile Number</b>	<b>11</b> <u>the service provider welcomes the involvement of an objective family advocate.</u>	<b><u>Community</u></b>
<b>Stmt #</b>	257 the person who is giving the services accepts the help of a family advocate.	URB-N
<b>Stmt #</b>	469 someone who is objective can intervene on behalf of families.	URB-E
<b>Pile Number</b>	<b>12</b> <u>service providers and families are able to use humor in their relationships.</u>	<b><u>Community</u></b>
<b>Stmt #</b>	117 providers and families are able to use humor in their relationships.	RUR-W
<b>Stmt #</b>	118 there is a lightness in the provider-family relationship - don't get hung up on political correctness.	RUR-W
<b>Stmt #</b>	477 people can laugh together.	URB-E
<b>Pile Number</b>	<b>13</b> <u>services to families are provided using a multi-disciplinary approach.</u>	<b><u>Community</u></b>
<b>Stmt #</b>	175 providers use a multi-disciplinary approach.	RUR-W
<b>Stmt #</b>	422 they are multi-disciplinary.	URB-E

<b>Pile Number</b>	<b>14</b> families get politically involved in advocating for change in government policies.	<u><b>Community</b></u>
<b>Stmt #</b>	273 representatives are elected by enlightened citizens and voters.	URB-N
<b>Stmt #</b>	350 families in communities are willing to get involved in advocating for changes in government policies.	RUR-E
<b>Pile Number</b>	<b>15</b> decision-making bodies change services to meet the needs of the whole community.	<u><b>Community</b></u>
<b>Stmt #</b>	228 services change with the changing needs of the community.	URB-N
<b>Stmt #</b>	242 all decision-making bodies are sensitive to the needs of the community.	URB-N
<b>Stmt #</b>	275 the society in which we live changes its value system to prioritize the health of its citizens.	URB-N
<b>Stmt #</b>	361 services meet the needs of the whole community (church, schools, families, work, employers, friends, etc.).	RUR-E
<b>Pile Number</b>	<b>16</b> the service systems support efforts to broaden services beyond "traditional" service provision.	<u><b>Community</b></u>
<b>Stmt #</b>	234 there are systems in place that help us look at broad changes in the provision of services.	URB-N
<b>Stmt #</b>	330 agency/policy-makers support direct workers' efforts to move beyond "traditional" ways to implement services.	RUR-E
<b>Pile Number</b>	<b>17</b> policy (legislated and agency) permits providers the flexibility to do what is needed for families.	<u><b>Community</b></u>
<b>Stmt #</b>	211 public policy permits flexibility.	URB-N
<b>Stmt #</b>	331 policy-makers (legislative and agency) change policies to allow providers to do what they need to do for families.	RUR-E
<b>Pile Number</b>	<b>18</b> when services to families remain consistent across political parties.	<u><b>Community</b></u>
<b>Stmt #</b>	240 legislators are sensitive to the needs of families.	URB-N
<b>Stmt #</b>	263 when services to families don't change just because the political party changes.	URB-N
<b>Pile Number</b>	<b>19</b> employers are supportive of employees who have family members with special needs.	<u><b>Community</b></u>
<b>Stmt #</b>	246 employers are more supportive in job/employment opportunities for adult individuals needing a less stressful work environment.	URB-N
<b>Stmt #</b>	359 parents receive support for the challenges that come in their jobs due to the special needs of a family member.	RUR-E
<b>Stmt #</b>	360 families' employers are provided with information and support to meet the needs of families who have family members with special needs.	RUR-E
<b>Pile Number</b>	<b>20</b> noticeable progress is made in child outcomes.	<u><b>Community</b></u>
<b>Stmt #</b>	124 you see progress with child and family outcomes.	RUR-W
<b>Stmt #</b>	166 there is noticeable change in the child/youth.	RUR-W

<b><i>Pile Number</i></b>	<b><u>21</u></b> <u>services lead to improving families' progress toward meeting their goals.</u>	<b><u>Community</u></b>
<i>Stmt #</i>	140 there is improvement in meeting goals.	RUR-W
<i>Stmt #</i>	167 families can tell there is change/growth in themselves.	RUR-W
<i>Stmt #</i>	212 people get better.	URB-N
<i>Stmt #</i>	436 services lead to progress.	URB-E
<b><i>Pile Number</i></b>	<b><u>22</u></b> <u>agencies work together (combine resources, information, and efforts) to meet the goals of families.</u>	<b><u>Community</u></b>
<i>Stmt #</i>	218 all the agencies work together.	URB-N
<i>Stmt #</i>	223 human service organizations combine resources and efforts to meet the needs of the community.	URB-N
<i>Stmt #</i>	253 each provider knows what the other providers are doing with a specific family.	URB-N
<i>Stmt #</i>	343 county agencies work together to meet the needs of families.	RUR-E
<i>Stmt #</i>	363 agencies pull their resources and information together to serve families.	RUR-E
<i>Stmt #</i>	434 the families feel the community providers work together.	URB-E
<i>Stmt #</i>	457 one agency shouldn't be responsible for everything.	URB-E
<i>Stmt #</i>	458 all the agencies working with a family communicate and work toward the same goals.	URB-E
<b><i>Pile Number</i></b>	<b><u>23</u></b> <u>people know how to appropriately respond to crisis situations.</u>	<b><u>Community</u></b>
<i>Stmt #</i>	233 crisis situations are immediately dealt with.	URB-N
<i>Stmt #</i>	247 law enforcement officials are better trained about how to respond to crises for children with mental health disabilities.	URB-N
<b><i>Pile Number</i></b>	<b><u>24</u></b> <u>educational system is prepared to be positive participants.</u>	<b><u>Community</u></b>
<i>Stmt #</i>	280 educational system is prepared to be positive participants.	URB-N
<b><i>Pile Number</i></b>	<b><u>25</u></b> <u>there is equal opportunity for services for all individuals.</u>	<b><u>Community</u></b>
<i>Stmt #</i>	216 the same level of service is available to everyone.	URB-N
<i>Stmt #</i>	256 families don't need to have power, pull, or education to get services.	URB-N
<i>Stmt #</i>	443 there is equal opportunity for services for all individuals.	URB-E
<b><i>Pile Number</i></b>	<b><u>26</u></b> <u>kids are happy with themselves.</u>	<b><u>Community</u></b>
<i>Stmt #</i>	224 kids are happy with themselves.	URB-N

<b>Pile Number</b>	<b>27</b> children are allowed to be children.	<b><u>Community</u></b>
<b>Stmt #</b>	365 children are allowed to be children.	RUR-E
<b>Pile Number</b>	<b>28</b> trusting relationships are built between providers and families.	<b><u>Community</u></b>
<b>Stmt #</b>	122 trust is built between providers and families.	RUR-W
<b>Stmt #</b>	311 families trust the providers.	RUR-E
<b>Stmt #</b>	431 the provider is "invited back to dinner" (when trust is developed).	URB-E
<b>Stmt #</b>	475 families and providers are able to develop relationships that foster mutual trust and respect.	URB-E
<b>Pile Number</b>	<b>29</b> families understand how to use impartial grievance procedures.	<b><u>Community</u></b>
<b>Stmt #</b>	157 there are fair and impartial grievance procedures.	RUR-W
<b>Stmt #</b>	158 grievance procedures are explained about how they work.	RUR-W
<b>Pile Number</b>	<b>30</b> the needs of families are met.	<b><u>Community</u></b>
<b>Stmt #</b>	147 the needs of the family are met.	RUR-W
<b>Stmt #</b>	339 all of the families' needs have been met.	RUR-E
<b>Pile Number</b>	<b>31</b> communication between parents and their children improves.	<b><u>Community</u></b>
<b>Stmt #</b>	172 children communicate better with parents.	RUR-W
<b>Stmt #</b>	174 parents learn to listen to their children.	RUR-W
<b>Pile Number</b>	<b>32</b> families are satisfied with the services they receive.	<b><u>Community</u></b>
<b>Stmt #</b>	266 families don't prematurely give up on the provider.	URB-N
<b>Stmt #</b>	301 families are satisfied with the service.	RUR-E
<b>Stmt #</b>	432 the family recommends the services they receive to someone else.	URB-E
<b>Stmt #</b>	456 families are satisfied with outcomes.	URB-E
<b>Pile Number</b>	<b>33</b> everyone is treated equally in the service process.	<b><u>Community</u></b>
<b>Stmt #</b>	139 everyone is treated equally.	RUR-W
<b>Stmt #</b>	156 families are treated equally.	RUR-W
<b>Stmt #</b>	447 everyone feels equal in the service process.	URB-E
<b>Pile Number</b>	<b>34</b> families are active in all aspects of services.	<b><u>Community</u></b>
<b>Stmt #</b>	119 families are active in all aspects of services.	RUR-W

<b>Pile Number</b>	<b>35</b> service providers and families truly work as a team.	<b><u>Community</u></b>
<b>Stmt #</b>	151 I know I am part of the team.	RUR-W
<b>Stmt #</b>	403 the families help plan the services.	URB-E
<b>Stmt #</b>	463 there is coordination among service providers and families.	URB-E
<b>Stmt #</b>	468 service providers and families work as a team.	URB-E
<b>Pile Number</b>	<b>36</b> families are invested in the service process.	<b><u>Community</u></b>
<b>Stmt #</b>	314 families are consistent in following through with services.	RUR-E
<b>Stmt #</b>	317 families are invested in the process because they know they have something to gain.	RUR-E
<b>Pile Number</b>	<b>37</b> organizations provide community-specific cultural competence training to employees at all levels.	<b><u>Community</u></b>
<b>Stmt #</b>	232 organizations insist on providing cultural competence training at least annually at all levels.	URB-N
<b>Stmt #</b>	238 training is provided to help the system understand the cultures of the community.	URB-N
<b>Stmt #</b>	262 educational opportunities about cultural diversity are made available to staff.	URB-N
<b>Pile Number</b>	<b>38</b> families are educated about the organizations' cultures and mandates.	<b><u>Community</u></b>
<b>Stmt #</b>	126 families are willing to allow providers to educate them about the provider agency.	RUR-W
<b>Stmt #</b>	310 providers educate families about the organizations' cultures and mandates.	RUR-E
<b>Pile Number</b>	<b>39</b> flexibility is built into the service system to provide unique/non-traditional services to meet family needs.	<b><u>Community</u></b>
<b>Stmt #</b>	219 the system has the flexibility to provide unique/non-traditional services to families.	URB-N
<b>Stmt #</b>	409 flexibility is built into the program to address a variety of needs.	URB-E
<b>Pile Number</b>	<b>40</b> there is continuity of care for families over the long haul.	<b><u>Community</u></b>
<b>Stmt #</b>	313 families know there is consistency in services being provided over the long haul.	RUR-E
<b>Stmt #</b>	459 there is continuity of care as youth transition into adulthood ("age-out").	URB-E
<b>Stmt #</b>	461 there is continuity of care for people across developmental stages.	URB-E
<b>Pile Number</b>	<b>41</b> there is inter-agency cultural and historical understanding.	<b><u>Community</u></b>
<b>Stmt #</b>	111 there is inter-agency cultural understanding.	RUR-W
<b>Stmt #</b>	245 relationships and history of agencies in URB-N are understood.	URB-N

<b>Pile Number</b>	<b>42</b>	service providers have a credible reputation for serving families.	<b><u>Community</u></b>
<b>Stmt #</b>	217	the agency has a good reputation across neighborhoods.	URB-N
<b>Stmt #</b>	237	self-presentation of service providers is credible to the family.	URB-N
<b>Pile Number</b>	<b>43</b>	the educational needs of all children are met and supported.	<b><u>Community</u></b>
<b>Stmt #</b>	254	a professional is relieved of their duties when not following the ARD.	URB-N
<b>Stmt #</b>	362	the educational needs of all children are met and supported.	RUR-E
<b>Pile Number</b>	<b>44</b>	families have a lot of options for services.	<b><u>Community</u></b>
<b>Stmt #</b>	128	there are a lot of options for services.	RUR-W
<b>Stmt #</b>	337	families have alternatives for services/treatment/interventions.	RUR-E
<b>Pile Number</b>	<b>45</b>	community ownership of services is valued by community members and supported by service providers.	<b><u>Community</u></b>
<b>Stmt #</b>	114	providers can step back and allow other community members to take a leadership role.	RUR-W
<b>Stmt #</b>	351	community members have internal ownership of services.	RUR-E
<b>Pile Number</b>	<b>46</b>	families view service providers, policy-makers and agency administrators as helpful and motivating.	<b><u>Community</u></b>
<b>Stmt #</b>	120	families think of providers as helpful rather than a hindrance.	RUR-W
<b>Stmt #</b>	222	motivation is encouraged rather than isolating people.	URB-N
<b>Stmt #</b>	480	providers, policy-makers and administrators of public and private child-serving agencies are helpful.	URB-E
<b>Pile Number</b>	<b>47</b>	providers value and honor input from the whole family.	<b><u>Community</u></b>
<b>Stmt #</b>	109	providers don't impose their own solutions on families.	RUR-W
<b>Stmt #</b>	153	providers ask families for their input and don't just tell families what to do.	RUR-W
<b>Stmt #</b>	169	providers value family's input.	RUR-W
<b>Stmt #</b>	213	families' and clients' rights and ideas are respected.	URB-N
<b>Stmt #</b>	405	families' opinions are recognized.	URB-E
<b>Stmt #</b>	407	families' opinions are honored.	URB-E
<b>Stmt #</b>	428	everyone in the family has a voice.	URB-E

<b>Pile Number</b>	<b>48</b>	<b>higher education institutions know their communities and can teach students about alternative types of referrals.</b>	<b><u>Community</u></b>
<b>Stmt #</b>	258	educational institutions know their communities and can teach students methods of referral.	URB-N
<b>Pile Number</b>	<b>49</b>	<b>family voice and choice are prioritized.</b>	<b><u>Community</u></b>
<b>Stmt #</b>	102	families have a voice and choice about what's going on.	RUR-W
<b>Stmt #</b>	406	families' opinions are acted upon.	URB-E
<b>Stmt #</b>	411	family voice and choice are prioritized.	URB-E
<b>Pile Number</b>	<b>50</b>	<b>families are given the time and consideration their situation deserves.</b>	<b><u>Community</u></b>
<b>Stmt #</b>	450	families are given the time and consideration their situation deserves.	URB-E
<b>Pile Number</b>	<b>51</b>	<b>services enhance family life.</b>	<b><u>Community</u></b>
<b>Stmt #</b>	414	they enhance family life.	URB-E
<b>Pile Number</b>	<b>52</b>	<b>workers are given rapid due process for accusations made by consumers.</b>	<b><u>Community</u></b>
<b>Stmt #</b>	278	workers are given rapid due process for accusations made by consumers.	URB-N
<b>Pile Number</b>	<b>53</b>	<b>agency policies allow employees to have case-related grief time.</b>	<b><u>Community</u></b>
<b>Stmt #</b>	276	agency policies allow employees to have case-related grief time.	URB-N
<b>Pile Number</b>	<b>54</b>	<b>professional and direct care staff receive equitable pay.</b>	<b><u>Community</u></b>
<b>Stmt #</b>	274	professional and direct care staff receive equitable pay.	URB-N
<b>Pile Number</b>	<b>55</b>	<b>staff are hired who have experienced mental health illnesses.</b>	<b><u>Community</u></b>
<b>Stmt #</b>	272	staff are hired who have experienced mental health illnesses.	URB-N
<b>Pile Number</b>	<b>56</b>	<b>services are available for mental health/mental retardation dual diagnoses needs.</b>	<b><u>Community</u></b>
<b>Stmt #</b>	269	services are available for mental health/mental retardation dual diagnoses needs.	URB-N
<b>Pile Number</b>	<b>57</b>	<b>there are no more waiting lists.</b>	<b><u>Community</u></b>
<b>Stmt #</b>	268	there are no more waiting lists.	URB-N
<b>Pile Number</b>	<b>58</b>	<b>there is not an over-representation of children in alternative education.</b>	<b><u>Community</u></b>
<b>Stmt #</b>	267	there are not an over-representation of children in alternative education.	URB-N

<i>Pile Number</i>	<b>59</b> continuing education is offered to both families and professionals.	<u><i>Community</i></u>
<i>Stmt #</i>	265 continuing education involves families and professionals.	URB-N
<i>Pile Number</i>	<b>60</b> persons don't insult one another by trying to be too culturally polite.	<u><i>Community</i></u>
<i>Stmt #</i>	264 persons don't insult one another in an effort to be polite.	URB-N
<i>Pile Number</i>	<b>61</b> consumers are not submitted to abusive workers (verbal abuse, physical mgmt, environmental constraints).	<u><i>Community</i></u>
<i>Stmt #</i>	279 consumers are not submitted to abusive workers (verbal abuse, physical mgmt, environmental constraints).	URB-N
<i>Pile Number</i>	<b>62</b> people don't hear professionals make remarks based on ethnic origins.	<u><i>Community</i></u>
<i>Stmt #</i>	259 you don't hear professionals make remarks based on ethnic origins.	URB-N
<i>Pile Number</i>	<b>63</b> services and systems are non-competitive.	<u><i>Community</i></u>
<i>Stmt #</i>	231 services and systems are non-competitive.	URB-N
<i>Pile Number</i>	<b>64</b> the elderly are valued.	<u><i>Community</i></u>
<i>Stmt #</i>	230 the elderly are valued.	URB-N
<i>Pile Number</i>	<b>65</b> practitioners can actually impact changes in the system of care.	<u><i>Community</i></u>
<i>Stmt #</i>	208 practitioners can actually impact changes in the system of care.	URB-N
<i>Pile Number</i>	<b>66</b> animosity is not present between systems and families.	<u><i>Community</i></u>
<i>Stmt #</i>	209 animosity is not present.	URB-N
<i>Pile Number</i>	<b>67</b> there are ways to measure achievement.	<u><i>Community</i></u>
<i>Stmt #</i>	165 there are ways to measure achievement.	RUR-W
<i>Pile Number</i>	<b>68</b> families get a response when they make a request.	<u><i>Community</i></u>
<i>Stmt #</i>	143 you get a response when making a request.	RUR-W
<i>Pile Number</i>	<b>69</b> providers don't assume families won't understand what's going on with the family/situation.	<u><i>Community</i></u>
<i>Stmt #</i>	135 providers don't assume families won't understand what's going on with the family/situation.	RUR-W
<i>Pile Number</i>	<b>70</b> families have a lot of options available when choosing service providers.	<u><i>Community</i></u>
<i>Stmt #</i>	129 there are a lot of options for service providers.	RUR-W
<i>Pile Number</i>	<b>71</b> families are happy to see providers.	<u><i>Community</i></u>
<i>Stmt #</i>	116 families are happy to see providers.	RUR-W

<b>Pile Number</b>	<b>72</b> <u>there is consistency in who provides services to families.</u>	<b><u>Community</u></b>
<b>Stmt #</b>	474 there is consistency in who provides services to families.	URB-E
<b>Pile Number</b>	<b>73</b> <u>the roles of each person involved in services are clear (parent, counselor, child).</u>	<b><u>Community</u></b>
<b>Stmt #</b>	364 the roles of each person involved in services are clear (parent, counselor, child).	RUR-E
<b>Pile Number</b>	<b>74</b> <u>families and service providers are not judgmental about one another.</u>	<b><u>Community</u></b>
<b>Stmt #</b>	454 families are nonjudgmental of service providers.	URB-E
<b>Stmt #</b>	455 families and service providers don't stereotype or make assumptions about the other.	URB-E
<b>Pile Number</b>	<b>75</b> <u>care is developmentally appropriate and not diagnosis driven.</u>	<b><u>Community</u></b>
<b>Stmt #</b>	437 services are developmentally appropriate.	URB-E
<b>Stmt #</b>	444 services are not diagnosis driven.	URB-E
<b>Stmt #</b>	478 care is appropriate.	URB-E
<b>Pile Number</b>	<b>76</b> <u>parents are kept informed of their child's treatment and progress.</u>	<b><u>Community</u></b>
<b>Stmt #</b>	163 providers keep parents informed of their kids' progress.	RUR-W
<b>Stmt #</b>	164 providers provide families with specific information about their kids.	RUR-W
<b>Stmt #</b>	206 parents are kept informed of their child's treatment.	URB-N
<b>Pile Number</b>	<b>77</b> <u>families are referred to as people and don't feel labeled or stigma associated with receiving services.</u>	<b><u>Community</u></b>
<b>Stmt #</b>	123 families are not in denial of the need for services.	RUR-W
<b>Stmt #</b>	133 providers refer to families as people instead of just cases.	RUR-W
<b>Stmt #</b>	221 it is not embarrassing for children and families to receive services.	URB-N
<b>Stmt #</b>	320 families don't feel stigma associated with receiving services.	RUR-E
<b>Stmt #</b>	321 families don't feel labeled.	RUR-E
<b>Pile Number</b>	<b>78</b> <u>opportunities are available for families to support and share information with one another.</u>	<b><u>Community</u></b>
<b>Stmt #</b>	346 families communicate with different families to support and educate one another about services available.	RUR-E
<b>Stmt #</b>	357 there is a support system for single parents and families who feel isolated.	RUR-E
<b>Stmt #</b>	358 agencies provide opportunities for families to share information with one another.	RUR-E

<b>Pile Number</b>	<b>79</b> <u>service providers truly understand what's important to families.</u>	<b><u>Community</u></b>
<i>Stmt #</i>	141 providers are able to look at the true issues of the family.	RUR-W
<i>Stmt #</i>	203 they understand what's important to me.	URB-N
<i>Stmt #</i>	316 the families don't say, "Yes, but..." (provider hasn't hit on what family is wanting).	RUR-E
<i>Stmt #</i>	325 providers meet families where they are.	RUR-E
<i>Stmt #</i>	402 the families feel understood.	URB-E
<b>Pile Number</b>	<b>80</b> <u>families feel they are treated with dignity and respect.</u>	<b><u>Community</u></b>
<i>Stmt #</i>	101 families report back that they feel respected.	RUR-W
<i>Stmt #</i>	152 families are treated with respect.	RUR-W
<i>Stmt #</i>	214 there is mutual respect between families and the system.	URB-N
<i>Stmt #</i>	215 the dignity of the family is respected.	URB-N
<i>Stmt #</i>	260 the majority of those served feel they are respected.	URB-N
<i>Stmt #</i>	302 families feel they are treated with dignity and respect.	RUR-E
<i>Stmt #</i>	410 families are able to maintain their dignity while receiving services.	URB-E
<i>Stmt #</i>	435 families are respected.	URB-E
<b>Pile Number</b>	<b>81</b> <u>service providers know when to offer empathetic and/or sympathetic support to families.</u>	<b><u>Community</u></b>
<i>Stmt #</i>	132 providers are able to empathize with families - walk a mile in families' shoes.	RUR-W
<i>Stmt #</i>	134 providers acknowledge when they are not able to/should not empathize, but need to just sympathize.	RUR-W
<i>Stmt #</i>	149 providers are supportive of family needs.	RUR-W
<i>Stmt #</i>	467 individuals are empathic.	URB-E
<b>Pile Number</b>	<b>82</b> <u>there is two-way respectful communication between children and service providers.</u>	<b><u>Community</u></b>
<i>Stmt #</i>	171 providers have good communication with the children.	RUR-W
<i>Stmt #</i>	353 there is two-way respectful communication between children and agency providers.	RUR-E
<b>Pile Number</b>	<b>83</b> <u>kids begin taking responsibility for their own behavior.</u>	<b><u>Community</u></b>
<i>Stmt #</i>	173 kids learn to express their feelings with words instead of with anger.	RUR-W
<i>Stmt #</i>	220 children start to take responsibility for their own healthcare.	URB-N

<b>Pile Number</b>	<b>84</b> families know the service providers care.	<b><u>Community</u></b>
<b>Stmt #</b>	113 families know the providers care.	RUR-W
<b>Stmt #</b>	160 providers care.	RUR-W
<b>Stmt #</b>	315 providers demonstrate caring of families.	RUR-E
<b>Stmt #</b>	433 the families feel cared about.	URB-E
<b>Pile Number</b>	<b>85</b> services and programs meet the scheduling needs of the family.	<b><u>Community</u></b>
<b>Stmt #</b>	103 family programs fit the scheduling needs of the family.	RUR-W
<b>Stmt #</b>	227 services and programs are offered at family-friendly times.	URB-N
<b>Pile Number</b>	<b>86</b> families' time is respected.	<b><u>Community</u></b>
<b>Stmt #</b>	146 appointments are kept on time.	RUR-W
<b>Stmt #</b>	451 families' time is respected.	URB-E
<b>Pile Number</b>	<b>87</b> families feel listened to and heard by service providers.	<b><u>Community</u></b>
<b>Stmt #</b>	159 providers listen.	RUR-W
<b>Stmt #</b>	322 families feel listened to and heard.	RUR-E
<b>Pile Number</b>	<b>88</b> parents and children are individually treated with respect.	<b><u>Community</u></b>
<b>Stmt #</b>	162 not only parents are treated with respect, but so are the kids.	RUR-W
<b>Stmt #</b>	338 people respect the individual as a person.	RUR-E
<b>Pile Number</b>	<b>89</b> service providers make every effort to find help for families without passing the buck to another agency.	<b><u>Community</u></b>
<b>Stmt #</b>	145 all avenues are covered in order to help.	RUR-W
<b>Stmt #</b>	148 providers don't pass the buck from one organization to another.	RUR-W
<b>Stmt #</b>	155 providers can look for an answer if they don't know it.	RUR-W
<b>Stmt #</b>	161 providers make every effort to find someone who can handle problems they can't handle themselves.	RUR-W
<b>Pile Number</b>	<b>90</b> services are individualized (not everyone is offered the exact same services in the exact same way).	<b><u>Community</u></b>
<b>Stmt #</b>	401 they are individualized.	URB-E
<b>Stmt #</b>	408 not everyone is offered the exact same services in the exact same way.	URB-E
<b>Stmt #</b>	476 services are personalized.	URB-E

<b><i>Pile Number</i></b>	<b><u>91</u></b> services are child-centered and allow children to have a voice in what services they receive.	<b><u>Community</u></b>
<b><i>Stmt #</i></b>	352 children have a voice in what services they receive.	RUR-E
<b><i>Stmt #</i></b>	442 services are child-centered.	URB-E
<b><i>Pile Number</i></b>	<b><u>92</u></b> providers actually do what they say they are going to do.	<b><u>Community</u></b>
<b><i>Stmt #</i></b>	202 benefits stated are actually provided.	URB-N
<b><i>Stmt #</i></b>	306 providers do what they actually say they are going to do.	RUR-E
<b><i>Pile Number</i></b>	<b><u>93</u></b> providers work with and provide services to the entire family rather than only the identified child.	<b><u>Community</u></b>
<b><i>Stmt #</i></b>	168 providers work with the entire family rather than only the child.	RUR-W
<b><i>Stmt #</i></b>	355 providers include the entire family structure in services.	RUR-E
<b><i>Stmt #</i></b>	356 services offer opportunities to other members of the family, especially the other children.	RUR-E
<b><i>Stmt #</i></b>	446 services include everyone with mental illness and their families.	URB-E
<b><i>Pile Number</i></b>	<b><u>94</u></b> families are accurately informed of services and resources that are available to them.	<b><u>Community</u></b>
<b><i>Stmt #</i></b>	341 services are advertised and families know about them.	RUR-E
<b><i>Stmt #</i></b>	348 agencies have a resource where families can look up what services and family resources are available.	RUR-E
<b><i>Stmt #</i></b>	448 families are informed of services and resources that are available.	URB-E
<b><i>Stmt #</i></b>	449 accurate and relevant information about services is given to families.	URB-E
<b><i>Pile Number</i></b>	<b><u>95</u></b> service providers can admit they do not have the understanding necessary for working with a family.	<b><u>Community</u></b>
<b><i>Stmt #</i></b>	154 providers can admit when they are wrong.	RUR-W
<b><i>Stmt #</i></b>	308 providers can admit they do not have the level of understanding necessary for working with family.	RUR-E a
<b><i>Pile Number</i></b>	<b><u>96</u></b> service providers don't impose their own values and beliefs on families.	<b><u>Community</u></b>
<b><i>Stmt #</i></b>	107 providers don't impose their own beliefs on families.	RUR-W
<b><i>Stmt #</i></b>	108 providers don't impose their own values on families.	RUR-W
<b><i>Stmt #</i></b>	236 the system and provider do not impose their personal values on families.	URB-N
<b><i>Stmt #</i></b>	419 the values of the provider are not projected on the family.	URB-E

<b><i>Pile Number</i></b>	<b><u>97</u></b> service providers are educated about the cultural differences of families they are serving.	<b><u>Community</u></b>
<i>Stmt #</i>	104 providers are educated to cultural differences.	RUR-W
<i>Stmt #</i>	243 individual staff providing services achieve a level of cultural competence.	URB-N
<i>Stmt #</i>	244 relationships and history of ethnic groups in URB-N are understood.	URB-N
<i>Stmt #</i>	261 individual staff make efforts to educate themselves about countries and religions of people different from them.	URB-N
<i>Stmt #</i>	307 providers seek to understand and inform themselves of knowledge about the cultures of families with whom they are interacting.	RUR-E
<b><i>Pile Number</i></b>	<b><u>98</u></b> services to families are nonjudgmental and affirming of families' cultures and backgrounds.	<b><u>Community</u></b>
<i>Stmt #</i>	176 providers don't look down on caregivers because they don't have the same level of education or knowledge.	RUR-W
<i>Stmt #</i>	251 services to families are nonjudgmental and affirming.	URB-N
<i>Stmt #</i>	324 providers are not judgmental of families' culture.	RUR-E
<i>Stmt #</i>	439 services are non-judgmental.	URB-E
<i>Stmt #</i>	440 services are provided without provider making assumptions about family.	URB-E
<i>Stmt #</i>	453 service providers are nonjudgmental.	URB-E
<b><i>Pile Number</i></b>	<b><u>99</u></b> families and service providers are willing to share their cultures and beliefs with each other.	<b><u>Community</u></b>
<i>Stmt #</i>	112 families feel free to be as open as they want to be about their beliefs.	RUR-W
<i>Stmt #</i>	470 people are willing to share their cultures with each other.	URB-E
<b><i>Pile Number</i></b>	<b><u>100</u></b> providers are willing to ask questions and allow families to be experts on their own cultures.	<b><u>Community</u></b>
<i>Stmt #</i>	105 providers allow families to be experts on their own cultures.	RUR-W
<i>Stmt #</i>	106 providers are willing to ask questions to learn about families' cultures.	RUR-W
<i>Stmt #</i>	309 providers are open to letting families educate them about the family's culture.	RUR-E
<i>Stmt #</i>	323 providers ask families about their culture.	RUR-E
<b><i>Pile Number</i></b>	<b><u>101</u></b> culturally appropriate services are ensured to meet the needs of families.	<b><u>Community</u></b>
<i>Stmt #</i>	479 there is a culturally appropriate way to meet the needs of culturally and racially diverse groups.	URB-E
<i>Stmt #</i>	481 services are ensured for families without regard to race, culture or ethnicity.	URB-E

<b>Pile Number</b>	<b>102</b>	<u>service providers consider the culture of the whole person (spiritual, physical, financial, mental, family unit).</u>	<b><u>Community</u></b>
<i>Stmt #</i>	354	providers can consider the whole person (spiritual, physical, financial, mental, family unit).	RUR-E
<i>Stmt #</i>	413	some culturally-based services are provided.	URB-E
<i>Stmt #</i>	482	there is productive cross-cultural intervention.	URB-E
<b>Pile Number</b>	<b>103</b>	<u>the cultural demographics of those served reflect the community's population.</u>	<b><u>Community</u></b>
<i>Stmt #</i>	226	the demographics of those served reflect the community's population.	URB-N
<i>Stmt #</i>	415	services are targeted to more than one cultural group.	URB-E
<b>Pile Number</b>	<b>104</b>	<u>systems and service providers reflect ("look like") the diverse cultures in their community.</u>	<b><u>Community</u></b>
<i>Stmt #</i>	115	there is a lot of diversity within the provider group.	RUR-W
<i>Stmt #</i>	137	employees are representative of the population.	RUR-W
<i>Stmt #</i>	207	the ratios of different ethnic groups among the families and staff reflect the ratios of these groups in the community.	URB-N
<i>Stmt #</i>	225	staff look like the people they are working with (language, race, ethnicity, etc.).	URB-N
<i>Stmt #</i>	241	all decision-making bodies reflect the community.	URB-N
<i>Stmt #</i>	271	staffing ratios represent ethnic composition of clientele served.	URB-N
<i>Stmt #</i>	328	agencies/systems reflect ("look like") the cultures in their community.	RUR-E
<b>Pile Number</b>	<b>105</b>	<u>service provision involves mutual understanding between provider and families.</u>	<b><u>Community</u></b>
<i>Stmt #</i>	110	service provision is a two-way street of understanding between provider and families.	RUR-W
<i>Stmt #</i>	138	everyone is on the same page.	RUR-W
<i>Stmt #</i>	462	there is mutual understanding between families and service providers.	URB-E
<b>Pile Number</b>	<b>106</b>	<u>the line of communication is always open.</u>	<b><u>Community</u></b>
<i>Stmt #</i>	144	the line of communication is always open.	RUR-W
<i>Stmt #</i>	426	communication is open.	URB-E
<b>Pile Number</b>	<b>107</b>	<u>services are provided within families' own communities.</u>	<b><u>Community</u></b>
<i>Stmt #</i>	430	services are within the neighborhood.	URB-E
<i>Stmt #</i>	452	needs are identified and met within families' own communities.	URB-E
<i>Stmt #</i>	465	services are provided close to families' homes.	URB-E

<b>Pile Number</b>	<b>108</b>	<u>services are available to families regardless of families' financial resources.</u>	<b><u>Community</u></b>
<b>Stmt #</b>	249	services are accessible regardless of families' financial resources.	URB-N
<b>Stmt #</b>	326	families do not feel their lack of money will limit the services they can receive.	RUR-E
<b>Stmt #</b>	340	services are available for families even when they don't have financial resources.	RUR-E
<b>Stmt #</b>	418	they are economically sensitive.	URB-E
<b>Pile Number</b>	<b>109</b>	<u>agency forms and documents are printed in the cultural language of families.</u>	<b><u>Community</u></b>
<b>Stmt #</b>	333	forms/documents are translated into the cultural language of families.	RUR-E
<b>Stmt #</b>	345	agency literature is printed in everyone's languages.	RUR-E
<b>Pile Number</b>	<b>110</b>	<u>families can access services and providers with no barriers (transportation, language, education, cost).</u>	<b><u>Community</u></b>
<b>Stmt #</b>	127	there is easy accessibility for families to providers.	RUR-W
<b>Stmt #</b>	332	families can access the services with no barriers (transportation, language, education, cost).	RUR-E
<b>Stmt #</b>	464	services are easily accessible and convenient.	URB-E
<b>Pile Number</b>	<b>111</b>	<u>service providers use family-friendly language that is free of technical jargon.</u>	<b><u>Community</u></b>
<b>Stmt #</b>	136	providers explain things in terms families can understand.	RUR-W
<b>Stmt #</b>	327	providers and agencies use family-friendly language.	RUR-E
<b>Stmt #</b>	421	the communication is in the terminology of the family.	URB-E
<b>Stmt #</b>	429	services lack technical jargon.	URB-E
<b>Pile Number</b>	<b>112</b>	<u>families are able to communicate in their own language with service providers.</u>	<b><u>Community</u></b>
<b>Stmt #</b>	130	services are provided in different languages.	RUR-W
<b>Stmt #</b>	347	families are able to communicate in their own language.	RUR-E
<b>Stmt #</b>	420	the language is in that of the family.	URB-E
<b>Pile Number</b>	<b>113</b>	<u>services are family-driven (families are in charge of their own services).</u>	<b><u>Community</u></b>
<b>Stmt #</b>	336	families are in charge of their own services (when working with providers).	RUR-E
<b>Stmt #</b>	417	they are family-driven (family makes the decisions).	URB-E
<b>Pile Number</b>	<b>114</b>	<u>when service providers respect parents' choices without being judgmental.</u>	<b><u>Community</u></b>
<b>Stmt #</b>	250	when professionals respect parents' choices.	URB-N
<b>Stmt #</b>	425	the family is able to reject services without judgment from the provider.	URB-E

<b>Pile Number</b>	<b>115</b>	<u>families feel comfortable accessing services and asking questions of service providers.</u>	<b><u>Community</u></b>
<i>Stmt #</i>	131	families feel comfortable calling on providers for help, not just because they are calling out of desperation.	RUR-W
<i>Stmt #</i>	204	all families feel comfortable accessing care.	URB-N
<i>Stmt #</i>	312	families feel comfortable seeking services.	RUR-E
<i>Stmt #</i>	423	the family feels comfortable to approach the service provider regarding need for change.	URB-E
<i>Stmt #</i>	424	the family feels comfortable to approach the service provider with questions.	URB-E
<b>Pile Number</b>	<b>116</b>	<u>services and supports are strengths-based and draw on the existing resources of families.</u>	<b><u>Community</u></b>
<i>Stmt #</i>	201	they are strength-based, family-driven.	URB-N
<i>Stmt #</i>	303	providers draw on the resources that families currently have.	RUR-E
<i>Stmt #</i>	304	providers draw on families' existing strengths.	RUR-E
<i>Stmt #</i>	412	family strengths are highlighted and utilized.	URB-E
<i>Stmt #</i>	471	services and supports are strengths-based.	URB-E
<b>Pile Number</b>	<b>117</b>	<u>families are able to find resources on their own and use new resources to help themselves.</u>	<b><u>Community</u></b>
<i>Stmt #</i>	239	client self-help is encouraged and supported.	URB-N
<i>Stmt #</i>	318	families are able to help themselves.	RUR-E
<i>Stmt #</i>	319	families are offered and they accept new tools for solving their own problems.	RUR-E
<i>Stmt #</i>	335	families can find their own resources.	RUR-E

## APPENDIX I

### Aggregate Study Bridging Values by Cluster

<b>Cluster 1: Service Provider Competencies</b>		<b>Bridging Value</b>
81	service providers know when to offer empathetic and/or sympathetic support to families.	0.05
93	providers work with and provide services to the entire family rather than only the identified child.	0.06
69	providers don't assume families won't understand what's going on with the family/situation.	0.07
100	providers are willing to ask questions and allow families to be experts on their own cultures.	0.09
11	the service provider welcomes the involvement of an objective family advocate.	0.10
91	services are child-centered and allow children to have a voice in what services they receive.	0.10
96	service providers don't impose their own values and beliefs on families.	0.10
1	providers take the time to get to know and build rapport with the children and families they are serving.	0.13
<b>Average Bridging =</b>		<b>0.09</b>
<b>Cluster 2: Family-Centered Services</b>		<b>Bridging Value</b>
98	services to families are nonjudgmental and affirming of families' cultures and backgrounds.	0.00
85	services and programs meet the scheduling needs of the family.	0.01
73	the roles of each person involved in services are clear (parent, counselor, child).	0.02
79	service providers truly understand what's important to families.	0.02
8	the services provided are based on the specific needs of families.	0.03
113	services are family-driven (families are in charge of their own services).	0.06
105	service provision involves mutual understanding between provider and families.	0.06
<b>Average Bridging =</b>		<b>0.03</b>
<b>Cluster 3: Provider-Family Interaction</b>		<b>Bridging Value</b>
3	service providers truly support, value, and preserve the individual cultures of the families.	0.07
74	families and service providers are not judgmental about one another.	0.08
28	trusting relationships are built between providers and families.	0.09
35	service providers and families truly work as a team.	0.10
47	providers value and honor input from the whole family.	0.11
111	service providers use family-friendly language that is free of technical jargon.	0.12
12	service providers and families are able to use humor in their relationships.	0.14
114	when service providers respect parents' choices without being judgmental.	0.17
76	parents are kept informed of their child's treatment and progress	0.17
<b>Average Bridging =</b>		<b>0.12</b>

<b>Cluster 4: Culturally Accountable System Policies</b>		<b>Bridging Value</b>
101	culturally appropriate services are ensured to meet the needs of families.	0.07
21	services lead to improving families' progress toward meeting their goals.	0.09
61	consumers are not submitted to abusive workers (verbal abuse, physical mgmt, environmental constraints).	0.14
4	services are inclusive of all persons without discrimination.	0.17
7	a continuum of coordinated services and providers enable smooth service transitions for families.	0.19
25	there is equal opportunity for services for all individuals.	0.20
16	the service systems support efforts to broaden services beyond "traditional" service provision.	0.20
22	agencies work together (combine resources, information, and efforts) to meet the goals of families.	0.21
97	service providers are educated about the cultural differences of families they are serving.	0.23
104	systems and service providers reflect ("look like") the diverse cultures in their community.	0.23
<b>Average Bridging =</b>		<b>0.17</b>
<b>Cluster 5: Provider Accountability System Policies</b>		<b>Bridging Value</b>
9	providers think outside the box of their job description and extend themselves in serving families.	0.06
92	providers actually do what they say they are going to do.	0.08
89	service providers make every effort to find help for families without passing the buck to another agency.	0.10
102	service providers consider the culture of the whole person (spiritual, physical, financial, mental, family unit).	0.11
56	services are available for mental health/mental retardation dual diagnoses needs.	0.18
42	service providers have a credible reputation for serving families.	0.19
5	service plans are put in writing so everyone can be held accountable.	0.22
75	care is developmentally appropriate and not diagnosis driven.	0.24
95	service providers can admit they do not have the understanding necessary for working with a family.	0.40
<b>Average Bridging =</b>		<b>0.18</b>
<b>Cluster 6: Culturally Appropriate Services</b>		<b>Bridging Value</b>
90	services are individualized (not everyone is offered the exact same services in the exact same way).	0.01
39	flexibility is built into the service system to provide unique/non-traditional services to meet family needs.	0.01
116	services and supports are strengths-based and draw on the existing resources of families.	0.02
13	services to families are provided using a multi-disciplinary approach.	0.03
72	there is consistency in who provides services to families.	0.05
107	services are provided within families' own communities.	0.07
108	services are available to families regardless of families' financial resources.	0.11
<b>Average Bridging =</b>		<b>0.04</b>

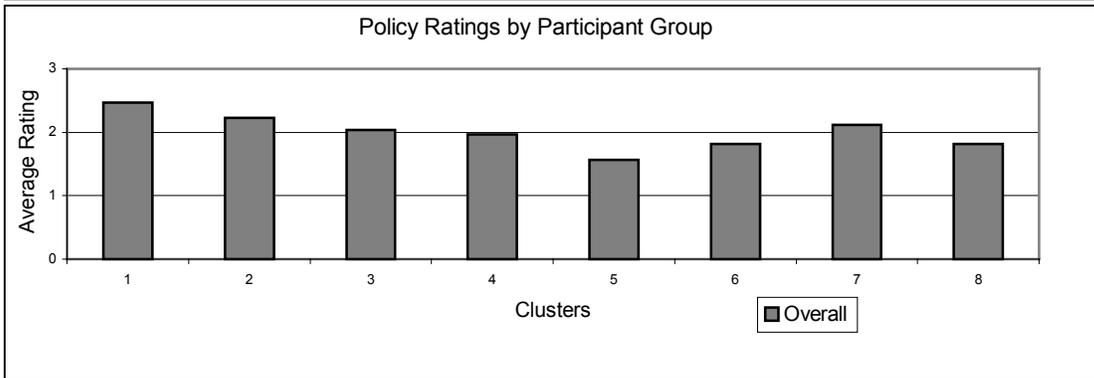
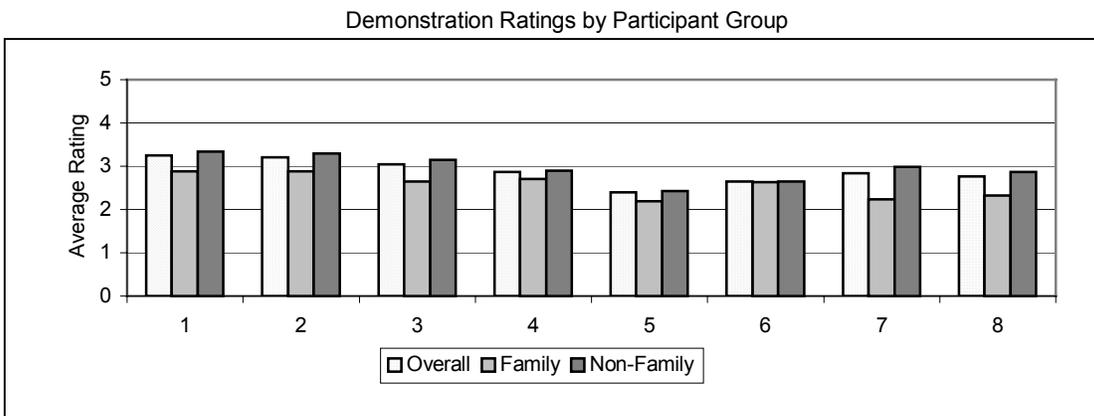
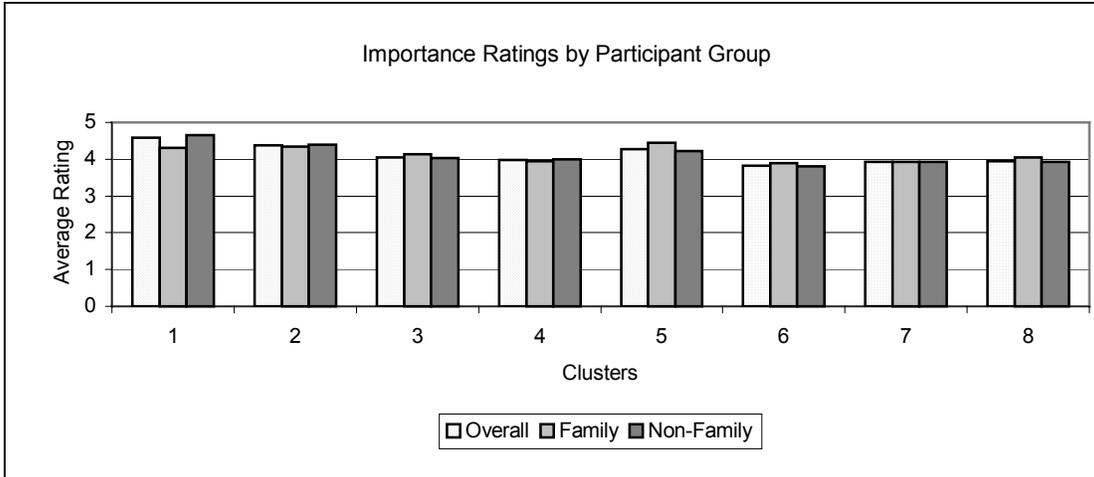
<b>Cluster 7: Gov't/Agency Community Involvement</b>		<b>Bridging Value</b>
103	the cultural demographics of those served reflect the community's population.	0.30
41	there is inter-agency cultural and historical understanding.	0.40
65	practitioners can actually impact changes in the system of care.	0.44
17	policy (legislated and agency) permits providers the flexibility to do what is needed for families.	0.50
15	decision-making bodies change services to meet the needs of the whole community.	0.50
37	organizations provide community-specific cultural competence training to employees at all levels.	0.52
45	community ownership of services is valued by community members and supported by service providers.	0.52
2	government's understanding of the community's service needs are supported through appropriate funding allocation structures.	0.58
<b>Average Bridging =</b>		<b>0.47</b>
<b>Cluster 8: Agency Policies</b>		<b>Bridging Value</b>
63	services and systems are non-competitive.	0.30
52	workers are given rapid due process for accusations made by consumers.	0.36
53	agency policies allow employees to have case-related grief time.	0.37
55	staff are hired who have experienced mental health illnesses.	0.41
54	professional and direct care staff receive equitable pay.	0.43
<b>Average Bridging =</b>		<b>0.37</b>
<b>Cluster 9: Removing Restrictions to Access</b>		<b>Bridging Value</b>
40	there is continuity of care for families over the long haul.	0.20
62	people don't hear professionals make remarks based on ethnic origins.	0.25
109	agency forms and documents are printed in the cultural language of families.	0.30
18	when services to families remain consistent across political parties.	0.39
6	"red tape" is not a barrier to families accessing services.	0.49
57	there are no more waiting lists.	0.51
19	employers are supportive of employees who have family members with special needs.	0.66
<b>Average Bridging =</b>		<b>0.40</b>
<b>Cluster 10: Education Involvement/Expectations</b>		<b>Bridging Value</b>
24	educational system is prepared to be positive participants.	0.76
59	continuing education is offered to both families and professionals.	0.81
58	there is not an over-representation of children in alternative education.	0.83
48	higher education institutions know their communities and can teach students about alternative types of referrals.	0.85
43	the educational needs of all children are met and supported.	1.00
<b>Average Bridging =</b>		<b>0.85</b>

<b>Cluster 11: Family Empowerment</b>		<b>Bridging Value</b>
50	families are given the time and consideration their situation deserves.	0.06
84	families know the service providers care.	0.06
10	families are empowered by the strengths and differences of their culture.	0.07
49	family voice and choice are prioritized.	0.07
80	families feel they are treated with dignity and respect.	0.08
34	families are active in all aspects of services.	0.09
36	families are invested in the service process.	0.09
115	families feel comfortable accessing services and asking questions of service providers.	0.11
44	families have a lot of options for services.	0.12
46	families view service providers, policy-makers and agency administrators as helpful and motivating.	0.15
78	opportunities are available for families to support and share information with one another.	0.16
87	families feel listened to and heard by service providers.	0.20
112	families are able to communicate in their own language with service providers.	0.22
<b>Average Bridging =</b>		<b>0.11</b>
<b>Cluster 12: Respectful Responsiveness to Families</b>		<b>Bridging Value</b>
71	families are happy to see providers.	0.03
86	families' time is respected.	0.05
110	families can access services and providers with no barriers (transportation, language, education, cost).	0.07
70	families have a lot of options available when choosing service providers.	0.07
99	families and service providers are willing to share their cultures and beliefs with each other.	0.08
68	families get a response when they make a request.	0.10
77	families are referred to as people and don't feel labeled or stigma associated with receiving services.	0.13
94	families are accurately informed of services and resources that are available to them.	0.14
<b>Average Bridging =</b>		<b>0.09</b>
<b>Cluster 13: Outcomes and Accomplishments</b>		<b>Bridging Value</b>
31	communication between parents and their children improves.	0.44
20	noticeable progress is made in child outcomes.	0.55
26	kids are happy with themselves.	0.57
27	children are allowed to be children.	0.58
67	there are ways to measure achievement.	0.59
14	families get politically involved in advocating for change in government policies.	0.60
83	kids begin taking responsibility for their own behavior.	0.61
64	the elderly are valued.	0.69
<b>Average Bridging =</b>		<b>0.58</b>

<b>Cluster 14: Positive Family/Provider Regard</b>		<b>Bridging Value</b>
66	animosity is not present between systems and families.	0.09
33	everyone is treated equally in the service process.	0.13
51	services enhance family life.	0.17
23	people know how to appropriately respond to crisis situations.	0.26
60	persons don't insult one another by trying to be too culturally polite.	0.41
<b>Average Bridging =</b>		<b>0.21</b>
<b>Cluster 15: Responsive Family/Provider Communication</b>		<b>Bridging Value</b>
82	there is two-way respectful communication between children and service providers.	0.12
106	the line of communication is always open.	0.17
30	the needs of families are met.	0.20
32	families are satisfied with the services they receive.	0.20
29	families understand how to use impartial grievance procedures.	0.23
117	families are able to find resources on their own and use new resources to help themselves.	0.25
88	parents and children are individually treated with respect.	0.25
38	families are educated about the organizations' cultures and mandates.	0.37
<b>Average Bridging =</b>		<b>0.22</b>

## APPENDIX J

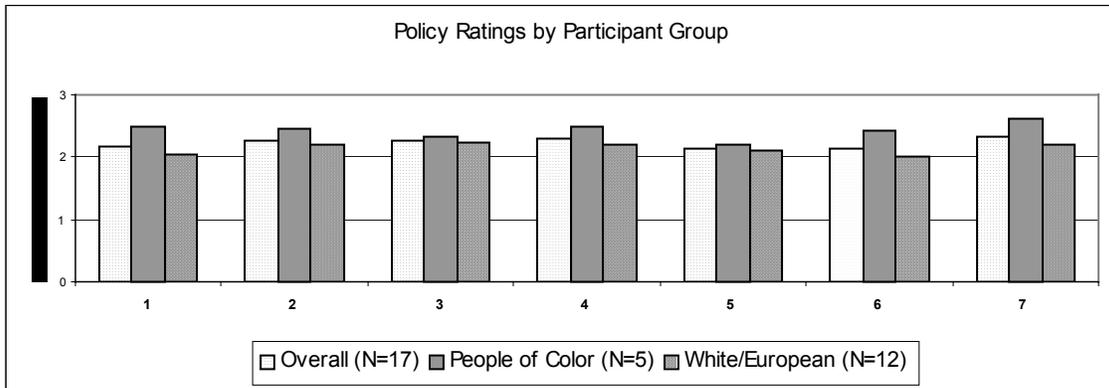
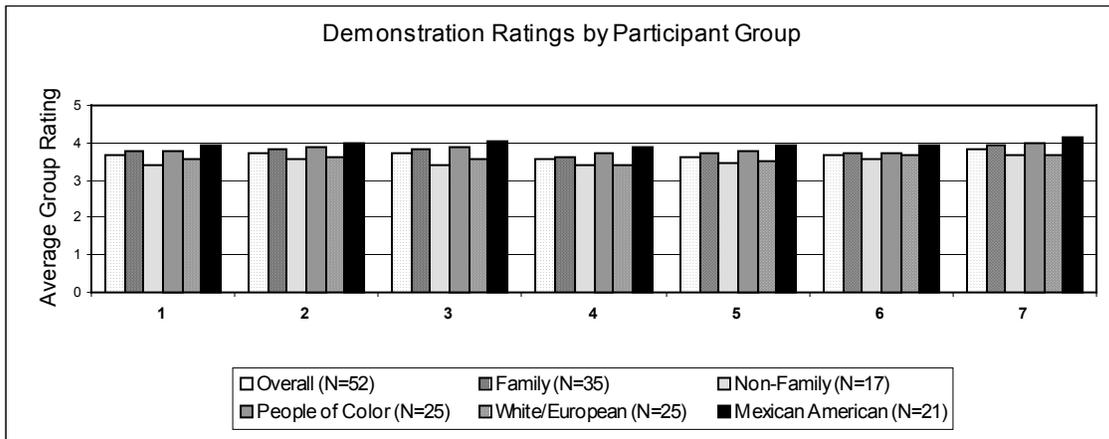
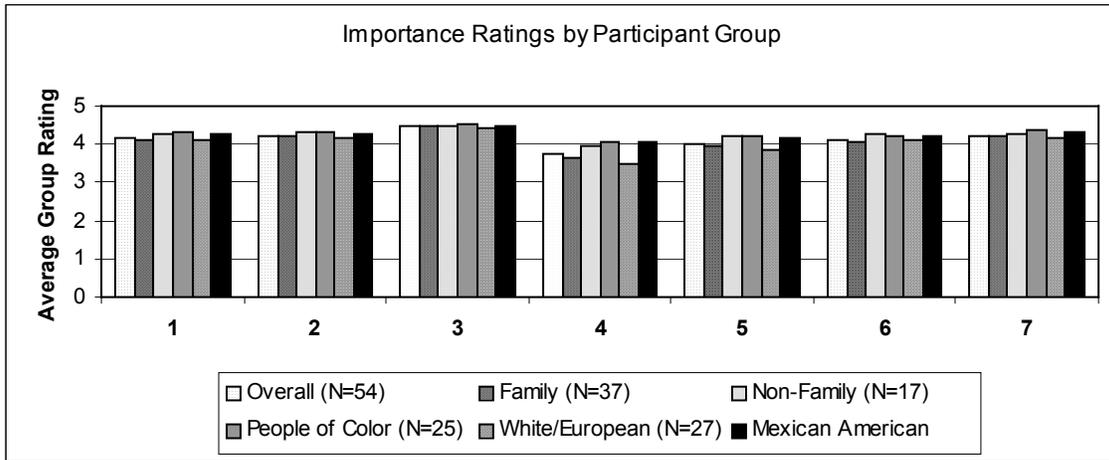
### URB-N



**Clusters**

- |   |  |
|---|--|
| <ol style="list-style-type: none"> <li>1. Respect &amp; Dignity of Family</li> <li>2. Family-Driven Service Delivery System</li> <li>3. Quality Assurance of System of Care Reform</li> <li>4. Characteristics of Effective Agencies</li> </ol> | <ol style="list-style-type: none"> <li>5. Responsive Resource Allocation Policies</li> <li>6. Changes in System Services with Needs of Consumer</li> <li>7. Cultural Competence: Staff &amp; Training</li> <li>8. Local Service Policy Implications</li> </ol> |
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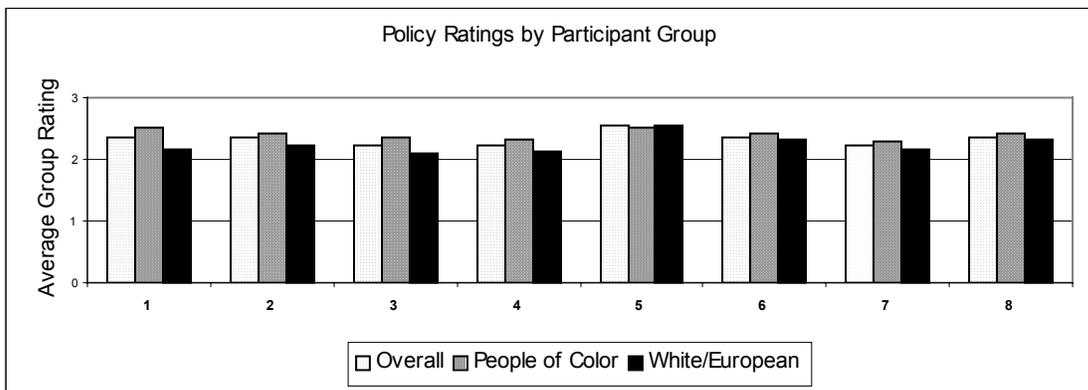
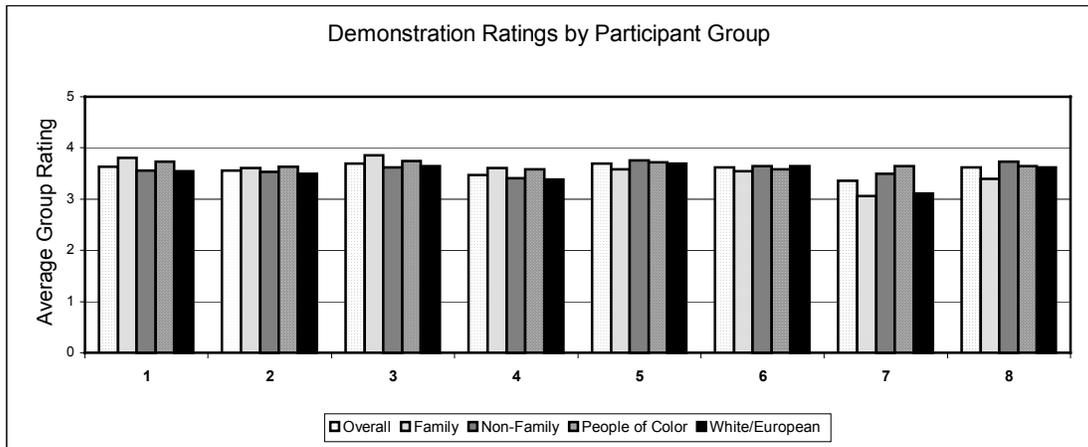
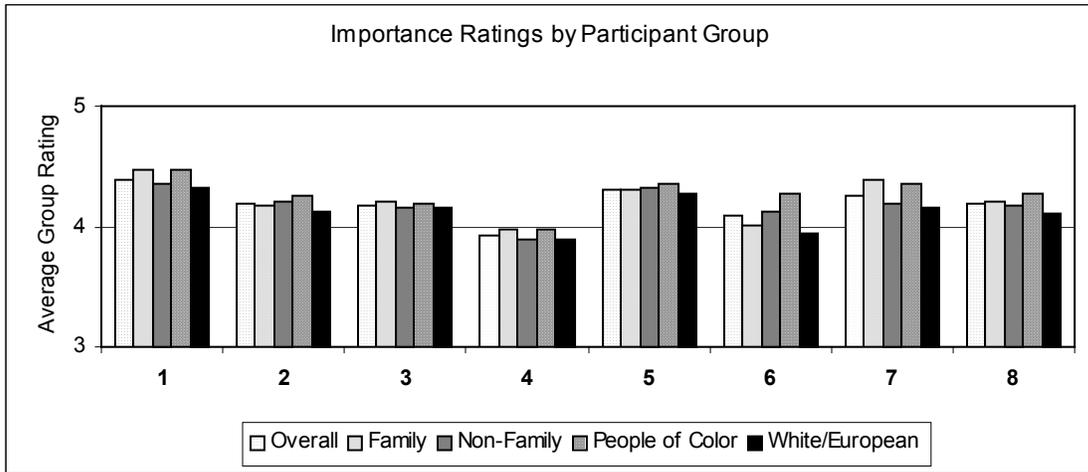
RUR-W



**Clusters**

- |                                   |                                     |
|-----------------------------------|-------------------------------------|
| 1. Families as Partners           | 5. Positive Interagency Interaction |
| 2. Good Service Practices         | 6. Responsive to Family Uniqueness  |
| 3. Positive Measurable Progress   | 7. Provider-Family Respect/Rapport  |
| 4. Culturally Responsive Services |                                     |

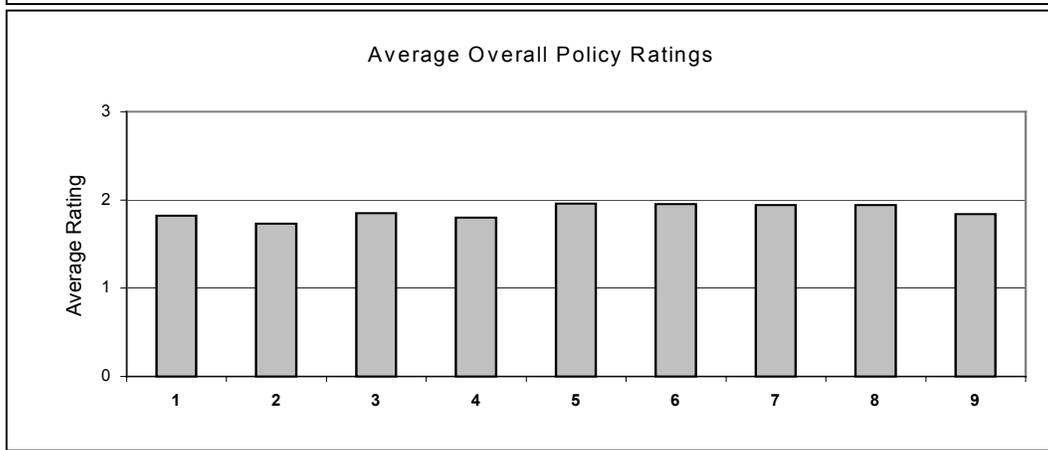
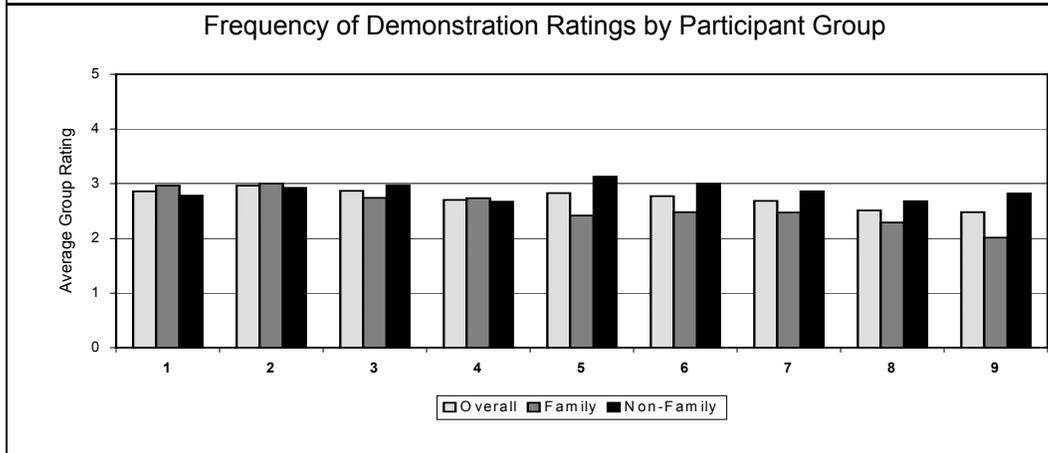
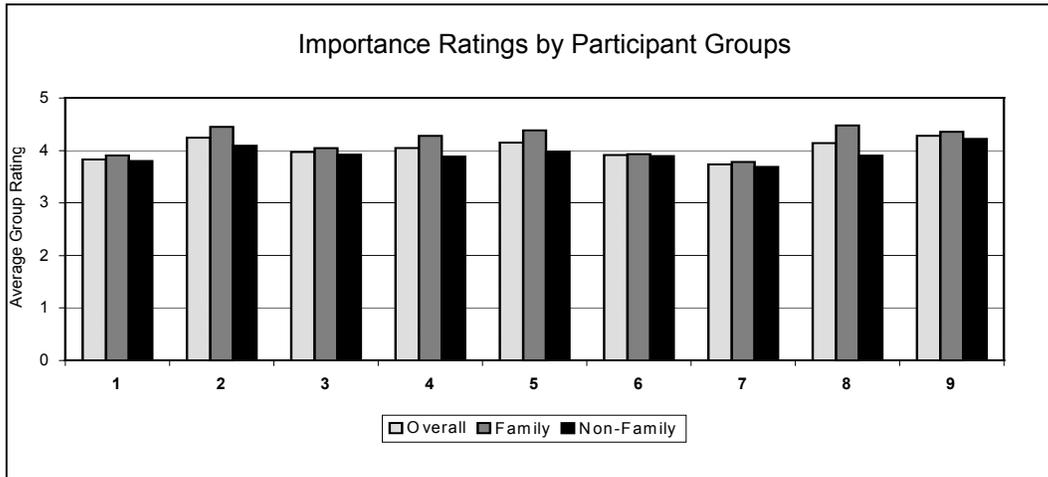
## URB-E



#### Clusters

- |   |  |
|---|--|
| <ul style="list-style-type: none"> <li>1. Family-Focused Services</li> <li>2. Empowering &amp; Respecting Families</li> <li>3. Developing Positive/Trusting Relationships</li> <li>4. Family/Provider Partnerships</li> </ul> | <ul style="list-style-type: none"> <li>5. Individualized Services</li> <li>6. Characteristics of Quality Services</li> <li>7. Continuity of Care</li> <li>8. The Role of the Service Provider</li> </ul> |
|---|--|

## RUR-E

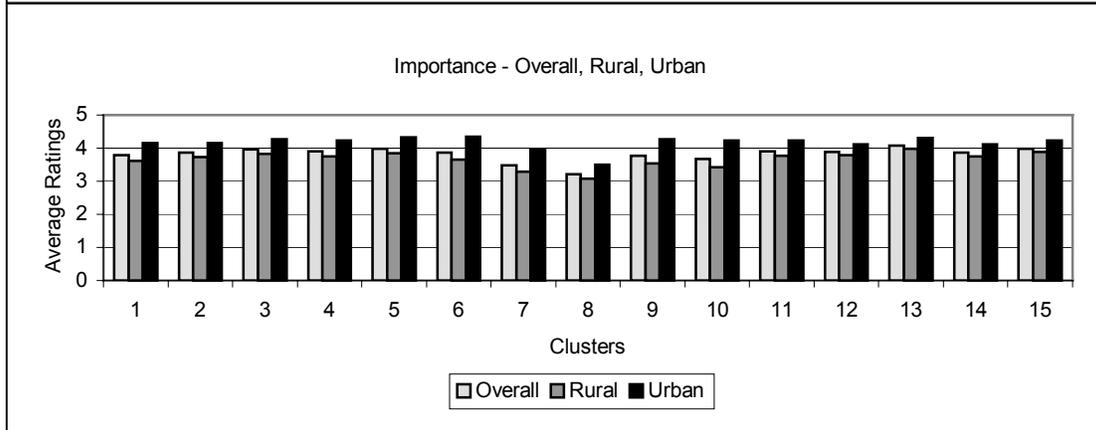
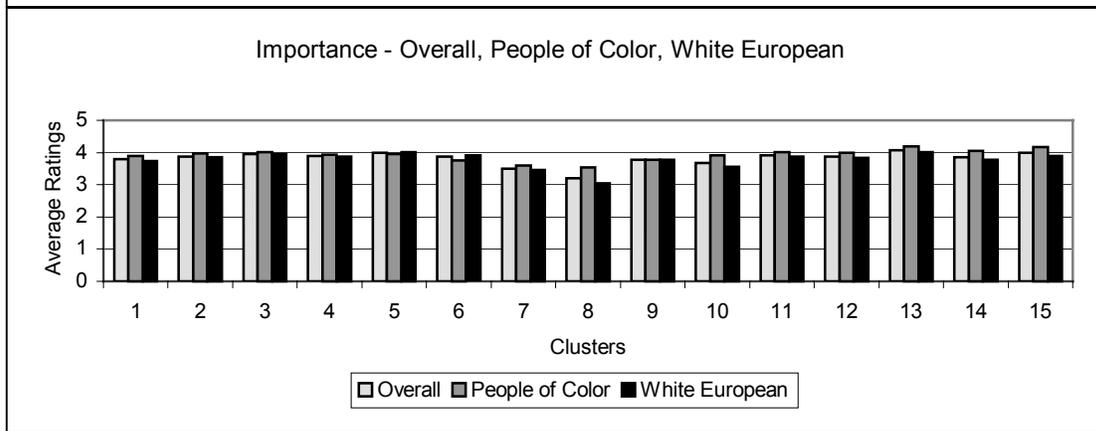
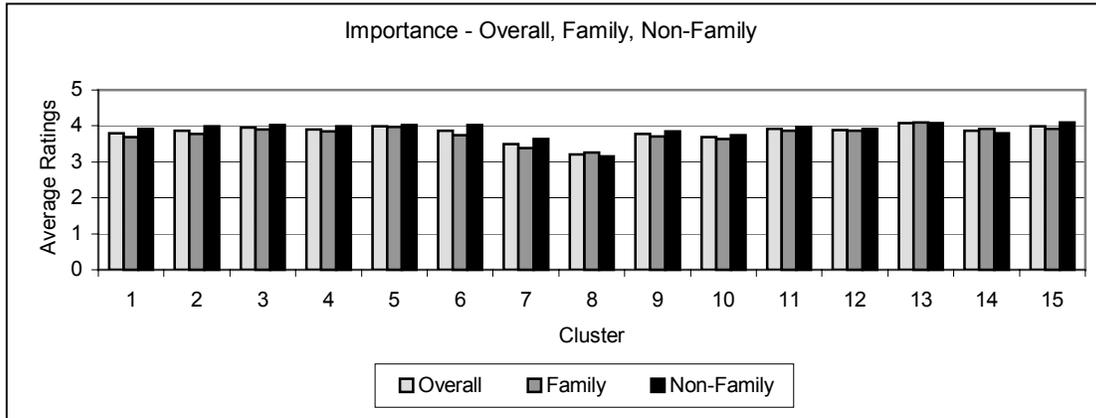


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|---|--|
| 1 - Family Follow-Through & Empowerment | 6 - Providers Embrace Family Culture             |
| 2 - Mutual Trust & Respect              | 7 - To Prevent Cultural Barriers                 |
| 3 - Meeting Individual Family Needs     | 8 - Service Accessibility                        |
| 4 - Famil Barriers                      | 9 - Enhancing Policy to Facilitate Collaboration |

Aggregate Study  
Pattern Match Comparison Correlations

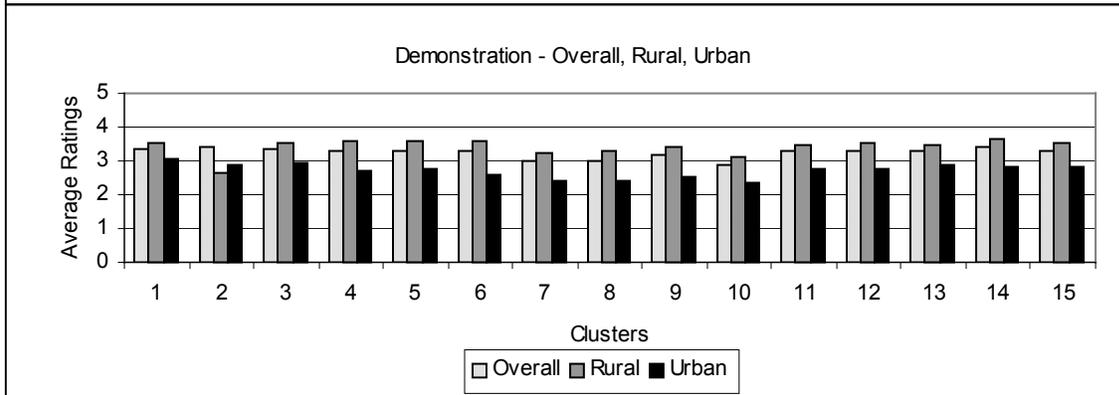
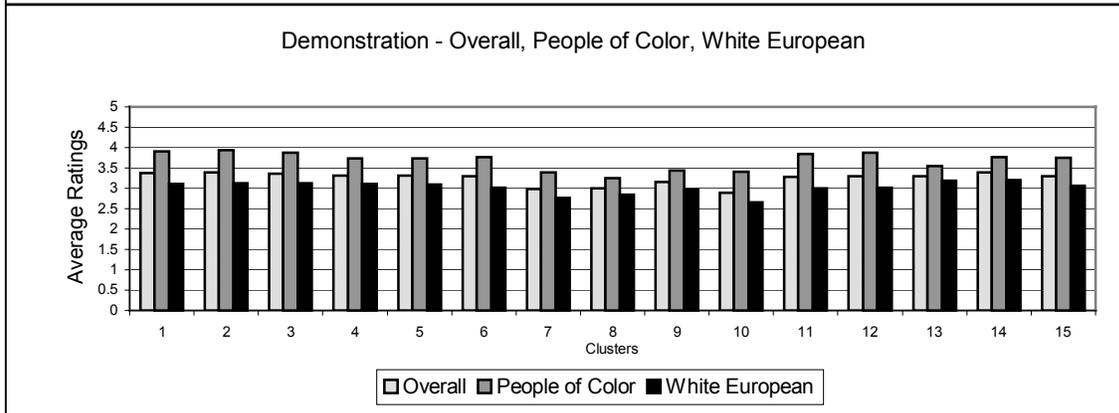
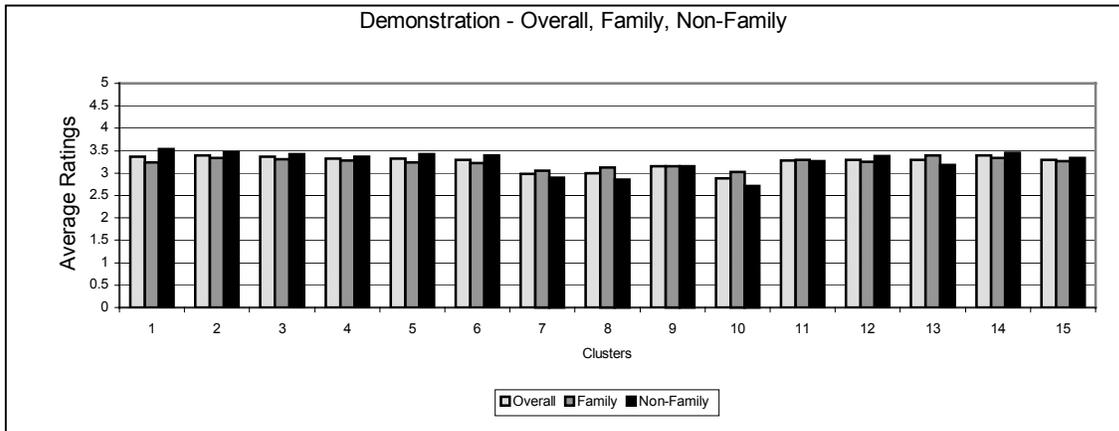
Group/Comparison	Importance	Demonstration	Policy	Importance vs. Demonstration
Total Participants (N=45)				.73
Family (n=26)				.75
Non-Family (n=19)				.67
Family vs. Non-Family	.86	.75		
People of Color (n=16)				.58
White/European (n=28)				.70
People of Color vs. White/European	.78	.71	.78 (n=8 vs. n=10)	
Gender – Female (n=34)				.71
Gender – Male (n=11)				.58
Gender – Female vs. Male	.85	.66	---	
Rural (n=31)				.72
Urban (n=14)				.38
Rural vs. Urban Communities	.78	.73	.59	
Household Income				
\$15K & Under vs. Over \$15K (n=13 vs. n=32)	.73	.60	---	
\$25K & Under vs. Over \$25K (n=20 vs. n=25)	.80	.74	---	
\$50K & Under vs. Over \$50K (n=32 vs. n=13)	.85	.87	---	
Disability-Family vs. No Disability- Family (n=11 vs. n=34)	.83	-.19		
Religious Group Affiliation (n=36)				.71
No Religious Group Affiliation (n=9)				.70
Religious Group Affiliation vs. No Religious Group Affiliation	.75	.73	---	
Age 40 & Over vs. Under 40 (n=24 vs. n=18)	.82	.76	---	

## Aggregate Study



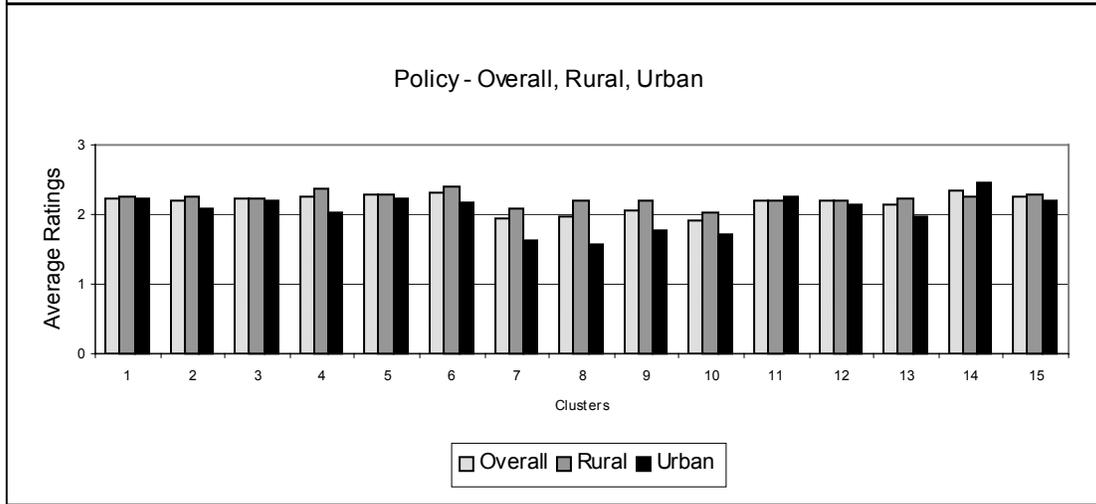
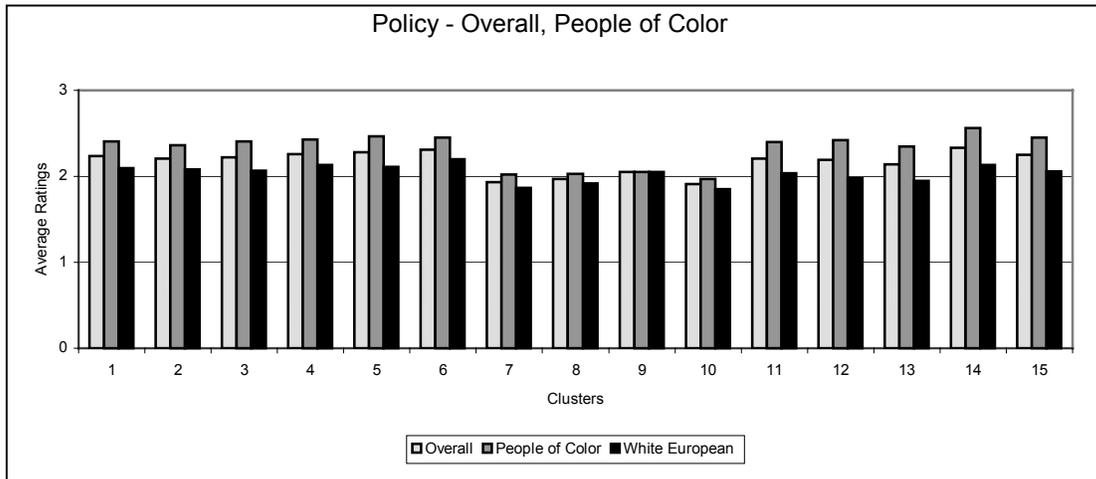
- Clusters**
- |   |  |
|---|--|
| <ul style="list-style-type: none"> <li>1: Service Provider Competencies</li> <li>2: Family-Centered Services</li> <li>3: Provider-Family Interaction</li> <li>4: Culturally Accountable System Policies</li> <li>5: Provider Accountability to Families</li> <li>6: Culturally Appropriate Services</li> <li>7: Gov't/Agency Community Involvement</li> <li>8: Agency Policies</li> </ul> | <ul style="list-style-type: none"> <li>9: Removing Restrictions to Access</li> <li>10: Education Involvement/Expectations</li> <li>11: Family Empowerment</li> <li>12: Respectful Responsiveness to Families</li> <li>13: Outcomes &amp; Accomplishments</li> <li>14: Positive Family/Provider Regard</li> <li>15: Responsive Family/Provider Communication</li> </ul> |
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## Aggregate Study



- |  |  |
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| <p>ce Provider Competencies<br/>         Family-Centered Services<br/>         der-Family Interaction<br/>         Accountable System Policies<br/>         to Families<br/>         turally Appropriate Services<br/>         Community Involvement<br/>         8: Agency Policies</p> | <p><b>Clusters</b></p> <p>9: Removing Restrictions to Access<br/>         10: Education Involvement/Expectations<br/>         11: Family Empowerment<br/>         12: Respectful Responsiveness to Families<br/>         13: Outcomes &amp; Accomplishments<br/>         14: Positive Family/Provider Regard<br/>         15: Responsive Family/Provider Communication</p> |
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## Aggregate Study



- Clusters**
- |   |  |
|---|--|
| <ul style="list-style-type: none"> <li>1: Service Provider Competencies</li> <li>2: Family-Centered Services</li> <li>3: Provider-Family Interaction</li> <li>4: Culturally Accountable System Policies</li> <li>5: Provider Accountability to Families</li> <li>6: Culturally Appropriate Services</li> <li>7: Gov't/Agency Community Involvement</li> <li>8: Agency Policies</li> </ul> | <ul style="list-style-type: none"> <li>9: Removing Restrictions to Access</li> <li>10: Education Involvement/Expectations</li> <li>11: Family Empowerment</li> <li>12: Respectful Responsiveness to Families</li> <li>13: Outcomes &amp; Accomplishments</li> <li>14: Positive Family/Provider Regard</li> <li>15: Responsive Family/Provider Communication</li> </ul> |
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## **Vita**

Tamara Sue Davis was born in Kokomo, Indiana on December 23, 1960, the daughter of Cora Sue Davis and Marvin Dale Davis. After graduating from Bristol Eastern High School, Bristol, Connecticut, in 1978, she attended Berea College in Berea, Kentucky for two years and the University of Kentucky for one and a half years. She subsequently lived in several states and attended various colleges while working as a secretary and assistant in business, military, higher education, and human service agencies. She eventually received her Bachelor of Science in Guidance and Counseling from the University of Louisville, Louisville, Kentucky, in May 1993. While working as a supervisor in children's emergency and community-based residential services, she attended the Kent School of Social Work, University of Louisville, and received her Master of Science in Social Work in December 1995. She then directed family services programs in a community-based nonprofit agency and served as administrative liaison for evaluation in county government human services until entering the Graduate School of the The University of Texas at Austin in August 1998. Throughout her doctoral studies she researched, presented and published on evaluation and research methods, federal evaluation policy, child welfare and child abuse prevention evaluation, and children's mental health systems of care.

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