THE PSYCHOSOCIAL IMPACT OF CULTURAL COMPETENCY AND THE ASIAN PACIFIC ISLANDER COMMUNITY’S UTILIZATION OF MENTAL HEALTH

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B.A., California State University, Sacramento, 2008

PROJECT

Submitted in partial satisfaction of the requirements for the degree of

MASTER OF SOCIAL WORK

at

CALIFORNIA STATE UNIVERSITY, SACRAMENTO

SPRING
2010
THE PSYCHOSOCIAL IMPACT OF CULTURAL COMPETENCY AND THE ASIAN PACIFIC ISLANDER COMMUNITY’S UTILIZATION OF MENTAL HEALTH

A Project

by

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Division of Social Work
Abstract

of

THE PSYCHOSOCIAL IMPACT OF CULTURAL COMPETENCY AND THE ASIAN PACIFIC ISLANDER COMMUNITY’S UTILIZATION OF MENTAL HEALTH

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Cultural competence has long been emphasized in the practice of mental health care. However, there still lies a broad definition of how the system of care constitutes cultural competence and how services should be delineated as best practices for those seeking culturally responsive treatment within the Asian Pacific Islander population. The purpose of this study was to determine if cultural competency components addressed in treatment contributed to the successful outcomes of the consumers served. A qualitative study was conducted with ten closed-case files from an outpatient mental health program, created to serve the Asian Pacific Islander population of Sacramento County. Although there were components of cultural competent practice implemented in the providers’ work with the consumers, the researcher cannot come to a definitive conclusion that it was the provider’s degree of cultural competence that directly contributed to the success rates of those that received mental health treatment.

___________________________________, Committee Chair

Date

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ACKNOWLEDGMENTS

I want to thank all of those who have supported me through the completion of my Master’s project. Special thanks to my family, girlfriend and friends for all your love, inspiration, patience, and support. Your thoughts and prayers will forever be in my heart.
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Chapter 1

INTRODUCTION

Cultural competence is defined as “understanding the concept of culture; appreciating the strengths inherent in all diverse cultures; acquiring a continuously growing knowledge base about clients’ cultures that can be applied to practice; and seeking to understand the nature of oppression and social diversity as they apply to various groups” (Krist-Ashman & Hull, 2006, p. 358).

In an ever-diversifying society, it would be expected of all persons in the social work disciplines to adapt and be culturally knowledgeable in addressing the needs of those seeking and utilizing social services. The quality of service and the relationship between social service providers and its community depends on whether the provider is habituated with the target population’s language, history, current events, and cultural practices (Gaylord, Hewitt, & Larson, 1998). Thus, the National Association of Social Workers compiled a set of standards in which all social workers are expected to abide by in the profession in order to ethically work competently with consumers. According to the NASW Code of Ethics, under section 1.05:

(a) Social workers should understand culture and its function in human behavior and society, recognizing the strengths that exist in all cultures.

(b) Social workers should have a knowledge base of their clients' cultures and be able to demonstrate competence in the provision of services that are sensitive to clients' cultures and to differences among people and cultural groups.
(c) Social workers should obtain education about and seek to understand the nature of social diversity and oppression with respect to race, ethnicity, national origin, color, sex, sexual orientation, age, marital status, political belief, religion, and mental or physical disability (National Association of Social Workers, 1999).

This section of the code assumes that the provider takes into account the importance of the consumers’ values, beliefs, traditions, and customs. Social workers should be self-reflective and aware of the impact of their own culture on the therapeutic relationship. Furthermore, providers should take into account all influential factors of their own culture when planning and delivering services (Cultural Competence, 2001, p. 1).

**Background of the Problem**

Cultural competence has long been emphasized in the practice of health care. However, there still lies a broad definition of how the system of care constitutes cultural competence and how services should be delineated as best practices for those seeking culturally responsive treatment. Rather than incorporating the intricate component of culturally responsive practice and understanding its positive effects on the clinical outcome of treatment; Western modalities in providing health care viewed illness as a universal process where one mode of treatment is believed to be applicable to all. Therefore, interventions and treatments were preconceived to be pertinent to all consumers without the understanding that health and illness are “culturally constructed experiences” and can manifest in many aspect of a consumer’s life (Wynaden, Chapman, Orb, McGowan, Zeeman, & Yeak, 2005, p. 89). In contrast to this “universal process,”
treatment and interventions should take a holistic approach where consumers are treated according to their self-directed, individual needs.

Due to prevalent stereotypes such as the *Model Minority* depicted throughout mainstream society, the Asian Pacific Islander (API) population is often overlooked in a needs assessment and perceived to thrive in our country. Contrary to popular belief that Asian Pacific Islanders have little to no major mental health challenges, “older Asian American women rank high in rates of depression and suicide; as do Native Hawaiian youth in relation to suicide and other mental health issues (Ida, 2007, 50).” Furthermore, given the recent and distressing migration history of many subgroups within the API population, two studies conducted with psychiatric patients found that fifty to seventy percent of the patients seen at these clinics were diagnosed with Post-Traumatic Stress Disorder (PTSD) (Abe, Zane, & Chun, 1994).

“The current mental health system has neglected to incorporate, respect or understand histories, traditions, beliefs, languages, and value systems of culturally diverse groups (Ida, 2007, p.50).” Consequences of not addressing these cultural dynamics in practice can lead to misinterpretations and overgeneralization of consumer mental health behaviors; subjecting individuals to acculturation stress, discrimination, prejudice, communication barriers, and political injustices (Lee & Mokuau, 2002). Clinically, the incompetent practice of not integrating cultural competence into assessments can result in misdiagnosis, unnecessary/inappropriate interventions, and poor quality of service (as cited in Lu, 2002; Lee, 1997; Hays, 2001; Ida & Yang, 2003; Davis, 2004, Ida, 2007).
Recovery must involve the whole person and includes the mental, emotional, physical and spiritual needs of each person. Recovery oriented care integrates primary health, mental health, and substance use [while] simultaneously helping an individual reclaim one's culture and community as part of feeling whole again. It is overcoming the double stigma of mental illness and their social standing (Ida, 2007, p.51).

Ignoring the consumer’s cultural beliefs and practices can give the impression that one’s cultural identification is neither important nor relevant in the treatment process. Such incompetent practice sets yet another barrier in which API consumers have to overcome in addressing their quality of care.

Statement of the Research Problem

The current mental health is not responsive to the cultural and linguistic needs of the Asian Pacific Islander population. Much of the Asian Pacific Islander population continues to be underserved and underrepresented in the current mental health system due to cultural and linguistic barriers that are not adequately addressed in our system of care.

Purpose of the Study

The goal of this study is to bring consciousness to how cultural competency should be integrated into services made available to the Asian Pacific Islander community. This research hopes to enhance the knowledge base of our social work colleagues on the issues of cultural competence, in hopes of enhancing the practitioner’s ability to provide more culturally competent services to their consumers. As social workers strive to professionalize the field, this study has great relevance to the social
work profession because as competent service providers, it is crucial to be culturally responsive and sensitive by being respectful of the values, beliefs, traditions, and customs of the consumers we serve. For the purposes of this research, cultural competence will equate to cultural specific expertise defined in Chapter II.

**Theoretical Framework**

Within the last three decades, there has been a movement taking place within the public mental health system and how it goes about delivering services in a more receptive, consumer-based methodology. A key component of this approach is the integration of the consumers’ culture, racial/ethnic background, values, beliefs, and spirituality as focal points of the recovery process. Thus, this researcher is adopting the conceptual approach of the “Recovery Model” to provide a means for examining the challenges of delivering culturally competent services to the API community. This model also serves as a guide to examine relationships between cultural competency components in mental health treatment in relation to the API community’s receptiveness to seeking and receiving mental health services.

The Recovery Model stresses the importance of meeting client needs through a consumer-centered approach. “Culture-centered” recovery reflects the growing understanding of the critical role that culture plays in creating the context for a resilient consumer recovery. A culture-centered approach seeks to understand a person-in-recovery from the individual’s cultural context through a holistic approach of body and mind (Dahlquist, Stafford, Patterson, Baptista, Hosseini, Sherman, & Curran, 2007, p. 18).
Furthermore, the Recover Model lays the foundation for a mental health system of care that values consumer participation and strives to eliminate “professional distance” by having providers build subjective awareness of the consumer’s “real life” experiences. This holistic approach not only focuses on the pathology of mental health illness; rather, the recovery process should also focus on the improvement of the consumer’s quality of life (Ragins, 2004). A recovery-based system of care would accomplish this goal by gaining an overall understanding the illness, its triggers, and medication treatment in correlation with stress management, skill building, integration of protective social networks, and family and consumer psychoeducation in symptom management. Thus, rehabilitative services would center on the ideology of valuing a person’s increase level of functioning and meaningful participation in the community while still coping and managing their symptoms (Ragins, 2004). The Recovery Model takes a progressive approach in transforming the current mental health system into a more holistically responsive system of care.

Definition of Terms

Access: the ability, right, or permission to approach, enter, speak with, or use (Access, 2009).

Acculturation: “multidimensional process whereby personal values, attitudes, beliefs, language, identity, and customs from one’s native culture are influenced by contact with a different culture” (Cameron et al., 2008, p. 290).
API: refers to the Asian Pacific Islander population (i.e. Cambodian, Chinese, Fijian, Filipino, Hawaiian, Hmong, Japanese, Korean, Laotian, Mien, Samoan, Tongan, and Vietnamese).

Barriers: a means that restrains or obstructs progress, opportunity, or access.

Competence: “Implies having the capacity of function effectively within the context culturally integrated patterns of behavior as defined by each cultural group” (California Mental Health Planning Counseling, 2003, p. 4).

Completed Treatment: refers to the categorization of consumers in this study who completed their mental health treatment (Type of discharge: “Client completed mental health service”).

Cultural competence: For the purposes of this study, cultural competence will equate to cultural-specific expertise as defined in Chapter 2.

Cultural formulation: For the purposes of this study, the researchers working definition of cultural formulation is the culminating integration of race, ethnicity, gender, sexual orientation, age, marital status, political belief, religion, and mental or physical disability and its influence in the psychological and social construct of one’s identity and their interactions with outside systems.

Culture: “the integrated pattern of human behavior that includes thought, communication, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social group” (California Mental Health Planning Counseling, 2003, p. 4).

Model Minority: stereotype suggests that Asian Americans are more academically, economically, and socially successful than any other racial minority groups. It is a set of
stereotypes that says all Asian Americans are successful in some way and that we really
do not face the same sort of struggles that other minorities in American face (Yoo, 2010;Xun, 2005).

Not Completed Treatment: refers to the categorization of consumers in this study who
did not complete their mental health treatment (Type of Discharge: “Clt rec’g MH svc
elsewhere-step up, Clt rec’g MH svc elsewhere-step down, Clt rec’g MH svc elsewhere-
transfer, Clt is no longer rec’g MH svc-ref/decline, Clt whereabouts unknown, Clt moved
out of Sac Co, Clt is deceased”).

Psychosocial: pertains to interactions between psychological and sociological factors.

Recovery:

Recovery is a process, a way of life, an attitude, and a way of approaching the
day’s challenges. It is not a perfectly linear process. At times, our course is erratic
and we falter, slide back, regroup and start again. . . .The need is to meet the
challenge of the disability and to re-establish a new and valued sense of integrity
and purpose within and beyond the limits of the disability; the aspiration is to
live, work, and love in a community in which one makes a significant

Stigma: For the purposes of this study, the term stigma is used in correlation of mental
health. It is defined a perceived “flaw resulting from a personal or physical characteristic
that is viewed as socially unacceptable; stigma associated with the process of seeking
mental health intervention is the negative perception that an individual who receives
psychological help is socially undesirable (Shea & Yeh, 2008, p.159).”
Assumptions

Cultural misunderstanding and culture-based alienation, economic barriers, mistrust, and stigma all play important factors in why the Asian Pacific Islander population do not seek or receive appropriate treatment. Language differences between providers and potential consumers are also relevant obstacles to treatment. Moreover, whether or not consumers are receiving culturally appropriate services, it factors into the utilization of mental health services by the underserved and underrepresented API community.

Justification

Social work is in a compelling position to improve health disparities among people with mental illness. Social workers are the nation's largest group of mental health providers and routinely work to promote holistic care and comprehensive health services for people with mental illness (Hahm, Speliotis, & Bachman, 2008, p. 97).

Cultural competence is a crucial factor at the forefront of making this progression. However, “knowledge of these cultural variations has failed to move health care out of its ethnocentric paradigm” (Wynaden et al., 2005, p.89).

Delimitations

Delimitations to this specific study include: 1) a small sample size; 2) results cannot be generalized to the entire Asian Pacific Islander community; 3) study is based on close case files of only one agency; 4) close case files were selected by the providing
agency; and 5) cultural assessment and service delivery is subjected to the individual style and experience of the mental health provider.

Summary

In assessing the barriers of cultural and social integration in the API population, access and attitudes towards helping professionals are influenced by linguistic challenges, knowledge about available resources, social stigma and cultural understanding of emotional and psychological treatment within the spectra of Asian culture (Shea & Yeah, 2008). This research will explore how cultural competency is currently integrated into the delivery of mental health services. More specifically, this study will examine the psychosocial impact of cultural competency and the Asian Pacific Islander community’s utilization of mental health.
Chapter 2

LITERATURE REVIEW

Introduction

In the early decades of the twentieth century, vocational and psychological counseling did not expand across all cultures in the population for a number of reasons. One reason was that persons of color faced discrimination and prejudice. They were also excluded from entering the helping professions; limiting the influence and incorporation of multicultural counseling. Since the implementation of the U.S. migration laws of 1965, the Asian population in the United States has called for recognition of the unique cultures that exist among the different Asian ethnicities (Ponterotto, Casas, Suzuki, & Alexander, 1995, p. 123). As a result of this multicultural lens, global studies now show that access by these groups to psychiatric services and preventive care has been limited (Wynaden, Chapman, Orb, McGowan, Zeeman, & Yeak, 2005, p. 89).

The fundamental differences among people arise from their familial relationships, nationality, racial and ethnic background, and individual experiences. Hence, diversity plays an intricate part in health and recovery behaviors of both the consumer and provider. To provide culturally competent care that is accessible and with favorable outcomes in creating positive interpersonal and satisfying experiences, it requires practitioners to have a greater understanding of the consumers’ social, cultural, economic and familial backgrounds.

The Federal government played a pivotal rule in recognizing the importance of human rights and how cultural competency should be integrated in the delivery of quality
health care. “Title VI of the Civil Rights Act of 1964 mandates that no person in the United States shall, on ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance” (National Center for Cultural Competence, 2009. P.1). Moreover, increasing one’s cultural knowledge and understanding on the part of the provider is a component of health care delivery that is important in reducing current health disparities among racial, ethnic and cultural groups.

In 1989, Cross, Bazron, Dennis and Isaac (1989) created a conceptual framework and definition that established a foundation in the field, Toward a Culturally Competent System of Care, Volume 1. This framework of practice goes beyond the micro level of health care delivery and pushes to implement a culturally competent system of care that is incorporated into policy, structure, behaviors, and attitudes in practice. Toward a Culturally Competent System of Care, Volume 1 is perceived to be universally applicable across multiple systems of care; and the emergence of cultural competency work in the past years has its foundation in this framework of practice (Goode, Dunne, & Bronheim, 2006). Cross et al. created a philosophical system of care that views cultural competency practice not as structured step-by-step approaches. Rather, Cross et al.’s framework claims that the complex delivery of cultural competency spans across a continuum based on six principles of practice: 1) cultural destructiveness (altering the attitudes, policies structures, and practices within a system that is destructive to a cultural group); 2) cultural incapacity (the inability of the system to respond effectively to the needs, interests and preferences of culturally and linguistically diverse groups); 3) cultural
blindness (the belief and practice of viewing and treating all individuals equals); 4) cultural pre-competence (the system’s self-awareness of their strengths and potential for growth to respond effectively to culturally and linguistically diverse groups); 5) cultural competency (the system’s acceptance and respect of cultural competence practice demonstrated through their mission, policies, best practices and community engagement) and 6) cultural proficiency (holding culture diversity to the highest esteem in guidance to endeavors) (Tawara, 2004). This framework of cultural competency not meant to define a system or organization in its structure. It is a concept created to help organizations expand and engage towards a positive understanding and delivery of cultural competent care. Thus, this culturally competent means of practice is not to be viewed in a linear manner; rather, it is to be viewed as a continuum for ongoing growth and adaptation.

With the emergence for a greater understanding and need for a diversified mental health system, in 2004 California voters passed a legislative bill (Proposition 63) that later created the Mental Health Services Act (MHSA) to transform the mental health system in California to meet the needs of marginalized groups within the population. A groundbreaking component of MHSA is the integration and promotion of culturally and linguistically competent services to underserved populations. Under stipulations of the Mental Health Services Act, the California Department of Mental Health (DMH) would contract with county mental health departments to create MHSA-funded programs (Cameron et al., 2008). Under the guidance of DMH, MHSA-funded programs are to develop and implement a system of care based on the principles of “community collaboration; cultural competence; client- and family-driven services; wellness focus,
which includes the concepts of recovery and resilience; and integrated services” (Cameron et al., 2008, p. 301).

The passage of MHSA led Sacramento County to fund three full-partnership MHSA programs, the Transcultural Wellness Center being the designated mental health program created to serve thirteen cultural groups of the API community. Leaders of Asian Pacific Community Counseling (providing agency) understood that it was a unique opportunity to provide culturally sensitive psychiatric rehabilitation and recovery services to the marginalized API communities of Sacramento County. The Transcultural Wellness Center is now implementing a system of care that is culturally unique in its integration of individuals and families in the blending of Western mental health modalities with “culturally specific somatic, spiritual, and medical strategies” in their delivery of therapeutic interventions and care (Cameron et al., 2008, p. 303).

Population Statistics and Mental Health Prevalence

In terms of percentage increase, Asian Americans are the fastest growing racial/ethnic group in the United States. The American Asian/Pacific Islander population grew 108% from 3,726,440 in 1980 to 7,273,662 in 1990, thus constituting 2.9% of the entire U.S. population according to the 1990 U.S. Census (U.S. Bureau of the Census, 1991). With recent estimates, Asian Americans now comprise nearly 5% and are the second fastest growing racial/ethnic groups in the United States (as cited in Cameron et al., 2008). Projections are that by the year 2020, the Asian American population will be approximately 20.2 million, or about 8% of the total U.S. population.
Not much is known about the rates of psychiatric disorders among the API population compared to other major ethnic groups. Although depression, anxiety and substance abuse have been reported, the manifestation and presentation of their symptomologies may be very different. Little is known about the mental health needs of children, adolescents, and older APIs. Asian Pacific Islanders have the lowest rates of utilization of mental health services among ethnic populations. Utilization of services tend be delayed until the need is severe and the family/community resources have been stressed (California Mental Health Planning Council, 2003; US Department of Health and Human Services, 2001).

Deconstructing Cultural Competence

As a provider, one must understand that sensitivity alone will not ensure effective or successful treatment of clients of diverse cultures. Conversely, mental health practitioners must understand the cultural influence of the client’s identity and apply that knowledge to their treatment plan. Given the increasing numbers of diverse populations within the United States, mental health professionals must be ever aware of and respond to the changing demographics by critically assessing the influence of culture on the consumers’ identity, behavior, attitude and mental health (Livingston, Holley, Eaton, Cliette, Savoy, & Smith, 2008). Livingston et al (2008) claims that there is a need to reassess our understanding of cultural competence not just as mere differences but to view cultural differences as valuable attributes in treatment in order to gain a deeper appreciation and acceptance of cultural and ethnic diversity.
In the Surgeon General’s Report, *Mental Health: Culture, Race and Ethnicity* (1999), culture influences many aspects of mental illness. Furthermore, the consumers’ cultural identity and perspective dictates behaviors, beliefs, practices and expectations around how one would approach the concept of health and healing. Furthermore, wellness and recovery predominately defined by the individual and the cultural group to whom he/she identifies. Thus, it is in the mental health providers’ commitment to providing cultural competent services that makes it vital to meeting the needs of the consumer and overcoming the barriers that many diverse communities face (California Mental Health Planning Council, 2003). Cultural sensitivity is relevant to provisions of mental health services because it affects the assessment process, etiology, the consumer’s manifestation of mental health symptoms and preferences in treatment. In practice, cultural competency is a component of service is a set of “attitudes, behaviors, and policies that enable a system, agency, or provider to treat culturally diverse clients effectively” (Mental Health Planning Council, 2003, P. 4).

In a society where such diverse Asian ethnic groups are perceived innately achieve, social perceptions such as the “Model Minority” blurs the wide-ranging social economic disparities among many Asian Americans (Lee, 1993). Although Asian Americans have the highest median household income of all ethnic groups and the rate of attaining college degrees are above the national average; sentiments of the model minority has overshadowed API ethnic subgroups that is in need of social services. Just as other ethnic groups, Asian Pacific Islanders also face social problems of poverty, acculturation, environmental stressors, juvenile justice, and substances abuse (Mental
Contradictory to the model minority stereotype, many Southeast Asian subgroups that often go unnoticed tend to have lower graduation rates and English proficiency than all racial and ethnic groups in the United States. Coinciding with these rates, Southeast Asian groups also have the highest utilization rates of public assistance of all major groups (Cameron et al., 2008). Furthermore, these negative perceptions are giving resurgence to anti-Asian sentiments and may have a negative impact upon immigrant newcomers who are expected to succeed upon entering the US. Thus, it is important to recognize the accomplishments of APIs within our society, but be consciously aware of the fact that many other API groups continue to struggle with poverty, psychiatric disability, and poor physical health (Cameron et al., 2008; Lee, 1993).

Our current system of care is not yet equipped to address the psychiatric needs of the API population. Challenges for mental health providers still lie around destigmatizing the concept of mental health and being sensitive to the help-seeking behaviors of the consumer within their own cultural perception and system of care. Although there have been considerable efforts to address diversity over the past century, there has been no resolution to the discourse of providing culturally competent services in mental health care because the mental health community failed to define the concept of culture and the intricate role it plays in the therapeutic framework of one’s recovery process (Livingston et al., 2008).

There is a general misconception that Asian Pacific Islanders are perceived to be one homogeneous ethnic group (Cultural Competence Standards in Managed Care...
Mental Health Services: Four Underserved/Underrepresented Racial/Ethnic Groups, 2007). In actuality, the Asian Pacific Islander population is composed of forty-three ethnic subgroups, each diverse in its own culture and linguistic variations; over one-hundred languages and dialects in all (Mental Health Fact Sheets, 1999). “Unfortunately, failure to make distinctions among the diverse ethnic, cultural, and language groups comprising Asian and Pacific Islanders, and tendencies to generalize their economic, social, and political circumstances, can lead to faulty conclusions about individuals’ mental health needs” (Cultural Competence Standards in Managed Care Mental Health Services: Four Underserved/Underrepresented Racial/Ethnic Groups, 2007, p. 1). Thus, cultural influences are relevant factors in the diagnosis and treatment of mental health disorders. According to Bussema and Nemec (1998), “Cultural differences exist in beliefs about the meaning and reality of mental illnesses, in how symptoms are expressed, and in what constitutes safe and effective treatment” (p. 71). Unfortunately, mental health service providers generally have a monocultural perception of treatment solutions that promotes Western values and viewpoints. Western philosophies tend not to be consistent with the viewpoints of persons from different cultural backgrounds. Recognizing how cultural influences and shapes the identity of a person helps prevent “placing anyone into the rigid mold of a particular cultural stereotype” (Bussema & Nemec, 1998, p. 72).

In understanding treatment from the client’s perspective, it is impossible to try to understand the consumer’s cultural background completely; rather, the provider should try to understand the cultural components that are salient to the therapeutic process. According to Stanley (2006), effective cultural practice means understanding care from
the consumer’s perspective. It also means acquiring a conceptualization of how the consumer views their mental health issues, means of addressing the illness, and their desired goals for treatment. If the consumer has a different understanding and means of resolution for their problems, he/she may be resistant to Western approaches. By utilizing a client-centered approach to providing service, the provider could more easily identify these barriers and discrepancies in treatment.

The barriers to care can simply be impeded by the consumer’s inability to speak the language and the providers’ inability to reciprocate the language support. According to the Surgeon General’s report, other barriers that discourages access and engagement in mental health services by racial, ethnic, and cultural groups include cost of services, lack of insurance, cultural stigma, cultural patterns of help seeking behaviors, mistrust in the health care system, and the mental health care system’s insensitivity to the needs of the consumer (California Mental Health Planning Council, 2003).

To work effectively with members of diverse backgrounds, one must first understand the conceptual framework of culture within the context of health and human behavior. In terms of human development, psychological development is one characteristic in which culture influences behavior and adaptation (Pumariega, Rogers, & Rothe, 2005). Our unique cultural values supplement a vital role in how we “experience, understand, express and address emotional, behavioral, and mental distress.” (Pumariega et al, 2005, p.542). Expression of mental distress differs greatly from culture to culture and symptomologies can range anywhere from the physical somatization to the
detachment of familial and social relationships. Treatment for mental distress can be equally diverse.

To attest to the diversity of mental health conceptualization among different API groups, Figure 1 (developed by Kramer, Kwong, Lee, & Chung, 2002, p. 227), depicts how differently these perceived homogenous groups culturally views mental illness. It identifies four different cultures and their respective beliefs about mental illness and treatment approaches for address mental health illness.

**Figure 1**

*Traditional Beliefs and Behaviors Relating to Mental Health*

<table>
<thead>
<tr>
<th>Culture</th>
<th>Beliefs</th>
<th>Coping Behaviors and Treatments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chinese</td>
<td>Mental illness caused by lack of harmony of emotions or by evil spirits</td>
<td>Often try traditional herbs and acupuncture first; healers may be used concurrently to get rid of evil spirits</td>
</tr>
<tr>
<td>Japanese</td>
<td>Mental illness caused by evil spirits; often thought not to be real illness</td>
<td>Delay or avoid seeking professional help; many will use traditional sources of care</td>
</tr>
<tr>
<td>Korean</td>
<td>Mental illness caused by disruption of harmony within individual or by ancestral spirit coming back to haunt patient because of past bad behavior; result of bad luck or misfortune; payback for something done wrong in the past; is considered shameful</td>
<td>May deny problems, resulting in helplessness and depression; not likely to reveal the problem unless asked; may show signs through nonverbal communication and posture; may use shamanism</td>
</tr>
<tr>
<td>Vietnamese</td>
<td>Depression is sadness</td>
<td>Not readily acknowledged because of stigma; usually try home remedies, spiritual consultations, or Chinese herbs before seeking Western medical care; some use of exorcists; seek help only when problems become acute or obvious; family members try to cheer up or distract the patient</td>
</tr>
</tbody>
</table>
Culture of Collectivism and the Stigmatism of Mental Health

According to Leong et al. (1995), there is one cultural difference that must be noted: Western values emphasize the use of verbal communication, the presence of ambiguity and a focus on the individual, which often involves encouraging clients to put their own individual goals ahead of the goals of the collective. Asian Americans, on the other hand, generally have more “allocentric values that involve some subordination of one’s individual goals to the goals of the collective” (as cited in Ponterotto et al., 1995, p. 430). Therefore, when working with many API individuals, the cultural belief in the collectivist tradition frowns upon the open expression of emotions that may disrupt familial and community harmony.

Participants in Lee et al’s study (2009) reported that within cultural norms, mental health is often not understood for its significance. The associated stigma of seeking professional health care may undermine traditional help seeking behaviors (Lee et al, 2008). In the majority of Asian cultures, great importance is placed on family construct, emotional restraint, upholding the family honor and avoidance of shame. This contradicts Western modalities in counseling that emphasizes self-disclosure and expressiveness of relational, social, emotional and mental health challenges (Shea & Yeh, 2008). Asian Americans with difficulties are expected to take an interpersonal perspective in coping with their challenges. Many API individuals will not normally openly express psychological or emotional suffering due to the shame and social stigma it may bring upon the individual’s family and community (Kramer, Kwong, Lee, & Chung, 2002). Consequently, this cultural practice makes it difficult for an API individual to respond to
traditional counseling modalities, especially when many mental health disorders have an hereditary link to past generations. Many immigrant families have high expectations for their children and many are expected to succeed in order to bring honor and positive affirmation to the family name. Nevertheless, if the child develops or is perceived to have a mental illness, it would have a negative reflection on the family’s reputation as a collective.

**Help-seeking Behavior**

In addition to the stigma of mental health in Asian communities, providers must also have awareness that help-seeking behaviors of Asian groups differ greatly from non-minority populations. Participants reported that treatment would not be sought unless it is deemed unmanageable by the family. It is not likely for members of the Asian community to voluntarily seek help from mainstream health services (Wynaden et al., 2005).

According to Lee et al (2009), traditional Asian beliefs infer that mental health issues is due to an imbalance of a person’s emotional regulation; caused by lack of self control. Thus, it is perceived to be shameful for an individual to reveal that he/she has a mental health condition. If the individual were not able to cope with their condition, he/she would often turn to the family, churches, medical physicians, elders, or clan members (Shea & Yeh, 2008). Seeking professional psychological help is not a welcoming option because of the social stigma that is often associated with mental illness. Consequently, mental health conditions are often kept hidden to uphold the cultural norm (Lee et al, 2009). Even if participants were able to seek counseling, a
barrier would often exist within the therapeutic relationship between providers and
consumers because family members were not receptive and would not condone the idea
that their family member is receiving counseling services. “Extrafamilial intervention
such as seeking professional psychological help is often considered shameful and a
violation of family hierarchy and may bring disgrace to the family, as seeking outside
help may indicate inadequacy on the part of the family member” (Shea & Yeh, 2008, p.
158). The individual’s family would rather isolate the issue rather than face the reality
that their family many be labeled in a negative manner (Wynaden et al., 2005, p. 90-91).
“Shame and stigma are believed to figure prominently in the lower utilization rates of
AA/PI” (Mental Health Fact Sheets, p. 1).

Acculturation

Another factor that is important to understanding many API populations in
conjunction with mental health is the degree to which the individual adheres to their
traditional value systems and cultural practices. That differentiation will vary from
generation to generation given the individual’s level of acculturation. Acculturation is the
“multidimensional process whereby personal values, attitudes, beliefs, language, identity,
and customs from one’s native culture are influenced by contact with a different culture”
(Cameron et al., 2008, p. 290). Due to migration, many immigrants are placed in a social
construct where individuals are forced to cope, make sense of their new social
environment, and decide how he/she will integrate him/herself into the host culture.
Cultural competency plays a vital role in how an individual or group acculturates (Padilla
& Perez, 2003). According to Cameron et al. (2008), acculturation often coincides with
one’s ethnic identity. A study conducted by Lieber, Chin, Nihira, and Mink (2001), found that bicultural groups with high levels of acculturation and ethnic identity tend to have a better quality of life than marginalized groups (those with low acculturation and low ethnic identity) (as cited in Cameron et al., 2008). Marginalized groups struggle with negative emotions in adapting to their host country while bicultural groups understand the need to acculturate as a means of survival while acknowledging that cultural differences exist (Cameron et al., 2008).

Gaps in the Literature

Although this literature review addresses the concept of cultural competence and its implications in service in relation to the consumers of the Asian Pacific Islander population, the literature does not give concrete means to what is best practice in delivering culturally competent care in mental health. Furthermore, research does not give evidence of how cultural competent services are received or reciprocated between consumers and providers. As reported by the California Mental Health Planning Council, little is known about the prevalence and needs of mental health disorders among the diverse API populations. This researcher’s study will review how one mental health program integrates cultural competency components to their delivery of care to the API community of Sacramento County.

Conclusion

Increased awareness of cultures and the acceptance of a multicultural society can enlighten the experience in which providers can learn from consumers and improve upon the therapeutic alliance, while providing effective service and increasing satisfaction of
those accessing and utilizing mental health services. In contrast, lack of cultural understanding can contribute to difficulty accessing and engaging in mental health services by the consumer. Leong and Lau’s (2001) study on barriers to accessing effective mental health care services for Asian Americans reported underutilization as well as earlier termination of treatment services when compared to non-minority consumers (as cited in Wynaden et al., 2005, p. 89). This literature review addressed how cultural differences and cultural competency practice can influence the Asian communities’ access and utilization to mental health services.
Chapter 3
METHODOLOGY

Introduction

The purpose of this study is to examine the psychological and sociological factors affecting the Asian Pacific Islander population’s utilization of mental health services in regards to seeking and receiving culturally competent/responsive services. The researcher’s interest in exploring how cultural competency is integrated into mental health services for Asian Pacific Islanders has its basis in the researcher’s involvement as a second year MSW intern with the Transcultural Wellness Center at Asian Pacific Community Counseling. The Transcultural Wellness Center was created on the foundation of providing culturally and linguistically appropriate and competent mental health services to a population that is often underserved and underrepresented in our current system of care. As an integral component and direct service provider to Asian Pacific Islanders within the local community of Sacramento County, the researcher sought to gain a better understanding of how cultural competent services have a direct effect on how this population responds to mental health treatment.

Study Design

To understand the psychological and sociological phenomenon among this population, the researcher elected to conduct a qualitative study. According to Yin (2008), case studies have four primary applications in evaluation research: 1) Explain the “presumed casual links” in real-life interventions that are far too complex for survey and experimental modalities (p. 19); 2) Demonstrate an intervention in connection with the
real-life context of its occurrence (p. 19); 3) Depict certain topics of study in both evaluation and descriptive mode (p. 19); and 4) Understand scenarios in which the intervention being utilized has not only one, but also multiple outcomes (p. 19-20). Moreover, through this modality of conducting research, case studies give the researcher opportunities to draw a single conclusion from multiple sources. Thus, allowing the researcher to arrive at broad generalizations of variables found without presenting on the results of each individual case.

Study Sample

Given the chosen methodology of this study, no human subjects were utilized. Rather, an analysis of secondary data was employed for this study through ten closed-case files provided by the Transcultural Wellness Center (TWC) at Asian Pacific Community Counseling (APCC) in Sacramento County.

APCC randomly selected ten closed case files that fit the following criteria: six files constituted cases of short-term duration—even if the client only came to one treatment session. Through the demographic information provided in these clients’ charts, these short-term client’s were categorized as dropout clients in Sacramento County’s mental health system. The remaining four files constituted cases where the client sustained treatment for an extended period of time. These are the clients that completed treatment through mental health services provided by the Transcultural Wellness Center at APCC. Data utilized for this study was delimited from 2007 until the end date of the client’s services.
The researcher conducted a comparative case study method to: (a) identify whether there was a correlation between cultural competency components within the services provided and (b) how API consumers utilize mental health services. More specifically, a multiple-case study research design was employed due to the feasibility of its methodology to investigate the empirical nature of this topic.

Data Collection.

In compliance with Health Insurance Portability and Accountability Act (HIPAA) regulations, all files were kept at the APCC and were not taken out of the office. Copied files were made available to the researcher without personal identifiers (name, addresses, phone numbers, etc.). These were previously removed by a volunteer at the agency. No personal identifiers were utilized during any aspect of this research study. All copied closed-case files and information pertaining to the writer’s research were destroyed upon completion of the data analysis process.

To guard against researcher bias and to protect the privacy and confidentially of those currently within the care of the Transcultural Wellness Center, the researcher worked in collaboration with APCC’s board of directors, the executive director of APCC, and the program clinical director of TWC to set boundaries of data collection as a qualitative study of closed case files. In addition, the researcher was guided by thesis instructor’s input on appropriate methodology. Finally, the researcher used “multiple sources of evidence in a manner encouraging convergent lines of inquiry” with use of progress notes, client demographic forms (Sacramento County Mental Health Department of Behavioral Health Services’ Client Data Sheet), and the researcher’s specialized
knowledge (Yin, 2009, p. 42). Given the researcher’s position at the agency, the researcher is also considered a source of evidence because of his specialized knowledge of the services provided and how cultural competent services were integrated into the client’s treatment. With this process of triangulation and collaboration, “any case study finding or conclusion is likely to be more convincing and accurate if it is based on several different sources of information, following a corroboratory mode” (Yin, 2009, p. 115-116).

To further ensure the quality of the research, only agency documentation was used as a source of evidence. The evidence provided is stable because it can be reviewed repeatedly. It is unobtrusive because the information provided by the case files was not created as a result of the case study. Evidence is exact, because it contains sources of reference and details of the event.

To eliminate the structural bias of services provided, rather than looking at the duration of the services as a variable to cultural competent practice, the researcher altered the parameters of the study to examine the frequency of services provided during the client’s time in treatment. Additionally, collaborative work is a component of services provided, so for cases in which the client was a minor, the researcher also explored cultural component services provided to the family members as well. The researcher conducted and collected the data over a five-week span at Asian Pacific Community Counseling.
Data Analysis

A content analysis was performed to analyze the data. As is recommended in qualitative data analysis, the data collected from each case were categorized by demographic and cultural competency variables. The data were then analyzed within and across cases to indentify themes and patterns. The analysis adhered to four phases: data making, data reduction, analysis, and interpretation.

Protection of Human Rights

Working with the Transcultural Wellness Center’s Clinical Director, APCC’s Executive Director and APCC’s standing board members; this researcher was granted permission to conduct the study pending approval from both the Sacramento County’s Research, Evaluation and Performance Outcomes department and the Department of Health and Human Services Research Review Committee. Approval from Sacramento County’s Research, Evaluation and Performance Outcomes department and the Department of Health and Human Services Research Review Committee was received April 2, 2009. Approval from the CSUS human subjects committee was sought and granted. Approval # 08-09-117.
Chapter 4
DATA ANALYSIS

The data-making phase of data analysis process consisted of the researcher reviewing the closed case files for culturally competency components provided within service. As cultural competency components were identified, the researcher logged the information identified by the type of service provided, the date of service, and the context in which the service was provided to assure that no conclusion drawn via the service provided was taken out of context and misrepresented. The data reduction phase of this project consisted of identifying two separate units of text encoding: key-word-in-context and identifying themes within the data logged and categorizing it within a means of practice that met the cultural need of the client receiving mental health care. As the researcher reviewed the progress notes of services provided, key themes related to cultural competency emerged from the data. These themes were also categorized and logged. This process of data reduction is the researcher’s means of breaking down the data through a coding process.

Codes serve to summarize, synthesize, and sort many observations made of the data...coding becomes the fundamental means of developing the analysis...Researchers use codes to pull together and categorize a series of otherwise discrete events, statements, and observations which they identify in the data (Charmaz, 1983, p. 112, as cited in Seidel, 1998).

By comparing and contrasting the data collected from clients that completed treatment and from clients that dropped out of service, the researcher entered the analysis
phase of the research process by identifying whether or not cultural competent practice appeared to play a role the success rate of the client’s treatment.

**Demographic of Participants**

As stated in Chapter 3, the closed case files were randomly selected by the hosting agency (Asian Pacific Community Counseling) under the criteria of participants who completed their mental health treatment with the program and those that did not complete treatment (for reasons defined in Chapter I; under definitions). For the purposes of this research, the closed-case files were analyzed for cultural competency practice utilized by providers as a component of treatment to better engage and serve consumers of the Asian Pacific Islander community in mental health treatment. The demographics of the participants are identified in Table 1 for those who completed treatment and in Table 2 for those who did not complete treatment.

Table 1

*Completed Treatment*

<table>
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<tr>
<th>Completed Treatment</th>
<th>Age</th>
<th>Gender</th>
<th>Ethnicity</th>
<th>Place of Birth</th>
<th>Years in U.S.</th>
<th>Primary Language</th>
<th>Preferred Language</th>
<th>Duration of Service</th>
<th>Frequency of Service</th>
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<td>Ethnicity</td>
<td>Place of Birth</td>
<td>Years in U.S.</td>
<td>Primary Language</td>
<td>Preferred Language</td>
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<td>Frequency of Service</td>
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</table>

Table 1 reflects the demographics of client files that completed treatment. Of the ten files selected, four of the client files indicated that the consumer completed treatment
under Sacramento County Mental Health Division’s classification. The age range of those who completed treatment was from 8 to 15 years old. As indicated in the table, all four participants were youth; no adults were represented in this group. There were three male participants and one female participant. The ethnicities represented in this group were Korean, Hmong, Vietnamese/Chinese and Mien. One participant was born outside of the United States with 3 ½ years residency, while the other three were born in the United States. Each of the participants was bilingual, but elected to receive services in their preferred language, English. The duration of the participants’ time in service ranged from 13 to 16 months. The frequency of services provided by their mental health providers ranged from 55 to 80 documented services.

Each of the participants had a support (mother or father) who was also a participant in the client’s treatment process. Of the four supporting members, two parents were non-English speaking and required services to be provided in their preferred language. The other two parents were able to communicate with the client’s treatment providers without language support.

For the purposes of this study, demographics of the treatment providers were also provided to identify possible ethnic matching and cultural components that may be relevant for the purposes of this study. Of the four clients, two of the clients had treatment providers who identified with the same cultural ethnicity and/or was capable of providing services in the language of the client and their supporting member.
Table 2

*Did Not Complete Treatment*

<table>
<thead>
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<th>Did Not Complete Treatment</th>
<th>Age</th>
<th>Gender</th>
<th>Ethnicity</th>
<th>Place of Birth</th>
<th>Years in U.S.</th>
<th>Primary Language</th>
<th>Preferred Language</th>
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<td>Ethnicity</td>
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<td>N/A</td>
<td>English</td>
<td>English</td>
<td>8 months</td>
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<td>Malaysia</td>
<td>Since Youth</td>
<td>English</td>
<td>English</td>
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Table 2 reflects the demographics of client files that did not complete treatment. Of the ten files selected, six of the client files indicated that the consumer did not completed treatment under Sacramento County Mental Health Division’s classification of discontinued service. The age range of those who did not complete treatment ranged from 12 to 39 years old. As depicted in Table 2, three participants were youths and three participants were adults. There were three male participants and three female participants. The ethnicities represented in this group were Hawaiian, Hmong, Laotian, Hmong/Caucasian, Chinese and Tongan. 2 of the 6 participants were born outside of the United States and immigrated to the U.S., while the other four were born in the United States. 3 of the 6 client’s in this group are bilingual. Only 1 of the 3 bilingual clients preferred to have services provided in their native language. 3 of the 6 participants’ primary language and preferred language for service were English. The duration of the participants’ time in service ranged from 3 ½ to 16 months. The frequency of services provided by their mental health providers ranged from 31 to 231 documented services.

Of the 6 clients that did not complete services, 3 had a supporting member that participated in the client’s treatment process. 2 of the 3 clients with supporting members had supporting members that were non-English speaking and required services to be provided in their preferred language. 3 of the 6 did not have a support member participating in the client’s treatment.

In regards to the demographics of the treatment providers in this group, of the 6 clients, 3 of the clients had treatment providers who identified with the same cultural
ethnicity and/or were capable of providing services in the language of the client and their supporting member.

*Cultural Competency Themes Identified in Data*

In reviewing the contents of the material provided, the researcher was able to identify cultural competency components/themes in the data collected. These themes fall within the parameters of the researcher’s definition of cultural competency. The results of the cultural components identified of those that completed treatment and those that did not complete treatment are depicted in Table 3 and 4.

**Table 3**

*Cultural Components in Practice of Clients Who Completed Treatment*

<table>
<thead>
<tr>
<th>Completed Treatment</th>
<th>Ethnic Matching/ Sought expertise</th>
<th>Language Support (by provider/ interpreter)</th>
<th>Support Collaboration (Collectivism)</th>
<th>Immigration History</th>
<th>Acculturation/ Assimilation</th>
<th>Cultural Brokerage / Practice/ Traditional Healing Practices</th>
<th>Religious /Spiritual</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client #1</td>
<td>2</td>
<td>6</td>
<td>28</td>
<td>2</td>
<td>3</td>
<td>6</td>
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<tr>
<td>Client #2</td>
<td>18</td>
<td>31</td>
<td>7</td>
<td>0</td>
<td>2</td>
<td>9</td>
<td>1</td>
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<td>Client #3</td>
<td>2</td>
<td>36</td>
<td>46</td>
<td>0</td>
<td>0</td>
<td>4</td>
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<td>Client #4</td>
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<td>3</td>
<td>34</td>
<td>0</td>
<td>0</td>
<td>3</td>
<td>1</td>
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</table>
Table 4

Cultural Components in Practice of Clients Who did not Complete Treatment

<table>
<thead>
<tr>
<th>Did not Complete Treatment</th>
<th>Identified Cultural Competency Components in Practice (by number of times addressed in service)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Ethnic Matching/Sought expertise</td>
</tr>
<tr>
<td>Client # 5</td>
<td>5</td>
</tr>
<tr>
<td>Client # 6</td>
<td>4</td>
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<td>12</td>
</tr>
<tr>
<td>Client #10</td>
<td>55</td>
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</tbody>
</table>

Ethnic Matching and Seeking Cultural Expertise

In the case notes for both groups (those who completed and those who did not), ethnic matching was documented via cultural identification or language brokerage. A higher frequency in this area indicate that ethnic matching is an identified need, and/or that the primary mental health provider working with the consumer is of the consumer’s cultural identification or obtains cultural expertise regarding the consumer’s culture. The data do not show a significant correlation between ethnic matching and completion of treatment (Refer to Weaknesses of Study Design for further explanation).
Cultural Collectivism (Support Collaboration)

In comparing the two groups for competency in the category of cultural collectivism, the data show that the support members’ degree of involvement (in a positive manner) played a significant role in helping the consumer meet his/her treatment goals. In the group that did not complete treatment, the participants had no supporting members or had a support member who was not actively engaged in the consumer’s treatment. In reviewing Table 3 and 4, the frequency in which support members are involved in the treatment supports the previous inference. The excerpt below, from a case file (Client #2; Completed Treatment), depicts a case staffing between a counselor who sought consultation from the clinician (a cultural expert of the consumer). This excerpt not only portrays providers having active engagement with a support member but also demonstrates how a provider seeks cultural expertise from a colleague of the consumer’s same cultural identification:

Clinician reported that it is normal for client’s mother to be protective of him with the tendency to generalize accidents that can occur when he is away due to the [loss] of mother’s older son. Clinician advised that it would be more culturally appropriate and acceptable to explain thoroughly with mother the [treatment] plans; including how beneficial it will be for the client and all of the precautions taken to protect him.

Many Asian Pacific Islander cultures place great emphasis on collectivism. The providers’ role in facilitating the need to involve support members in the consumer’s system of care is a crucial component of competent practice. For those who completed
treatment, it appears that collectivism/collaboration contributed to positive outcomes. Providers reinforced the beliefs that treatment does not end once the consumer leaves the clinic but it must be implemented at home as well. This is done through the sharing and psychoeducation of the mental health providers’ expertise in treatment blended with consumer and support members’ expertise of their own cultural beliefs and practices. It shows that the provider does have a level of expertise in being culturally sensitive to the collectivist nature of those they serve.

*Language Support and Treatment*

Language is an important component of practice not only in one’s ability to communicate, but it also plays in intricate role in providing cultural brokerage. Thus, this component of cultural competent practice is one of the more significant areas of practice in delivering services to the Asian Pacific Islander population. It is significant not only in terms of providing services to the consumer but it is significant in collaborative work with the consumer’s support members as well. Whether services were provided in English or in the client’s native language; providers in both groups assessed, documented, and provided services in the consumer’s/support member’s preferred language. Data collected in this area were not reliable due to the fact that some providers documented the language support, while others did not. The frequency in which language support was provided to the consumer/support member is that of those who documented the use of language in each individual treatment session.
Immigration History

In regards to the consumers’ immigration history, data was limited to the initial assessment. This component of the consumers’ social history was addressed with the consumer during the early assessment phase of practice in cases 1, 9 and 10. The consumer in case file 1 was the only consumer that had this cultural component addressed in service (one time): “Immigrated to U.S. in 2006, still adjusting to new host country (Client #1; Completed Treatment)....” There was no documentation of any follow up assessment, intervention or treatment plan outside of this particular session.

Acculturation / Assimilation

In the group of those that Completed Treatment, 2 of the 4 cases (Client #1 and 2) had documentation of providers addressing issues of acculturation/assimilation. Of the clients that Did not Complete Treatment, 2 of the 6 case files had documentation of providers addressing consumers’ issues regarding acculturation/assimilation:

Client #9; Did not Complete Treatment:

[Clinician’s Assessment] Client experiencing conflict and challenge of her own cultural identity since she was young. Feelings of insecurity, hopelessness, and unsatisfied of her own cultural identity, and inappropriate guilt.

Client #10; Did not Complete Treatment:

Counselor and client talked about verbalizing and understanding of the benefits for self and others of living within the laws and rules of home and society. Asked client to commit to staying within boundaries of the care home and abiding with the law.
Later Session] Reminded client to remember to think first before reacting negatively to anything that makes him angry. [To] remember the rules at the homecare and the law of the land.

In both groups of those that *Competed Treatment* and those that *Did not Complete Treatment*, treatment providers addressed the consumer’s cultural struggle with acculturation and assimilation of their own culture and that of the host country.

*Cultural Brokerage, Practice, and Traditional Healing Practices*

This area of culturally competent practice had fair documentation in both groups, those that *Completed Treatment* and those that *Did not Complete Treatment*. Issues addressed included cultural brokerage between providers and consumers; cultural sensitivity regarding the consumer’s cultural practice; and the use of the consumer’s traditional healing practices in service.

Client #1; *Completed Treatment*:

Clinician staffed mother’s clinician. Clinician shared her expertise about a Korean mother’s cultural values to “over love” the children and “feels sorry” and is difficult for mother to be “firm”… Also discussed the generational gap between client and mother [and] how mother can address issue of “setting limits” at a level that the client understands while empowering mother.

Client #2; *Completed Treatment*:

Specialist was educated by Hmong staff person regarding client and mother on traditions of Hmong culture. Hmong staff person provided cultural formulation [brokerage] and linkage between writer, client, and mother. Shared the
significance of the traditional wedding gown, its design, and what the colors represent. Client identifies himself as “White” Hmong, which differs in dialect from “Green.”

Client #5; Did not Complete Treatment:

[Client] reported having suicidal ideation[s]. Explored with client on ways to prevent or monitor client’s suicidal ideation. [Client] ambivalent about seeking treatment for alcohol and drug treatment. Client discussed cultural factors in substance abuse.

Client # 1; Completed Treatment:

[Client] reported that mother will arrange acupuncture service to improve client’s health… Client states that it was a scary process in the past but found it to be helpful later.

Client#4; Completed Treatment:

Father states that being a single father is challenging for him being both “mom” and “dad.” Father states he feels like his “spirit” or soul is not with him sometimes. Client’s grandmother knows how to do a Buddhist ritual that may help bring his soul back. Encouraged father to continue supporting client through treatment.
Spiritual and Religious Beliefs

Much like immigration history and acculturation/assimilation, this component of cultural practice was only addressed in 3 of the 10 case files. Of the ten case files, only one provider integrated the consumer’s religious/spiritual beliefs in the therapeutic process:

Clinician met with client, his mother, and sister for assessing client’s problem areas and service needs. Engaged client and his family members [in] play therapy. Mother discussed the family religion-Buddhism. [Family] attends a temple in their neighborhood every Sunday. [Later Session] Clinician accompanied client and his family (mother and sister) to attend a Buddhist ceremony at a Chinese religious temple in Sacramento. Provided support for client and his family to pray and obtain remedy for religious blessing.

[Clinician’s Assessment] Ceremony is traditional healing art and belief within Chinese culture (Client #3; Completed Treatment).

Providers in case files 2 and 4 only assessed the consumer’s/support member’s religious/spiritual affiliation in the early assessment phase of service. Consumers of those that Did not Complete Treatment had no assessment or integration of their religious/spiritual affiliation while in service.

Interpretation of Data

Although there were components of cultural competent practice implemented in the providers’ work with the consumers, the researcher cannot come to a definitive conclusion that it was the providers’ degree of culturally competent practice that directly
contributed to the success rates of those that received mental health treatment among the API community. This determination is based on the fact that the cause and effect of cultural competent practice and the consumers’ success rate in treatment are not mutually exclusive. Specific to the six case files of those who did not complete treatment in this study, other influencing factors of termination include lack of consumer engagement, lack of support from support members, homicide, and client movement (moving in and out of Sacramento County).

Again, the researcher’s conclusion is based on the researcher’s analysis of the contents provided through a closed-case file study. However, as stated earlier, there were key cultural competent components found in the data. Thus, one cannot conclude that the consumers’ work with providers did not contribute to the success rate of those who sought mental health treatment in the API community. Much of theme/components identified in the research certainly influenced the client’s perception, access, engagement and utilization of mental health services.

Weaknesses of Study Design

Unfortunately, conducting a research project in an attempt to understand how cultural competency is implemented in mental health practice in order to measure *The Psychosocial Impact of Cultural Competency and the Asian Pacific Islander Community’s Utilization of Mental Health Services* did not yield the results the researcher expected. In examining close case files, the researcher could not obtain an understanding of how culturally competent practices was truly implemented by the provider. In analyzing the data through a secondary source, the progress notes provided did not give a
full depiction of the consumer-provider relationship. Notes are often too vague and do not measure the intangibles of cultural competency components implemented in practice. Through this modality of conducting a study, the researcher loses the personable and immeasurable aspects of how mental health services are directly influenced by the consumer’s cultural beliefs.
Chapter 5

CONCLUSION AND CONTRIBUTIONS

In conducting this study the researcher found that it is difficult to assess the level of cultural competency provided in mental health services and its impact without 1) a working universal (measurable) and internationally accepted definition of cultural competency; 2) a universally accepted and standardized tool that can measure the degree in to which cultural competency is implemented in service; 3) direct participation of the consumer in this research. Much of what is addressed in the literature review discusses how there is a need and importance to integrate cultural competency in mental health practice but little is written on how one can do so and how it can be measured in direct practice.

Currently, the most accepted and utilized definition of cultural competency views cultural competency as “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 (Cultural Competence Definition, 2008, p. 3).” The use of this definition is neither measurable nor is it specific to how one would be considered to be culturally competent in working with diverse populations. This definition is subjective in presentation and does not “define” how culturally competent practice should be implemented in direct service.

The same inclination can be said with regards to many cultural competency assessment tools utilized to measure the provider’s level of competence. Many of the assessment tools utilized inquire how a provider, agency, and/or policy assess themselves
or itself (through self-reflection) in areas of personal reflection, policy and procedures, and service delivery. This makes it difficult to understand how cultural competence is implemented in practice because these assessment tools only tests the provider’s level of self-awareness and does not inquire of the consumer’s perception of what cultural competency means to them in the process of receiving mental health services.

In the end, the only true experts in culture and its significance for treatment are the consumers themselves. They are the tools that providers should utilize to help measure cultural competency and its relationship to successful outcomes within the Asian Pacific Islander population. Through working with the consumer as a partners rather than clients, providers would be able to understand the cultural barriers that impede consumer access and utilization of mental health services. Consumers are the experts/guides to how one identifies with their culture and its significance in how he/she perceives and receives mental health services. Through understanding consumers as individuals, providers can reassess our understanding of cultural competence not just as mere differences but to view cultural differences as valuable attributes in the engagement and delivery process of mental health treatment.

Thus, this researcher believes that cultural competency should be viewed on a continuous spectrum in which the provider is never under the assumption that he or she is an “expert” in any area of cultural understanding and practice. This conclusion is based on the understanding that culture is unique to every individual. The consumer’s cultural identity is relative to the influences of race, ethnicity, national origin, color, sex, sexual orientation, age, marital status, political belief, religion, and mental or physical disability.
Furthermore, these components of culture influence consumers differently among individuals and with varying degrees.

The writer’s research in cultural competence is limited to only certain areas of culturally competent practice. It by no means encompasses every aspect of one’s culture and its implications in service and practice. In the current mental health system where cultural and linguistic needs of consumers are often overlooked, with legislations such as the Mental Health Services Act of California and programs similar to the Transcultural Wellness Center of Asian Pacific Community Counseling, mental health care is making a progressive transformation in which consumers are no longer seen as a diagnosis to be treated. Rather, mental health care is viewed as a recovery process in which consumers can overcome and manage symptomologies through a holistic system of care with medical, social, cultural and community integration.

In conducting this study, the researcher hopes to contribute to the understanding that there is still limited research and understanding of how to integrate and deliver culturally competent care to an Asian Pacific Islander population. This researcher places greater value on consumer expertise in the delivery of culturally competent care. If this researcher were to attempt to answer the research question, there is still a high need to incorporate more culturally sensitive services that help consumers accept and understand the concept of mental health illness and treatment from the consumer’s cultural perspective. This suggests that in order to determine the effects of cultural competent practice within the Asian Pacific Islander population eligible for MHSA services, the research design must incorporate the following recommendations:
1) The use of a concrete, universally accepted and measurable definition of
cultural competency in relation to mental health service delivery.

2) Use of a standardized cultural competency tool that assesses and measures the
degree in which culturally competent practice is implemented from both the
provider and consumer’s perspective.

3) The inclusion of consumer’s and support member’s direct input of his/her
understanding of mental health and what recovery and treatment means to
him/her through a cultural perspective. The consumer and their support
members are the ones living through mental health challenges, having their
input would greatly improve the quality and richness of this research.
REFERENCES


Cultural competence standards in managed care mental health services: Four underserved/underrepresented racial/ethnic groups. (2001). *SAMHSA health*


