Final Report

Consumer-Driven Standards and Guidelines in Managed Mental Health for Populations of African Descent

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Disclaimer: The set of guidelines that are included in this document are general suggestions made by the panel for consideration by clinicians, who must continue to rely on their own professional judgement and training and the individualized assessment and needs of their patients. There is no representation here that these guidelines are appropriate for any particular patient. The panel that developed these guidelines disclaim all liability and cannot be held responsible for problems that may arise from their use.

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Preamble

The accurate diagnosis, prevention, or efficacious treatment of mental illness in any population requires in-depth and unbiased knowledge of the individual's culture in conjunction with knowledge about the illness presented. Clinical intervention methods, models, or skills that are not based in cultural competency fail to reflect what is known about the relationship between culture, mental illness, help seeking, recovery, and social policy. Culturally incompetent clinical services are unacceptable, unethical, and prima facie evidence of mal-practice and educational deficit. To ensure cultural competency, professional schools in universities and colleges must include content on culture and specific competencies and skills in their pre-service curriculum and continuing education programs. Professional associations and licensing organizations must include culturally competent standards and guidelines in their expectations for accreditation, membership, and credentialing.

Historically, mental health policies, systems, plans, and providers lacked an understanding or appreciation of the role of culture or race in mental health, mental illness, and clinical care. The development of managed care has illustrated the extent to which effective services is contingent on cultural competency. Meeting the needs of consumers of African descent, who have a mental illness, requires managed care plans to include cultural competency in the design, delivery, and evaluation of services and outcomes. Without cultural competency, access to mental health care for consumers of African descent will be limited; costs will outweigh profits; quality will be lacking; and poor outcomes will stimulate demand for additional services.

The unparalleled rise in the cost of health and mental health care in the American economy provides an opportunity
for health care plans, policy makers, and providers to recognize cultural competency as a means of insuring access, quality, cost efficiency, and relevant outcomes. The standards and guidelines that are included in this report are designed to assist health care plans, policy makers, and providers in their efforts to design, finance, and deliver effective services to consumers of African descent who have mental illness.

In an effort to develop guidelines that are useful for clinical work with consumers of African descent, it is worth noting that this is a heterogenous population, whose individual qualities, characteristics and choices should not be eliminated in the quest to develop generic standards for managed care. Consumers must maintain their rights to determine when to seek care, from whom, in what combination or setting, and the extent to which their families, community, or church is involved in their care.

I. Guiding Principles

1. Principle of Advocacy & Participation:

Mental illness does not preclude the participation of consumers of African descent and their families from (1) designing managed care services that fit their culture, (2) participating in the development of policies to guide managed care systems, and (3) providing feedback on the quality of services they receive. Consumers of African descent and their families are enhanced by the opportunity to advocate in behalf of their needs. Where advocacy opportunities are either denied or viewed as negative by managed care systems, the health status of consumers of African descent and their families is at risk.

2. Principle of Collaboration & Empowerment:

Consumers of African descent and their families have the capacity to collaborate with managed care systems and providers in determining the course of treatment. The greater the extent of this collaboration the better the chances are that

recovery and long term functioning will occur and be sustained. The risk of psychological dependency and lower functioning increases with a decrease in collaboration by consumers and families. Empowering consumers and families enhances their self esteem and ability to manage their own health.

3. Principle of Holism:

Consumers of African descent are more likely to respond to managed care systems, organizations, and providers who recognize the value of holistic approaches to health care and implement these in their clinical work, policies, and standards. Where holistic approaches are absent, there is greater risk that consumers of African descent will over-utilize mental health services resulting in increased costs.

4. Principle of Feedback:

Managed care systems, organizations, and providers can improve the quality of their services and enhance desired outcomes of their service delivery to consumers of African descent where there are legitimate opportunities for feedback and exchange. Where such opportunities for feedback are absent, there is a greater likelihood that the system of managed care services and policies will not be congruent with the needs of consumers of African descent and will not result in high levels of consumer satisfaction. Managed care systems that lack opportunities for this feedback limit their chances of making culturally specific corrections in their approaches to services while simultaneously increasing their risks.

5. Principle of Access:

In order for consumers of African descent to seek, utilize, and gain from mental health care in a managed health plan, services, facilities, and providers must be accessible. Where services and facilities are geographically, psychologically, and culturally accessible, the chances that consumers of African descent will respond positively to treatment for mental illness are increased. Inadequate access to services result in increased costs, limited benefit to the consumer, and a greater probability that services will not result in the outcomes desired.

6. Principle of Universal Coverage:

Populations of African descent have higher than average frequencies of unemployment and receipt of transfer payments, but lower disposable income. Where health care coverage, benefits, and access are based on employment or ability to pay, consumers of African descent are more likely to be medically under-served. The greater the extent to which health care is universally available without regard to income, the greater the likelihood that the health status of consumers of African descent will be enhanced.

7. Principle of Cultural Competency:

Recovery and rehabilitation are more likely to occur where managed care systems, services, and providers have and utilize knowledge and skills that are culturally competent and compatible with the backgrounds of consumers of African descent their families, and communities.

8. Principle of Integration:

Consumers of African descent have higher than expected frequencies of physical health problems. Integrating primary care medicine, mental health, and substance abuse services in a managed care plan increases the potential that consumers of African descent will receive comprehensive treatment services and recover more rapidly, with fewer disruptions due to a fragmented system of care.

9. Principle of Quality:

The more emphasis that is placed in managed care systems on ensuring continuous quality culturally competent service to consumers of African descent, the greater the likelihood that illness will be prevented; sickness treated appropriately and costs lowered. The less emphasis placed on providing quality services to consumers of African descent, the greater the chances that costs will increase.

10. Principle of Data Driven Systems:

The quality of decision making, service design, and clinical intervention for consumers of African descent in managed health care is increased where data on prevalence, incidence and service utilization is used to inform and guide decisions.

11. Principle of Outcomes:

Consumers of African descent and their families evaluate services on the basis of actual outcomes relative to the problems that stimulated help seeking in a managed care environment. The greater the extent to which managed care plans, organizations, and providers emphasize and measure these outcomes in comparison to the expectations of consumers of African descent, the higher the degree of consumer satisfaction.

II. Major Values

Systems, organizations, and providers that design and deliver managed mental health services to consumers of African descent and their families must recognize the extent to which help seeking, conceptualization of illness, involvement in treatment, and emphasis on recovery in this population is guided by a series of shared interconnected cultural values:

1. Choice by Consumers & Families
2. Service Delivery in the Community
3. Affordable Services
4. Dignity & Self Worth as Reflected in Clinical Treatment
5. Diversity in Providers
6. Equality, Fairness & Honesty
7. Family Preservation
8. Health Maintenance
9. Inclusion & Participation in Policy Making
10. Individual Worth
11. Acquisition of Knowledge
12. Least Restrictive Level of Service
13. Service Delivery by Minority Professionals
14. Oral Tradition & Expression
15. Ownership, Jobs, & Investment
16. Quality of Service & Satisfactory Outcomes
17. Interpersonal Relationships

18. Respect for Elders, Self, & Community
19. Prevention of Disease
20. Privacy & Confidentiality of Information
21. Racial Identity & Group Affiliation
22. Recovery & Rehabilitation
23. Spirituality & Religious Expression
24. Time Investment & Timeliness of Service
25. Work & Productivity

III. Prevalence & Incidence of Mental Disorders in People of African Descent

Health Care and Race (Davis, 1997)

Historical and current data about the health status of American populations confirms that there are very significant differences in prevalence and incidence of physical and mental health problems between groups based on color, income, and residence. Also noted are major differences in help seeking patterns (Neighbors, 1986). In two special reports, (Robert Wood Johnson, 1991; Center for Health Economics Research, 1993), it was noted that people of color, particularly residents of inner cities, showed major disparities in their health status when compared to other populations. The disparities noted in the literature cover the range of disorders from high neonatal mortality rates per live birth, higher rates of heart and circulatory problems, disproportionate rates of AIDS and related deaths, greater prevalence of chronic conditions, higher rates of edentulism, and higher rates of admissions to psychiatric facilities (Robert Wood Johnson, 1991; Center for Health Economics Research, 1993). The high incidence of substance abuse, physical injuries and deaths from violence greatly distinguish low income black neighborhoods and communities in terms of potential and actual costs of health care. According to some reports, substance abuse is the most significant health problem in the nation(Institute for Health Policy,

1993). These populations also show lower availability of health insurance and a significantly lower proportion of health professionals within easy access of their neighborhoods.

Historic Patterns of Utilization of Mental Health Service Use by Race

From the time that state governments decided to provide and finance residential care for the long term mentally ill, major public policy paradoxes have been raised and debated about race and mental illness (Jarvis, 1844). The first of these paradoxes centers on the incidence and prevalence of severe mental illness in populations of African descent, while the second centers on the extent to which these populations require and consume public and/or proprietary mental health services (Snowden & Cheung, 1990).

Historically, the answers to these two interrelated sets of public policy paradoxes concerning race and mental illness have been more a reflection of the prevailing racial climate in American society at large than with objective epidemiological or ethnographic data. A cursory review of the data on admissions to inpatient psychiatric facilities (Snowden & Cheung, 1990; Scheffler, & Miller, 1989; Manderscheid, 1987) shows disproportionately high rates of admissions by race to all types of facilities. This data (Snowden & Holschuh, 1992; Snowden & Cheung, 1990; Manderscheid, 1987) shows that between 1980 and 1992, the rate of admission for all persons to state hospitals in the United States was approximately 163.6 per one hundred thousand. The rate for whites was 136, while the rate for Hispanics was 146 and the rate for Native Americans and Asians was 142 per 100,000 (Manderscheid,1987). The admission rate to state hospitals for consumers of African descent for that same year was 364.2 per 100,000 population. When admissions to private psychiatric hospitals is considered by race, it is noted that the rate for all persons was 62.6 per 100,000, while the rate for whites was slightly above the mean at 63.4. The rate of admissions to private psychiatric hospitals for Hispanics was 34.4, while the rate for Native Americans and Asians was 29.6. The rate for consumers of African descent was close to the national mean at 62.9. Admissions

to general hospitals with psychiatric units showed similar patters by race and ethnicity. For the population as a whole the rate per 100,000 was 295.3 per 100,000, while the rate for the white population as a whole was 284.9. The rate of admissions for Hispanics was 227 and the rate for Native American and Asians was 221.7. The rate during the same period for consumers of African descent admitted to general hospital psychiatric units was 386.6 per 100,000. While the national mean admission rate to Veterans' Administration Hospitals was 70.4 per 100,000, populations of African descent had a rate of 118.2 per 100,000. No other racial or ethnic population had an admission rate to the Veterans' Administration Hospitals that approximated the rate for populations of African descent. When age is examined, the relationship between admissions to psychiatric hospitals and race is more pronounced. For example, the rate of admissions to state psychiatric hospitals for consumers of African descent between the ages of 18-24 was 598 per 100,000 while the national mean was 163.6 (Manderscheid, 1987). The most excessive rate found was for consumers African descent between the ages of 25-44 where 753 per 100,000 were admitted to state psychiatric hospitals (Manderscheid, 1987). Although admissions are not indicative of actual prevalence rates in the population, what is shown clearly is a inveterate pattern of service utilization differentiated by race and class.

To a great extent, access to and consumption of psychiatric inpatient services by consumers of African descent has historically paralleled the prevailing theoretical views of their vulnerability and morbidity. During the colonial era, when blacks were believed to be less susceptible to mental disorder, public policies extended inpatient services to free blacks but denied similar services to enslaved blacks. Given the numerical imbalance between free and enslaved blacks at that time, the low utilization of existing services by slaves supported the hypothesis of lower susceptibility. The more recent idea that blacks were more vulnerable to major mental disorder parallels the socio-economic and political conflicts surrounding the abolition of slavery. As slavery drew to a close in 1863, public policies created separate mental institutions for blacks throughout the Southern and border states (Jarvis, 1844). As freedom for blacks

drew closer, it was predicted that there would be a need for a major increase in mental hospital beds to accommodate those who would suffer from post slavery stress disorder. Data from the 1840 census was used to show that the frequency of mental illness was eleven times higher for free Northern blacks than for those in bondage in the South (Thomas & Sillen, 1972). Similar data was used to show that the ratio of serious mental illness in Southern blacks was considerably less than the ratio in Southern whites, while the reverse was found in Northern states.

At the other extreme in the policy paradox was the view current between 1945 and 1985 that black and other urban populations were far more susceptible to major mental illness because of a greater frequency of poverty, life stress and migration to urban areas. It was this data and its conclusions that President Kennedy used to base a portion of his successful legislative rationale for the establishment of community mental health centers in 1963. The prevailing belief that blacks were more vulnerable to mental illness resulted in policies that facilitated excess admissions from 1863 to the 1990's. During this time, the number of blacks admitted to various psychiatric institutions grew at a disproportionate rate, with a sizeable number admitted involuntarily (Snowden & Holschuh, 1992; Manderscheid, 1987; Romm, 1988).

Data drawn from the National Institute of Mental Health (Manderscheid, 1987) showed that blacks were more frequently diagnosed on admission with severe mental illness than other ethnic or racial populations. Admissions of blacks to state mental hospitals showed that 56% of these individuals received a primary diagnosis of schizophrenia, while only 38% of all individuals admitted received a similar diagnosis. Hispanics too received a disproportionately high(44%) rate of severe mental illness diagnoses on admission to state mental institutions. Jones (1986), Garretson (1993), Flaskerud (1992), and Lawson et al (1994) conclude that the primary reason for the disproportionate rate of severe mental illness diagnoses are errors made by diagnosticians who are unfamiliar with mental illness as it is manifested in populations of color.

Decades of knowledge in the literature on how populations of African descent consume mental health services shows the following trends:

1. Consumers of African descent, with major mental illness, drop out of services at a significantly higher rate than white populations
2. Consumers of African descent use fewer treatment sessions for their mental health problems than white populations
3. Consumers of African descent enter mental health treatment services at a later stage in the course of their illness than do white populations
4. Consumers of African under-consume community mental health services of all kinds
5. Consumers of African descent over-consume inpatient psychiatric care in state hospitals at twice the rate of corresponding white populations
6. Consumers of African descent are more often mis-diagnosed by mental health practitioners than white populations
7. Consumers of African descent are more often diagnosed as having a severe mental illness than whites

Managed Behavioral Health Care and Race: Implications

This data reflects a number of conclusions that may be helpful as the nation sets it course towards managed behavioral health care in the public and private sectors. First, it is clear that under the present and prior systems of care, consumers of African descent with serious mental illness were not served well: diagnoses were found to have been in error; admission rates were disproportionately high; involuntary admissions were used with great frequency; and the most severe mental illness labels were ascribed at a rate that appears higher than its expected frequency in the population. Of significance as well are the findings of different patterns of help seeking and help utilization on the part of African American populations. Populations of African descent tend to delay seeking help for psychiatric problems(as well as major health problems) from formal health systems until conditions have become more serious or

chronic and most other community and familial resources have been exhausted. Consumers of African descent also do not tend to remain engaged in outpatient services or utilize as many service units as other populations, although their diagnoses are more severe. Each of these conclusions portends important clinical and marketing issues for managed behavioral health care processes and values. As new managed care policies and services are being developed there is a greater need to focus more attention on the service issues and dilemmas related to race and severe mental illness. While a key aim of managed care policy and processes is designed to reduce unnecessary services and excessive costs, the role of race and service utilization remains poorly understood.

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

IV. Definition of Practice Guidelines Used in the Report:

-The term practice guideline refers to a set of patient care strategies developed to assist in clinical decision making(Zarin, 1993).

-The best treatments and the range of appropriate treatments available to patients with mental illness(Zarin, 1993).

- A listing of key decision points and general suggestions in the day to day treatment of patients with various psychiatric disorders(McEvoy, 1996)

- Systematically developed statements on (medical) practice that assist a practitioner and a patient in making decisions about appropriate health care for specific medical conditions(United Healthcare, 1994)

- Description of a course of treatment or established practice pattern designed to guide clinical treatment decisions (Bazelon Center for Mental Health Law, 1995)

-Terms used synonymously include practice parameters, standard treatment protocols & clinical practice guidelines(United Healthcare, 1994)

Working Definition as used in this report

- A set of strategies, techniques, and treatment approaches that support or lead to a specific standard(s) of care that guides mental health systems, clinical care, and professions in their relationships to consumers(Davis, 1997)

Clinical Guidelines Needed to Provide Managed Mental Health Services to consumers of African descent:

1. Prevention, Education, & Outreach
2. Comprehensive Assessment & Triage
3. Development of Treatment Plans
4. Implementation of Treatment Plans
5. Self - Help Opportunities
6. Access to Services
7. Styles of Communication
8. Ongoing Program Development
9. Outcome Evaluation
10. Discharge Planning

Guidelines for each of these areas were developed by the Panel.

V. Definition of Standards Used in the Report:

-Standards are the "generally accepted principles for the best/most appropriate way to provide clinical care for patients with mental illness(Traw, 1994).

-Standards are the level of clinical practice that is considered as legally and professionally expected to be found in treating an illness. Deviation from this standard is considered as malpractice(Traw, 1994)

Working Definition as Used in this Report:

-Standards are the criteria or set of rules that describe the expected levels of clinical and system behavior as well as courses of action based on research and experience (Davis, 1997)

Example of a Clinical standard: Assessment of consumers of African descent must include an evaluation of their individual, strengths and assets within the context of family and community resources. Consumers should receive a comprehensive functional based on a multi-dimensional focus, including general health functioning, psychiatric status, social and family supports, in addition to an evaluation of cultural, as well as socioeconomic stressors and factors affecting their condition.

VI. Definition of (Cultural)Competency Used in the Report:

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

-Competent means properly or well qualified (and) capable(Myers, 1995)

-Cultural competency is a set of congruent attitudes, behaviors, and policies that come together in a system, agency, or among professionals to enable them to work effectively.........(Isaacs & Benjamin, 1991)

Working Definition Used in this Report:

Cultural competency is acceptance and respect for difference, continuing self-assessment regarding culture, attention to the dynamics of difference, ongoing development of cultural knowledge and resources and flexibility within service models to work towards better meeting the needs of minority populations(Cross, Bazron, Dennis, & Isaacs, 1989).

VII. Standard and Guidelines for Prevention, Education & Outreach(PE&O):

Standard - Each managed care plan must include a prevention, education, and outreach program that incorporates culturally competent approaches, behaviors, and communication styles in its development and implementation. In the development and implementation phases, consumers of African descent, their families, and community organizations must be involved. The PE&O programs must include culturally specific knowledge of psychiatric impairment and treatment as these apply to the occurrence of mental illness, its distributional pattern, and help seeking behaviors of people of African descent.

Guidelines - 1- Managed care plans must develop mechanisms that target populations to increase their
knowledge of what the community wants, needs, how and in what form it obtains new information, and its experiences with existing services.

2- Managed care plans must base their prevention, education, and outreach efforts on principles and standards that have been researched and shown to have a positive relationship to the desired outcomes.

3- The location of behavioral health services must be a joint decision between managed care plans, providers and consumers.

4- Prior to the development of PE&O, managed care plans must identify and document how they assessed and plan to apply information and knowledge about risk factors associated with consumers of African descent and their families.

5- Managed care plans must provide a range of alternative services to consumers of African descent and their families.

6- PE&O approaches must include specific services for at risk youth in the family of the primary consumer.

7- Managed care plans must provide consumers of African descent and their families with education and information about the service benefits that are available and how to access them.

8- PE&O approaches must include consideration of the family system in which the primary consumer lives.

9- Managed care plans must develop intensive outreach for consumers of African descent and their families.

10- PE&O plans and methods must include linkages with religious organizations in the community and must include training of members to assist in the education of consumers about mental health service.

11- Managed care plans must offer programs to educate professionals and consumers on mental health service delivery and how consumers of African descent and their families can assume responsibility for their own
health and prevention of illness.

12- Managed care plans must develop and maintain an updated listing of community resources that may be beneficial in providing PE&O services to consumers of African descent and their families.

VIII. Standard and Guidelines for Styles of Communication

Standard - Cross cultural communication support must be provided at the option of consumers of African descent and their families at no additional cost. Consumers of African descent may speak a variety of dialects, languages, or communicate in non-standard English. Access to communication services must be available at each point of entry into the system and throughout the system. Culturally informed individuals must be utilized but are not an acceptable substitute for culturally competent staff. Culturally proficient interpretative services are necessary for quality clinical care provision to consumers of African descent.

Guidelines - 1- The use of family members as culturally informed individuals, including children when appropriate, must be encouraged.

2- Culturally informed individuals, working with consumers of African descent and their families, must be supervised by a culturally competent clinical provider.

3- Training must be provided to mono-cultural clinicians in the recognition and navigation of cross cultural communication styles used by consumers of African descent and their families.

4- All pertinent materials and forms, especially consent and statements of rights, provided to consumers of African descent and their families must be interpreted from the appropriate cultural perspective, as measured by consumer satisfaction surveys.

5- Individuals with culturally different or unique communication styles must only be placed in restricted residential settings that have the capacity to communicate with them effectively.

6- A single fixed point of administrative responsibility for cross-cultural communication support services must be designated.

7- Sufficient numbers of culturally competent professional staff of African descent must be available in managed mental health services to support the work of culturally informed individuals.

8- A regularly updated directory of culturally informed individuals, who are available within twenty-four hours for routine and within one hour for urgent situations must be maintained by the mental health organization.

9- All levels of care must meet the standards for the provision of cross-cultural communication support.

10- Providers in a managed care setting must be able to understand and interpret a broad series of culturally specific verbal and non-verbal responses by consumers of African descent.

11- Where reading materials, instructions, or information is essential, managed care providers must offer appropriate assistance to ensure that the consumer of African descent understands what is being communicated.

IX. Standard and Guidelines for Access to Clinical Services

Standard - Access to services must not only be individually oriented, but also family oriented in the context of the values held by consumers of African descent. Access criteria for different levels of care must include health, medical, behavioral, and functional, in addition to diagnostic. Criteria must be multidimensional including: psychiatric, medical, spiritual, social, behavioral, and community support.

Guidelines - 1 - Specific procedures must be developed to ensure comparability of access across populations and specifically for consumers and families of African descent. African American behavioral health specialists (AABHS) with culturally competent training must be involved in the development of these procedures.

2- Access must be decentralized and facilitated through multiple community based outreach, case-finding approaches, and in-home mobile assessment. These approaches include strategic co-location within African American community organizations, social service agencies, community action agencies, health centers, churches, Mosques, schools, and neighborhood locales which are accessible to public transportation.

3- Gatekeeping and service authorization for consumers and families of African descent must be performed by or under the supervision of a culturally competent mental health professional.

4- Equal availability of telephone and other means of access, for consumers and families of African descent must be assured.

5- Programs serving consumers and families of African descent must provide culturally inviting environments(e.g. decor, ambiance) as measured by consumer satisfaction surveys

6- Points of access must demonstrate cultural competency in overcoming barriers to service, such as lack of transportation, lack of child care, cultural insensitivity and attitudes as measured by consumer satisfaction surveys.

7- Restrictive clinical placements of consumers of African descent must be made only with the involvement and concurrence of culturally competent clinicians. Restrictive placements include inpatient, residential, and involuntary treatment.

8- The use of telephone numbers(e.g. 1-800) for access must not be exclusive of other points of entry for 24 hour crisis service and must be accompanied by education of consumers and families of African descent in the use of such access procedures. Staff providing telephone access services must be culturally and linguistically competent, and have access to African American mental health staff for consultation.

9- Legal documentation of citizenship or residency must not be a requirement for service and must not serve as a barrier to service access. Legal status must not be confused with sponsored and unsponsored status.

10- Consumers and families of African descent must be provided a culturally based orientation and ongoing education as needed about their benefits package in a managed care environment.

11- Ability to pay must not be a barrier to accessing services in a managed mental health care environment.

12- Culturally competent provider education about access issues must be documented by the caregiver.

13- Clinical and functional assessment scales utilized by managed mental health care systems, organizations, or providers must be culturally competent, reliable, and validated for use with consumers and families of African descent.

X. Standard and Guidelines for Comprehensive Assessment

Standard - Assessment must include a multi-dimensional focus including functional, psychiatric, medical, and social status as well as family support. Additionally, an evaluation of cultural and socio-economic stressors and factors must be completed. The assessment must be of appropriate breadth and depth to establish the nature of problems, the consumer's willingness and ability to work, and the provider's ability to deliver culturally competent services. All assessment scales and measurement tools must be culturally sensitive, administered, and scored by culturally competent providers.

Guidelines - 1- Cultural factors in the assessment process relating to age, gender, sexual orientation, and relational roles must be addressed for both consumers and families of African descent

2- The assessment should identify beliefs and practices; family organization and relational roles(traditional & non-traditional); impact of ethnically related stressors such as poverty and discrimination; beliefs related to health/mental health; attribution of condition; spirituality; and previous attempts at help-seeking. History of immigration, assimilation, or acculturation should be considered as needed. Consumers must be asked why they are seeking services, what their expectations are of the agency, previous efforts to obtain and use help, and outcomes of previous treatment efforts. Consumers must be asked to identify the criteria they use to determine when their condition is improved.

3- The assessment should be family oriented, incorporating key members of both nuclear and extended families (especially family decision makers) as needed. The consumer must be asked to identify what family resources, if any, are available to help resolve the presenting problems.
4- Clinical and functional assessment scales used must be culturally sensitive for use with consumers of African descent.

5- For systems without culturally competent providers, consultation with such a provider is necessary to review the assessment as the level of care determination is made and, especially, to review more restrictive placement decisions involving involuntary commitment, placement, or treatment

6- Confidentiality requirements must be adapted to incorporate the values of consumers of African descent particularly the inclusion of families in decisions about services, so as not to serve as a barrier to care.

7- Consumers must be asked to identify what community resources can be used to help resolve the presenting problems.

8- Assess information or diagnosis of mental health status in the appropriate social context with regard to world view, socio-economic status, educational level, and family characteristics.

9- Consider the consumer's preference for therapeutic linkages to the African American Community or family prior to initiating service.

XI. Standard and Guidelines for the Plan of Treatment

Standard - The treatment plan for consumers and families of African descent must be relevant to their culture and life experiences. It must be developed by a culturally competent provider in conjunction with the consumer and family, where appropriate. In the absence of a culturally competent provider, review of the proposed plan of treatment and supervision by a culturally competent clinical consultant is necessary.

Guidelines - 1- The treatment plan for consumers of African descent must include consumer and family involvement, when appropriate, in its development and agreement

2- Group homes utilized as least restrictive placements must be monitored for compliance with state and local standards, regulations, and laws, as well as protocols for services. Where such protocols do not exist, they must be developed to insure that group homes do not become holding facilities.

3- If authorized by the consumer, the plan of treatment must include contact with and utilization of African American community organizations.

4- Psychotherapeutic modalities must be conducted within the context of the value system of consumers of African descent and their families (e.g. egalitarian, participatory, family focused, spirituality), and must address issues specific to consumers of African descent (racism, discrimination, violence, gender role conflicts, and life transitions).

5- Treatment planning must be based on knowledge and skills derived from culturally competent interventions and models of care. These include concepts of recovery and rehabilitation that also consider cultural norms, values (spirituality, community, family), and critical life experiences (i.e. racism & discrimination). (See the appendix for a listing of model intervention programs utilized with consumers of African descent).

6- Care planning and other critical treatment decisions for consumers of African descent must be performed or supervised directly by a culturally competent mental health professional. Managed care plans must include culturally competent independent practitioners within their networks.

7- The treatment plan for consumers of African descent must incorporate consumer-driven goals and objectives that are functionally defined and oriented towards measurable recovery and rehabilitative outcomes.

8- The treatment plan for consumers of African descent must address culturally defined and socio-economic needs.

9- Treatment plans for consumers of African descent must incorporate individual, familial, and community strengths. Additionally, cultural strengths, spiritual/religious persons, natural support systems, community organizations, and self-help organizations, and interagency resources are appropriate to include in the plan of care.

10- Treatment plans for consumers of African descent must reflect awareness of the mental health needs of the entire family, especially when children are the consumers. Coordination among multiple providers, with a single point of clinical accountability must occur and be documented.

11- Treatment plans for consumers of African descent must address coordination of mental health and physical health, substance abuse, as well as other needed clinical services such as housing, transportation, employment, and education.

12- The treatment plan for consumers of African descent must be developed so that interventions consider least restrictive placements, continuum of care, discharge, and cultural sensitivity in the treatment modalities and medication usage.
13- Level of care decisions must be based on established protocols that are culturally sensitive/competent. These protocols must be reviewed periodically by the consumer and family, as appropriate. Placement considerations must include consumer and family preferences. Placement with the family is preferable unless otherwise clinically contraindicated.

14- Develop creative options and procedures for consumers of African descent who, for whatever reason, have traditionally been labeled as non-compliant to treatment.

15- In developing creative options, the consumer's right to choice must be preserved. However, the provider has the ultimate responsibility for documenting both the recommendations and rationale for the

treatment plan as well as indorming the consumer and family of potential risks if recommendations are not followed.

16- Treatment plans dor consumers of African descent must include broad based culturally competent educational programs that explain the problem or conditions being treated, treatment methods, concepts of recovery, rehabilitation, prevention, and self-help approaches in communication styles understandable to the consumer.

17- Treatment plans dor consumers of African descent must be developed by a culturally competent staff. In the absence of a culturally competent staff, cultural competency training must be provided to staff and external consultation with a culturally competent mental health professional must be obtained.

18- The decision to go dorward with treatment with a consumer of African descent must be based on a mutually agreed upon written agreement or contract between the consumer and provider.

19- In cases of consumers who present with acute mental illnesses requiring psychopharmacological interventions, the provider must discuss the medications and describe their effects with the consumer and family as soon as the consumer is able. A signed statement by the consumer (and counter-signed by the provider) that this guideline has been dollowed must be inserted in the case record.

20- The plan of treatment must reflect specialized approaches to maintain continuity of care, prevent symptom relapse, and reduce re-hospitalization.

21- Culturally specific literature in the communication style, language, and appropriate to the literacy level of the consumer on the prevalence of psychiatric disorders, treatment options, and psychopharmacological interventions must be distributed to consumers of African descent and their families.

22- Indormed consent must be obtained prior to the dispensing of medication. The indormed consent document must be specific regarding the nature of the medication and its potential and demonstrated benefits and side effects. The physician prescribing the medication must be responsible for ensuring that medication indormation is explained in a culturally specific and clear manner. The consumer must acknowledge by signature that they understand the medication prescribed and its potential benefits

and side effects. The signed forms must be dated and included in the consumer's chart. The prescribing physician must be knowledgeable regarding the culturally specific effects of psychotropic medication in consumers of African descent.

XII. Standard and Guidelines for Self Help

Standard - Culturally competent self help groups will be created to provide services to consumers of African descent and their families. The self help groups must function as part of a seamless continuum of care. Self help groups for consumers of African descent must incorporate consumer-driven goals and objectives that are functionally defined and oriented towards rehabilitative and recovery outcomes.

Guidelines - 1- Managed care plans for behavioral health programs must include self help funding set aside to enable
consumers of African descent and their families to utilize this approach.

2- Consumers of African descent and their families must have a decision making role in the design, implementation, and evaluation of self help programs.

3- Existing self help structures, programs, agencies, and systems that provide services to consumers of African descent and their families must be identified, acknowledged, and evaluated to ensure that they meet these guidelines.

4- Self help planning for consumers of African descent and their families must include consumer and family education about problems and conditions being treated and treatment approaches. Cultural beliefs and attitudes about health, spirituality, mental health, as well as education about preventive approaches must be addressed.

5- Consumer self help groups must advocate on behalf of consumers of African descent and their families to ensure benefit packages, changes in benefits, alterations in services, location of service programs, and changes in providers are congruent with consumer needs

6- Self help planning for consumers of African descent and their families must address coordination of mental, spiritual, and physical health, as well as other needed social, treatment, and support services(e.g. housing, transportation, education, and substance abuse services) according to the health beliefs and practices of the consumer and family.

XIII. Standard and Guidelines for Implementation of the Treatment Plan

Standard - Case management for consumers and families of African descent must be based on the diagnosed level of care needed by the primary consumer. Case management should be centered on the operation of an interdisciplinary team. Case management should be advocacy based, and consumer and family driven. The managed care plan maintains responsibility for the successful and appropriate implementation of the case management plan and the provision of adequate administrative resources and endorsement.

Guidelines - 1- Case managers working with consumers of African descent and their families must be able to demonstrate training in cultural competence.

2- Case managers should be knowledgeable about the African American community, its resources, and natural supports.

3- Case managers should have access to flexible funds for the provision of wrap-around services.

4- Case management should be continuous and proportional to the degree of the consumer's need and level of impairment. The case manager should act as a single point of contact and have responsibility across all levels of the system of care.

5- The Health Plan should define and enforce maximum caseloads for case managers consistent with industry standards and accounting for the severity of the consumer impairment/case mix, enabling them to effectively serve consumers of African descent and their families and prevent burnout and turnover.

6- Where the case manager interacts with multiple agencies, the primary treatment agency must maintain the responsibility to ensure implementation of services on behalf of the client.

7- Practice privileges should be afforded to case managers across the entire system of care, including restrictive settings such as inpatient facilities.

8- Each member of the consumer's treatment plan has responsibility for developing progress notes and reports as appropriate.

9- The provider must periodically review the consumer's progress in accordance with the treatment plan. Changes in the components of the treatment plan must be reviewed with the consumer before implementation.

XIV. Standard and Guidelines for Discharge Planning

Standard - Discharge planning for consumers and families of African descent must include involvement of the consumer and family in the development and implementation of the plan and evaluation of outcomes. Discharge planning must be done within a culturally competent framework and in a communication style congruent with the consumer's values. The plan must allow for transfer to less restrictive levels of care in addition to termination of treatment based on accomplishment of mutually agreed terms of the treatment contract. The plan must include case management and aggressive outreach to assure contact is made with the consumer and family to avoid the tradition of "administrative" termination which may be the result of culturally inappropriate services.

Guidelines - 1- Discharge planning for consumers of African descent must involve the consumer, family, or legal guardian to the extent that the consumer wants family involvement. Decisions made by the consumer regarding family involvement must be documented in the medical record.

2- Discharge planning must identify goals at the initial point of assessment.

3- Discharge planning must include documentation that steps were taken to address linkages to the next level of care, and that a reasonable effort to define the next steps in treatment was made. The provider of case management must communicate, discuss, and facilitate the linkage to the next level of care.
4- Discharge planning for consumers of African descent must include the acknowledgment and recognition of skills needed and available resources to facilitate a successful recovery program.

5- Discharge planning for consumers of African descent must include the identification of personal, familial, community, and other support systems' strengths to help them improve and maintain healthy lifestyles.

6- Discharge planning for consumers of African descent must include an assessment of the biopsychosocial environment to ensure minimum disruption in the quality of the consumer's life.

7- Discharge planning must include identification of a primary provider to act as the single point of responsibility for coordinating care.

8- Discharge planning for consumers of African descent must include assurances that consumers who fail to return to treatment will receive three (3) active follow-up contacts, and these contacts are to be documented in the medical record.

XV. Standard and Guidelines for Outcome Evaluation

Standard - The individual consumer and family of African descent must be assured comprehensive and competent treatment and care as they interface with the managed care mental health system.

The managed mental health plan must have a regular quality monitoring and improvement program with clear and culturally appropriate indicators applicable to evaluating services to the consumer, family, and community of African descent.

Guidelines - 1- Outcome evaluation of services provided to consumers of African descent must include a mutually agreed upon signed contract between the consumer and provider stating expected outcomes of treatment and accomplishment of those outcomes.

2- Outcome evaluation of services to consumers of African descent must include a wide array of treatment demographics in order to develop reliable culturally specific outcome studies.

3- Development of instruments to evaluate outcome of services to consumers to African descent must include focus groups, with representation from all stakeholders. The goal of outcome evaluation is improvement in overall health status, quality of life, reduction in symptoms, and increase in functioning.

4- Quality improvement teams must include consumers of African descent and culturally competent mental health specialists who review data from quality indicators related to consumers of African descent and other populations of color. If deficiencies are discovered in the quality of care delivered, corrective actions and other monitoring processes must be identified, implemented, and evaluated to assure compliance and quality.

5- Consumer satisfaction will be conducted in personal, written, or telephone surveys.

6- Outcome evaluation of services to consumers of African descent must have the analysis of data done by culturally competent analysts.

7- Outcome evaluation of services to consumers of African descent must include face to face quality reviews conducted by consumers and families of color. Models of this kind of consumer involvement in quality reviews can be found in the states of Pennsylvania, Georgia, Ohio, & Colorado.

8- Outcome evaluation of services to consumers of African descent must be longitudinal in orientation to ensure long range trends that could result in improvements and opportunities are noted.

XVI. Standard and Guidelines for Ongoing Program Development

Standard - Ongoing program development for consumers of African descent must include a full array of available treatment modalities, particularly modalities that are culturally competent and effective with this population (e.g. family therapy, specialized group therapy, behavioral approaches, use of traditional healers, & outreach).

Guidelines - 1- Efforts by managed care plans, providers, or organizations to carry out on-going program development for consumers of African descent must include them, their families, and providers from the consumer's community.

2- Efforts by managed care plans, providers, or organizations to carry out on-going program development for consumers of African descent and their families must encourage and develop consumer run programs such as drop in centers, self help groups and crisis groups.

3- Efforts by managed care plans, providers, or organizations to carry out on-going program development for consumers of African descent and their families must include identification of gaps in the continuum of service delivery and policies.

4- Efforts by managed care plans, providers, or organizations to carry out on-going program development for consumers of African descent and their families must include knowledge and skill development of providers in how to effectively use alternative treatment programs.

5 - Efforts by managed care plans, providers, or organizations to carry out on-going program development for consumers of African descent and their families must include the creation of a human resource development system to recruit, retain, develop, and evaluate culturally competent providers. Models for this series of HRD functions are found in such states as Pennsylvania, California, New Jersey, and Ohio.

6- Efforts by managed care plans, providers, or organizations to carry out on-going program development for consumers of African descent and their families must include leadership training and development for all stakeholder groups.

7- Efforts by managed care plans, providers, or organizations to carry out on-going program development for consumers of African descent and their families must explore ways to consolidate services in one location to improve access (e.g. churches, schools, housing units, community agencies).

8- Efforts by managed care plans, providers, or organizations to carry out on-going program development for consumers of African descent and their families must identify and find ways to extend

services to at-risk, under-served, and potential consumers (e.g. unemployed, under-employed, students, homeless).

9- Efforts by managed care plans, providers, or organizations to carry out on-going program development for consumers of African descent and their families must include continuing education training and involvement of personal care physicians, ministers (church), and others who are often a significant point of contact for referrals to the service delivery system.

10- Efforts by managed care plans, providers, or organizations to carry out on-going program development for consumers of African descent and their families must be able to recognize when new programs are needed and determine the means of financing these programs

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XVII. Implementation Issues and Next Steps

Members of the Panel proposed that a number of action steps are required to advance this set of standards and guidelines. These steps include the following:

1- Coordination of this set of guidelines with those from other groups to develop a comprehensive set of standards and guidelines for populations of color.

2- Development of consumer satisfaction measures for populations of color

3- Identification of effective mental health programs in a managed care environment.

4- Development of age specific standards and guidelines for populations of color.

5- Development of diagnosis specific standards and guidelines for populations of color.

6- Development of standards and guidelines for mental health systems.

7- Identification of specific competencies necessary for the provision of treatment of mental health services to people of color.

8- Translation of these specific competencies into training and educational curriculum.

9- Development of cultural competency certification requirements for professionals.

10- Development and implementation of a national conference on cultural competency, managed care and people of color.

11- Inclusion of cultural competency standards and guidelines in national and state policies and contracts in managed care.

12- Development of a national web site where data and information about managed care from a people of color perspective can be obtained and applied by minority agencies, providers, and organizations.

XVIII. Managed Care Bibliography and African Americans:

Review of Bibliographic Materials

A. Basic Materials

1) Managed Behavioral Healthcare

Review of the literature did not disclose any current bibliographies that focus on core competencies needed for mental health service delivery to African Americans. Of the existing bibliographies that were reviewed, there were no articles, books, reports, or studies reported that focus specifically on African Americans or the competencies needed to provide quality services in managed care. This absence of attention in the literature is

not a recent phenomena. African Americans with mental illness have rarely been the subject of specific research attention in relationship to previous health care plans, policies,
or workforce competencies. Where research projects in these areas have been conducted
generally, there has been a noted absence of African Americans identified in the populations sampled. Clearly, there is a significant gap in the literature in this area that has
the potential for decreasing the quality of service provided to this population.

2) Training Professionals to Work with African Americans with Psychiatric Disabilities

The literature review did not reveal any bibliographies/publications specifically focused on training mental health providers to work effectively with African American populations in a managed care environment or in other healthcare plans. As will be noted in this report, published materials found tend to approach mental health care of African Americans from the standpoint of the relationship between race and treatment. This relationship has been addressed more recently under the general heading of cultural competency. This literature will be identified in the materials that follow.

B. General Workforce Competencies

A number of published articles were identified that focus on the skills and competencies needed for service delivery to individuals with severe mental illness. These are found in the materials produced by other members of the CMHS project, and are not included in this report. Consistent with the findings from other areas, there is a major gap in the literature in this area extending from the late 1970's to 1996. The following materials provide relatively broad direction for this area.

1) Cultural Competency

Comas-Diaz, L., & Griffith, E.E.(Eds.).(1988). Clinical Guidelines in Cross-Cultural Mental Health. New York: John Wiley Co.

Cross, T.L., Bazron, B.J., Dennis, K.W., & Issacs, M.R.(1992). Towards a Culturally Competent System of Care. Washington, D.C: CASSP Technical Assistance Center.

Chunn, J., Dunston, P.J., & Ross-Sheriff, F.(Eds.). (1983). *Mental Health and People of Color: Curriculum Development and Change.* Washington D.C: Howard University Press.

This is a compilation of articles that address curriculum issues in what was then termed the four core mental health disciplines: psychology, social work, psychiatry and psychiatric nursing. The authors apply these four curriculum areas to Black, Asian, Native American and Hispanic populations.

Deas-Nesmith, D., & McLeod-Bryand, S.(1992). Psychiatric Deinstitutionalization and Its Cultural Insensitivity: Consequences and Recommendations for the Future. Journal of the National Medical Association. Vol. 84, No. 12. 1036-1040.

This article focuses on the heretofore unexplored area of how deinstitutionalization impacts racial minorities. Of importance in the article is the juxtaposition made with efforts in the state of Ohio to address the byproducts of this national policy through culturally competent approaches.

Gary, L.E.(Ed.). (1978). Mental Health: A Challenge to the Black Community. Philadelphia: Dorrance & Co.

This book is consistent with the genre of articles that were published in the latter years of the 1970's. It includes conceptualization, policy, disorders, community strengths, service delivery systems, research(generally) and workforce considerations. While the articles are dated, some of the materials here are helpful for conceptualizing the dilemmas and challenges of providing services to African Americans in a managed care environment. A number of the individual articles cited in this anthology will be annotated in other sections of this bibliography.

Gary, L.E. & Weave, G.D.(1991). A Multidisciplinary National Conference on Clinical Training and Services for Mentally Ill Ethnic Minorities. Conference Proceedings. Washington D.C: Howard University Press.

Hanley, J.(Ed.). (1996). African American Behavioral Health Workforce Conference. Conference Proceedings. Atlanta: September 6-9, 1995.

The proceedings report on the first conference that focused on the training role, responsibility, opportunity, history and barriers facing historically black colleges and universities in meeting the human resource crisis associated with behavioral healthcare. The conference participants sought to identify the successful component of clinical training programs and curricula across disciplines that address the issues related to mental health of African Americans. Discipline specific plans were developed to assist universities interested in developing or expanding their curriculum. The conference also developed an outline of a strategic plan for increasing both the number of processional training programs within historically black colleges and universities but also the content of the curriculum within these programs. Individual presentations from colleges and universities that have developed successful training programs were made.

Leigh, W.A.(1994). Implications of Health Care Reform for Black Americans. Journal of Health Care for the Poor and Underserved. Vol. 5, No. 1. 17-32.

This article compares and contrasts the various health care reform options and plans proposed(by President Clinton and the U.S. Congress) prior to 1993, and the potential impact each of these plans would have on African American populations. The author

provides an excellent overview of the insurance status of the African American population and how this status will not be changed substantially under a managed care health plan. Leigh concludes the analysis by proposing a series of policy options for insuring greater equity for the African American population.

Lu, F.G.(1996, April). Getting to Cultural Competence: Guidelines and Resources. Behavioral Healthcare Tomorrow. 49-51.

Orlandi, M.A., Weton, R., & Epstein, L.G.(1992). Cultural Competence for Evaluators: A Guide for Alcohol and Other Drug Abuse Prevention Practitioners working with Ethnic/ Racial Communities. Washington D.C: U.S. Government Printing Office.

Ruiz, D.(1990). Handbook of Mental Health and Mental Disorders Among Black Americans. New York: Greenwood Press.

This work represents a comprehensive treatment of the social, structural, and cultural issues that impact mental health treatment of African Americans. This holistic approach examines a broad range of psychological stressors and their impact on mental health status of this population. The perspectives of social workers, psychologists, sociologists, psychiatrists and mental health administrators are incorporated in a multidisciplinary manner. The data on which a number of the articles were based had been drawn from studies conducted in the early 1980's.

Sanchez, A.M.(Ed.). (1996). Developing Culturally Competent State Mental Health Delivery Systems for Ethnically Diverse Adults with Serious Mental Illness. Draft Monograph. Boulder: WICHE.

This is a very comprehensive effort to identify the detailed elements in a culturally competent public delivery system. The most recent(August, 1996) draft provides an excellent overview of the conceptualization of a culturally competent public system of services and the linkages and implications to managed care. Of value as well is an extensive bibliography that covers issues across a number of racial and ethnic groups.

Tarpley, M.(Ed.) (1996). Mental Health Research and People of Color: Defining an Agenda for the Year 2000 and Beyond. Conference Proceedings. Worcester: October 13, 1995.

This set of proceedings had not arrived at the time this summary report was completed. These materials will be included in the summary at a later time.

Yee, T.T.(1993). General Principles for designing and developing culturally competent programs. San Francisco: Department of Public Health, Division of Mental Health and Substance Abuse.

2)Race and Diagnosis

Flaskerud, J.H., & Hu, L.(1992). Relationship of Ethnicity to Psychiatric Diagnosis. Journal of Nervous and Mental Disease. 180(5), 296-303.

Garretson, D.J.(1993). Psychological Misdiagnosis of African Americans. Journal of Multicultural Counseling and Development. 21, 119-126.

This article addresses the accuracy of psychological and psychiatric diagnosis of African Americans dating back to slavery. African Americans primarily took care of their mentally ill relatives at home because of (1) a lack of private and public facilities and (2) because of the extreme stigma attached to mental illness in the African American community. The author contends that poor data collection and reporting were major obstacles to accessibility and utilization of services by African Americans. The author also elaborates on several reasons for possible misdiagnosis: (1) social and cultural distance, (2) the diagnostic process, (3) continuation of stereotypes of African American psychopathology, and (4) cultural differences in values and life stressors. Clinicians must take into consideration the psychosocial values, racial and cultural dimensions, and the experiences of the African American consumer.

Jones, B., & Gray, B.(1986). Problems in Diagnosing Schizophrenia and Affective Disorders Among Blacks. Hospital and Community Psychiatry. 37(1), 61-65.

This article reviews the problem in diagnosing and distinguishing between schizophrenia, major affective disorders and specific problems related to diagnosis of these conditions in African American populations. The article suggests that African Americans are misdiagnosed more frequently than European Americans and receive inappropriate treatment. The problems in diagnosis have been attributed to: (1) thought content, (2) disorder of thought process, and (3) cultural distance between the patient and the clinician. The authors suggest that more attention be focused on cultural and racial differences of African American patients.

Lawson, W.B., Heplar, N., Holladay, J., & Cuffel, B. (1994) Race as a Factor in Inpatient and Outpatient Admissions and Diagnosis. Hospital and Community Psychiatry. 45(1), 72-74.

In this article the authors review the relationship between race and inpatient and outpatient admissions and diagnosis. Data presented shows that African Americans are hospitalized more often than other populations and more frequently diagnosed with schizophrenia. The data also confirms that African American populations are more frequently involuntarily committed to psychiatric hospitals. Differences in diagnosis have been attributed to misdiagnosis, failure to appreciate cultural differences in the presentation of symptoms and differences in the actual prevalence of rates of mental disorders. The authors draw two major conclusions: additional studies are needed to examine and explore these relationships more extensively and there are implications for training and educations of professionals who conduct assessments.

Williams, D.H.(1986). The Epidemiology of Mental Illness in Afro-Americans. Hospital and Community Psychiatry. 37(1), 42-49.

3)Treatment Issues and African Americans

Allen-Meares, P., & Burman, S.(1995). The Endangerment of African American Men: An Appeal for Social Work Action. Washington D.C: NASW, Inc.

This article gives informative data regarding African American men and examines the role the mental health practitioner should play in providing services to this population. It addresses institutional racism, the African American family, and policy issues related to African Americans. The authors suggest that mental health professionals must address life stresses, discriminatory practices, economic disparity, as well as other key issues. Professionals need to develop program strategies that strengthen social support networks and resources in the communities. The authors propose what is termed a model of activism as the vehicle for producing change in the status of African American men.

Bennett, M.(1988). African American Women, Poverty and Mental Health: A Social Essay. Chicago: Haworth Press, Inc.

This article examines the relationship between poverty in African American women and mental illness. The author proposes that intractable poverty contributes to the onset of mental illness. Furthermore, the author contends that lower end jobs in the labor market and public assistance are the primary sources of income and support for African American women with mental illness. To alter these circumstances, the author proposes that extensive mental health education programs are needed and must be geared towards changing the overall behaviors and attitudes of the women towards poverty. Bennet contends that it is important to also focus on changes in the political, economic, and social circumstances associated with poverty in this population.

Bui, Khanh-Van, T., & Takeuchi, D.T.(1992). Ethnic Minority Adolescents and the Use of Community Mental Health care Services. American Journal of Community Psychology. 20(4), 403-416.

The focus of this article was on determining the extent to which there were differences in the utilization of community mental health facilities by adolescents by race and ethnicity. When the data set on youth were compared and contrasted in the period between 1983 and 1988, it was shown that African American youth were disproportionately represented. In addition, African American youth were more likely to remain in treatment longer than other youth. Bui and Takeuchi note that there were significant differences in the socio-demographic profile of the youths by race. Black youths were more often from economically poor environments and were likely to have been referred by social agencies.

Comas-Diaz, L.(1992). The Future of Psychotherapy with Ethnic Minorities. Psychotherapy. 29(2), 88-94.

Comas-Diaz, L., Geller, J.D., Melgoza, B., & Baker, R.(1982). Attitudes and expectations about mental health services among Hispanics and Afro Americans. Paper presented at the 90th Annual American Psychological Association, Washington D.C.

Comas-Diaz, L., & Greene, B.(Eds.). Women of Color and Mental Health. New York: Guilford Press.

Helms, J.E.(1986). Expanding racial identity theory to cover the counseling process. Journal of Counseling Psychology., 33(1), 62-64.

Jackson, G.G. (1976). The African genesis of the Black Perspective in Helping. Professional Psychology. 7, 292-308.

Jenkins, A.H.(1985). Attending to self-activity in the Afro-American client. Psychotherapy. 22, 335-341.

Jones, E.E.(1978). Effects of race on psychotherapy process and outcome: An exploratory investigation. Psychotherapy: Theory, Research and Practice. 15, 226-236.

Jones, E.E.(1982). Psychotherapists' impressions of treatment outcome as a function of Race. Journal of Consulting and Clinical Psychology. 38, 722-731.

Jones, J.M. (1985). The sociopolitical context of clinical training in psychology: The ethnic minority case. Psychotherapy. 22 S, 453-456.

Neighbors, H.W., & Jackson, J.S.(1984). The use of formal and informal help: four patterns of illness behavior in the Black community. American Journal of Community Psychology. 12, 629-644.

Snowden, L.R., & Cheung, F.K.(1990). Use of inpatient mental health services by members of ethnic minority groups. American Psychologist. 45, 347-355.

Snowden, L.R., & Holschuh, J.(1992). Ethnic Differences in Emergency Psychiatric Care and Hospitalization in a Program for the Severely Mentally Ill. Community Mental Health Journal. 28(4), 281-291.

Solomon, P. (1987). Racial Factors in Mental Health Service Utilization. Psychosocial Rehabilitation Journal. 11(3), 3-12.

C. DISCIPLINE ORIENTATIONS/COMPETENCIES

Sue, D., Arredondo, P., & McDavis, R.J.(1992). Multi-cultural counseling competencies and standards. Journal of Counseling and Development. 70, 447-486.

1) Psychiatry

Bell, C.C., Bland, I. J., Houston, E., & Jones, B.E.(1983). Curriculum Development and Implementation: Enhancement of Knowledge and Skills for the Psychiatric Treatment of Black Populations. In Chunn, J.C., Dunston, P.J. & Ross-Sheriff, F.(Eds.). Mental Health and People of Color: Curriculum Development and Change. Washington D.C: Howard University Press. 205-238.

Bell et al identifies the absence of knowledge of African American populations with mental illness as a critical problem in psychiatry training programs. They propose that curriculum needs to be modified to include content on African American culture and that research be conducted on this population to support alternative models of care. These authors conclude that there is a need to bring about fundamental change in psychiatry training.
Although not extensive, the authors identify the content they believe needed in the curriculum as well as the strategies for successful change.

Butcher, R.O.(1993). Managed Care Now and Forever. Journal of the National Medical Association. 85(7). 505-507.

Butcher reports on a national conference of black health care professionals who examined the proposed changes in national health care policy in 1992. He proposed that numerous complex questions remain unaddressed about the impact of health reform on the African American population. Buthcer identified a number of these central issues: 1) access; 2) impact on the existing system of care; 3) changes in income of black health professionals; 4) a decline in opportunities for black professionals; 5) a decline in ownership and control of the health system by blacks; 6) deemphasis on prevention. The conference endorsed a recommendation that the nation provide 20% of all health care expenditures for prevention and health promotion. In addition, the conference endorsed the National Medical Association's proposal for a single payer system and universal coverage. Of note, the conference called for the integration of health, social services and mental health service administration at the federal level.

Carter, J. (1986). Deinstitutionalization of Black Patients: An Apocalypse Now. Hospital and Community Psychiatry. 37(1), 78-79.

This article discusses briefly issues related to African Americans with mental illness. The author notes that African Americans are the largest minority group in America, and that chronically mentally ill African Americans are victims of neglect by society and mental health professionals. The article gives data regarding unemployment and poverty of the African American population. The author also discusses over reliance on public psychiatric hospitals, lack of community support systems, discriminatory zoning regulations that confine African American mentally ill patients to dilapidated inner cities, and stereotyping. The author suggests that we reexamine the methods for developing and implementing treatment programs for racial minorities.

Dawson, G.(1994). For African Americans Real Health Care Reform or Business as Usual. Journal of the National Medical Association. 86(12), 893-895.

Dawson raises a number of critical questions about the extent to which African American populations obtain the quality of health care needed, in the fee for service or managed care systems. He cites studies that show major disparities in access to life sustaining and life enhancing care in the Veterans Hospital system. He reports that in this setting, where cost is borne by government, there are significant inequities in the distribution of major cardiac procedures along racial lines. Dawson concludes that if African Americans are unable to obtain care in those settings were income is held neutral, he questions the extent to which blacks will fare under newer health care policies and plans in which cost reduction is a significant force. Dawson predicts that black patients will not fare as well under a managed care policy in which income disparities will combine with race. This brief article seems to capture and express a number of the major concerns within the African American community about managed care. The bibliography that accompanies the article is extensive and covers a number of issues more related to general health care than behavioral health. In his conclusions, Dawson places an emphasis on finding solutions that change the overall health care system and its supporting policies.

Harvard Law Review.(1995, May). The Impact of Managed Care on Doctors who Serve Poor and Minority Patients. Harvard Law Review. 108, 1625.

Lavizzo-Mourey, R., Clayton, L.A., Byrd, W.M., Johnson., G., & Richardson, D.(1996). The Perceptions of African American Physicians Concerning Their Treatment by Managed Care Organizations. Journal of the National Medical Association. 88(4), 210-214.

The focus of this article is on the potential impact of managed care on the careers of black physicians. The authors propose that as managed care plans increase, the number and proportion of black physicians holding managed care contracts will decrease. The need for a focus on this aspect of managed care is based on the prediction that a disproportionate number of African American lives will be covered under managed care because Medicaid programs are increasingly shifting towards this kind of health coverage. As this shift in Medicaid occurs, Lavizzo-Mourey et al expresses concerns that quality of care for African Americans will decline. To obtain data for their study, the authors administered a questions to a sample of 305 black physicians. Seventy-one percent of the sample reported having at least one managed care contract while an equal percentage reported losing patients to managed care plans when these physicians were not accepted as part of the network. Only 25% of the sample reported an overall decline in the number of patients in their practices. The major finding in this study was that 88% of the black physicians had been denied participation in a managed care network.

Loring, M., & Powell, B.(1988). Gender, Race and DSM-III: A study of the objectivity of psychiatric diagnostic behavior. Journal of Health and Social Behavior. 29, 1-22.

This paper examines whether the DSM-III provides objective criterial for mental health professionals evaluating clients based on sex and race. The authors used two case studies and surveyed 290 psychiatrists. They caution the reader that the results may be skewed given that only two studies were used. They also recognize that other factors about the psychiatrist may influence the diagnosis, such as private vs. Public practice, age, and years

of service. The authors conclude by noting that eve with carefully designed standards, diagnosis is still a subjective undertaking.

Lu, F.(1995). American Psychiatric Association Practice Guidelines for Psychiatric Evaluation of Adults. Washington D.C: American Psychiatric Association.

These guidelines for assessing adults in psychiatric are make the point that during the psychiatric evaluation process, sociocultural and diversity characteristics and implications should be made. This is especially important when obtaining information from patients that includes personal history, using structured interviews, questionnaires, rating scales and conducting case formulations.

Moffic, H.S., Kendrick, E.A., Lomax, J.W. & Reid, K.(1987). Education in Cultural Psychiatry in the United States. Transcultural Psychiatric Research Review. 24, 167-187.

Pavkov, T.W., Lewis, D.A., & Lyons, J.S.(1989). Psychiatric Diagnoses and Racial Bias: An Empirical Investigation. Professional Psychology: Research and Practice.20(6), 364-368.

This article examines the relationship between race and schizophrenic diagnosis of patients in several mental hospitals in Chicago. It notes that data collected by NIMH indicates there are major disparities in types of diagnoses by racial identity. The literature suggests that racial bias occurs within the institutions that treat persons with severe mental illness. This article states that regardless of type of care, evidence exists that African Americans are more likely than other Americans to be subjected to seclusion and restraints or both in treatment settings. The authors also acknowledge the lack of culturally relevant diagnostic instruments, as well as misinterpretations of symptoms. Training of professionals in large urban areas was also addressed. Results suggest that African Americans, as well as other minority groups, may be misdiagnosed and mistreated due to racial bias of the mental health professions.

Sabshin, M., Diesenhaus, H., & Wilkerson, R.(1970). Dimensions of Institutional Racism in Psychiatry. American Journal of Psychiatry. 127(6), 787-798.

Sabshin et al conceptualized the problem of race and service delivery as being within the domain of white psychiatrists to recognize and change. The authors concluded that systems of mental health care reflected the generalized perspectives on race and culture as found in the wider society. The key to change according to these authors is for the profession to look internally at its own practices, organization and training. A considerable proportion of the December 1970 issue of this journal was devoted to issues of racism within the professional of psychiatry.

Shader, R.I.(1982). Cultural Aspects of Psychiatric Training. In Albert Gaw (Ed.). Cross Cultural Psychiatry. Boston: John Wright, 187-197.

Spurlock, J. (1982). Cultural Aspects of Mental Health Care for Black Americans. In Albert Gaw (Ed.). Cross Cultural Psychiatry. Boston: John Wright, 163-178.

Thomas, A., & Sillen, S.(1972). Racism and Psychiatry. New York: Brunner/Mazel. While not related specifically to managed care and African Americans, this work raised a number of significant questions about the racial context of professional training and education programs within universities. The authors propose that racist thinking is so significant a component of American culture that the mental health disciplines reflect similar thought that finds its expression in theory and practice.

Walton, T.M.(1994). Challenges for Health Professions in the Face of Health Care Market Reform. Journal of the National Medical Association. 87(4), 256-257.

Walton's focus is primarily on the implications of health care reform on black physicians. He indicates that managed care presents unique challenges to black physicians for a number of related reasons: 1) minority physicians are concentrated in primary care areas of practice; 2) minority physicians infrequently practice in group settings;) the patients seen by black physicians tend to be more often uninsured and underserved; 4) many black physicians are not board certified. Walton proposes that many of the processes employed in managed care arranges are at odds with the historical system of health care in the black community and are likely to increase the overall cost of providing services to this indigent population. Walton concludes that what is needed to provide quality services is an increase in cultural competency.

2.Psychiatric Rehabilitation

______No reference materials were identified in this speciality area that pertained to African Americans with mental illness or the related issues of training standards or competencies..

3.Psychology

______Bernal, M.E., & Padilla, A.M.(1982). Status of Minority Curriculum and Training in Clinical Psychology. American Psychologist. 37, 780-787.

Blount, R.L., Frank, N.C., & Calhoun, K.C.(1992). The Recruitment and Retention of Minority Students. The Clinical Psychologist. 45(1), 1-2.

Guzman, P.(1993). Guidelines for provides of psychological services to ethnic, linguistic and culturally diverse populations. Washington D.C: American Psychological Association.

The American Psychological Association's Board of Ethnic Minority Affairs provides guidelines for mental health professionals to improve the quality of psychological services to ethnic and culturally diverse populations.

Langley, M.R.

Lerner, B. (1972). Therapy in the Ghetto: Political Impotence and Personal Disintegration.

Baltimore: Johns Hopkins University Press.

The author reports on five years of research within a community mental health center that provided services to low income black and Hispanic patients. Of value the author examines a series of characteristics of therapists believed to be positively correlated with outcome for low income clients.

Leung, P.(Ed.).(1990). Focus: Ethnic minority issues in psychology. The Journal of Training and Practice in Professional Psychology. 4. Entire Issue.

Myers, H.F.(1992). Overview and Historical Perspectives on Ethnic Minority Clinical Training in Psychology. The Clinical Psychologist. 45(1), 5-21.

Myers, H.R., Taylor, S., & Davila, J.(1992). The Recruitment and Training of Ethnic Minority Clinical Psychologists in a Multicultural Context: The UCLA Program. The Clinical Psychologist. 45(1), 23-33.

Myers, L. J.(1995). Culturally competent service outcomes assessment tools: Guidelines for upgrading quality assurance. Columbus: Ohio Department of Mental Health.

This handout identifies three levels of the service delivery system that must be established to create and sustain culturally competent managed health care outcomes: **Administrative Performance Standards**(i.e. nontraditional available options; diverse representation of staff; accessibility; diagnosis and treatment plans reviewed by culturally proficient peers; training; evaluating and monitoring cultural competence and accountability to the community). **Clinical Performance Standards**: (i.e., treatment based on clients cultural

and value systems; cultural assessments; cultural competency training; consumer satisfaction surveys; culturally proficient interpreters). **Financial Performance Standards:**(i.e. most effective treatment is being sought and provided; access to treatment; training). The author states that cultural assessment instruments are currently being developed in areas of intake, diagnostic assessment, program evaluation and organization accountability. This is a most valuable resource document. When the materials discussed in the article are completed, this set of materials should help fill the gap in knowledge and information about what standards need to be developed to provide quality services to African American populations in both a managed care and fee for service environment.

Myers, H.F., & Wohlford, P., Guzman, L.P., & Echemendia, R.(Eds.) (1991). Ethnic Minority Perspectives on Clinical Training and Services in Psychology. Washington D.C: American Psychological Association.

Sabnani, H.B. & Ponterotto, J.G.(1992). Racial/ethnic minority-specific instrumentation in counseling research: A review, critique, and recommendations. Measurement and Evaluation in Counseling and Development. 24(4), 161-187.

This article reviews several instruments specifically conceived for use in ethnic, minority-focused psychological research. Scales and instruments include: 1) the African Self-Consciousness Scale; 2) the Cross-Cultural Counseling Inventory-Revised; 3) Modern Racism Scale; 4) Value-Oriented Scale; 5) the Racial Identity Attitude Scale; and 6) the Developmental Inventory of Black Consciousness. The article suggests that several of the scales are reliable for use with minority populations, but further research should be done to increase the reliability of each scale.

Wohlford, P., Myers, H.F., & Callan, J.(Eds.). (1995). Public Academic Linkages in Services, Research, and Training. Washington D.C: American Psychological Association.

4. Master's Level Mental Health Service Providers

Hardy, K.V., & Laszloffy, T.A.(1992). Training racially sensitive family therapists: Contents, contact and context. Families in Society. 6. 364-370.

Johnson, S.(1990). Towards clarifying culture, race and ethnicity in the context of multicultural counseling. Journal of Multicultural Counseling and Development. 18(1), 41-50.

June, L.N.(1986). Enhancing the delivery of mental health and counseling services to black males: critical agency and provider responsibilities. Journal of Multicultural Counseling and Development. 1(1), 39-45.

These authors examine the various perspectives held historically about how to provide mental health treatment to African American populations. They then propose a model of effective service delivery based on a series of specific guidelines.

5. Nursing

Osborne, O., Carter, C., Pinkleton, N., and Richards, H. (1993). Development of African American Curriculum in Psychiatric and Mental Health Nursing. In Chunn, J.C., Dunston, P.J., & Ross-Sheriff, F. Mental Health and People of Color: Curriculum Development and Change. Washington D.C: Howard University Press, 335-376.

Osborne et al identifies and discusses the shortage of African Americans in psychiatric nursing circa 1972. In addition the authors provide a valuable list of the indicators of mental health in the African American population that they see as useful in providing direct services. Of particular merit is the listing of principles the authors believe are needed to undergird a curriculum that focuses on meeting the needs of African Americans with mental illness. Of note, very fee other articles were found that approach the issues of mental health care of African Americans and the relationship to nursing competencies.

6. Social Work

Bush, J.A., Norton, D.G., Sanders, C.L., & Solomon, B.A.(1983). An Integrative Approach for the Inclusion of Content on Blacks in Social Work Education. In Chunn, J.C., Dunston, P.J., & Ross-Sheriff, F. Mental Health and People of Color: Curriculum Development and Change. Washington, D.C: Howard University Press. 97-126.

This article traces the lengthy effort within social work education to influence and amend the curriculum to include content generic to African Americans, but with a more specific focus on mental illness in this population. It is proposed that the most viable model for including such content is what is termed an integrative model. In this perspective, content on blacks with mental illness would be integrated throughout the curriculum rather than compacted into one course offering. The authors draw on a broad spectrum of other articles to develop a general framework of values, abilities, skills, attitudes, and competencies useful in working with African Americans with mental illness.

Dungee-Anderson, D., & Beckett, J.O.(1995). A Process Model for Multicultural Social Work Practice. The Journal of Contemporary Human Services. 459-466.

These authors provide the first three steps in an eight-step model that is designed to assist social workers increase the cultural competency of their clinical interventions. These three initial steps include acknowledging cultural differences, understanding the self, and knowledge of other cultures.

Harper, K.V., & Lantz, J.(1996). Cross Cultural Practice: Social Work with Diverse Populations. Chicago: Lyceum Books.

These two authors examine the relationship between the practice of social work and a series of diverse populations, differing by race, language, migratory status, ethnicity,

residence, sexual orientation, gender, age, military service, and prior trauma. The authors attempt to help the reader to become more knowledgeable about diverse groups as the basis for providing culturally sensitive and specific services.

Jackson, V.(Ed.) (1996). Managed Care Resource Guides. Washington D.C: National Association of Social Work.

The focus of this work is on assisting the social work profession to understand managed care and the impact managed care is likely to have on practice in private and agency settings. The document does not specifically address issues related to African Americans and severe mental illness.

Lum, D.(1986). Social Work Practice with People of Color. Monterey: Brooks/Cole Publishing Co.

The author provides an excellent framework for conceptualizing cultural differences and utilizing these differences as the basis for developing and providing competency based services to people of color.

National Association of Social Workers.(1984). Standards for the Practice of Clinical Social Work. Washington D.C: NASW

A generic set of standards for guiding the clinical practice of social work. This work does not specifically address the issues in practice of clinical social work with African Americans with mental illness.

National Association of Social Workers.(1992). NASW Standards for Social Work Case Management. Washington D.C: NASW.

A very good guide for understanding how social workers conceptualize case management and the differences between this view and care management and case management in managed care plans. No specific focus on African Americans is noted herein.

D. ROLES/VIEWS OF AFRICAN AMERICAN CONSUMERS

No reference materials were found that address this area for African Americans.

E. ROLES/VIEWS OF AFRICAN AMERICAN FAMILIES

Boyd-Franklin, N.(1989). Black Families in Therapy: A Multisystems Approach. New York: Guilford Press.

Lawson, W. B.(1986). Chronic Mental Illness and the Black Family. American Journal of Social Psychiatry. 6(1), 57-61.

Lawson proposes in this article that the role of the family generally has been neglected. He traces the history of blaming of families for the development of schizophrenia. In relationship to black families, Lawson indicates that these families have had to bear even greater burdens historically. Although Lawson's article does not provide a perspective from the African American family about mental illness, it does give some directions for the content of therapeutic work with these families.

Pickett, S.A., Vraniak, D.A., Cook, J.A., & Cohler, B.J.(1993). Strength in Adversity: Blacks Bear Burden Better than Whites. Professional Psychology: Research and Practice. 24(4), 460-467.

The authors indicate that the research literature has principally focused on the adjustment and coping of white families with a severely mentally ill members, leaving out other racial and ethnic groups and how they have managed severe illness. The research that was conducted by the authors included determining the coping ability and self-esteem scores of both black and white families with severely mentally ill children. The findings suggest that black families had higher than expected levels of self worth and correspondingly lower rates of depression than white families. Although the study is not directly related to managed care issues or workforce competencies, this article helps shape the issues relative to the need for culturally sensitive models and how different groups respond to and manage illness.

F. MANAGED CARE, AFRICAN AMERICANS AND MENTAL ILLNESS

Bluford, J.W.(1994). A Public Sector HMO in a Competitive Market: Ensuring Equity for the Poor. Journal of Health Care for the Poor and Underserved. 5(3), 192-199.

Center for Health Economics Research.(1993). Access to Health Care: Key Indicators for Policy. Princeton: Robert Wood Johnson Foundation.

An excellent resource for examining and comparing a series of health indicators for the American population as a whole. While the focus here is not specifically on managed behavioral health care or African Americans, the data are illustrative of the major disparities that exist in the general health area by race and social class. The charts and graphs included are excellent and in a number of instances show groups by race and social class.

Center for Vulnerable Populations.(1994). Health Reform and Vulnerable Populations. Spotlight. 2(1), 1-11.
This article discusses access to health care and the supportive services that are needed to maximize independent living for persons with special needs. It states that persons with disabilities account for significant expenditures in the health care system and that they tend to have lower incomes, much of which is used for health care. Many persons with disabilities rely on government programs for income and housing. The article suggest that more attention needs to be paid to the complex and multiple needs of these individual.

Davis, King E. (1996). Managed Care and People of Color: A Conceptual Framework.

(Unpublished). Statewide Public Psychiatry Conference. Cleveland: Case Western Reserve Department of Psychiatry.

One of a series of presentations and papers delivered over the past two years that examines managed care through a socio-political and economic lens. Managed care is compared and contrasted with Medicaid and states rights as strategies designed to curb costs and increase the control and power of state governments. The article traces the history of states rights as a strategy and concludes that it offers no real guarantees of equitable distribution of access, quality, or outcomes to African American populations. Of import, as well the article examines the absence of African American input into the formulation of national health care policy.

Group Health Association of America.(1994). Understanding Managed Care: Introductory Program for New Managers in HMOs. Conference Proceedings. Chicago: GHAA.

This is an extensive review of the concept of managed care and its most critical elements from the perspective of a trade organization. In volume two there are a series of presentations made that focus on the implications of managed care for populations of color and for rural poor populations.

Glazer, W. M., & Morgenstern, H.(1993). The impact of utilization management on hospital length of stay and illness. Administration and Policy in Mental Health. 21(1), 41-49.

This article presents a model study to test the impact of utilization management in the behavioral health field. The authors suggest using randomization when conducting studies of utilization management and cost effectiveness. Utilization management is used to manage health care costs by influencing patient care decision making through a case-by-case assessment prior to providing services. The results suggest that utilization management may negatively impact on minority populations.

Horn, R. (1994). Managed Care: Implications for Underrepresented Physicians. Jounral of Health Care for the Poor and Underserved. 5(3), 154-157.

Mental Health Statistics Improvement Program.(1995). Task Group on Enrollment and Encounter Data.
This report defines enrollment as the number of individuals covered or enrolled in a health plan. Encounter is defined as a face-to-face interaction between the enrollee and the provider. The purpose of the report is to offer a framework for the provision of management data such as 1) whether services are reaching the appropriate population; 2) what are the services and costs of data and 3) descriptions of the performance data.

The National Pharmaceutical Council.(1993). Ethnic and Racial Differences in Response to Medicines: Preserving Individualized Therapy in Managed Pharmaceutical Programs. . Pharmaceutical Medicine. 7, 139-165.

This article notes that genes in racial and ethnic groups may cause or create differences in reactions to medications. Due to standardization and uniformity, health plans have limited choices of medicines. Differences in medication are seen as representing some risks to the quality of care.

Phillips, J.N.(1994). Future Management Opportunities for Minorities in Managed Care. Journal of Health Care for the Poor and Underserved. 5(3), 247-251.

Randall, V.R.(1994). Impact of Managed Care Organizations on Ethnic Americans and Underserved Populations. Journal of Health Care for the Poor and Underserved. 5(3), 224-236.

Root, L.S.(1991). Cost controls on mental health services: Context and the role of the professional. Employee Assistance Quarterly. 7(2), 1-14.

This article maintains that pressures over the last ten years to control and cut costs in the general health environment have affected mental health care. Moreover, the author suggests that mental health services are very vulnerable to excess cost control measures. Often this emphasis on reduction of costs may mean that services are limited and individuals, groups, or populations may be excluded from needed services. To alter and reduce this possibility, Root proposes that mental health professionals must be active in taking a key leadership role in insuring that services continue to be provided where needed.

Smith, M.D.(1994). Managed Care and the Poor. Journal of Health Care for the Poor and Underserved. 5(3), 147-154.

Snowden, L.(1993). Emerging trends in the organizing and financing of human services: Unexamined consequences for ethnic and minority populations. American Journal of Community Psychology. 21(2), 1-12.

In this article, Snowden examines various organizational structures and various financial approaches as they help explain managed care. He maintains that ethnic status makes for increased vulnerability to service gaps, inefficiencies and fragmentation. He suggests that as efforts are made to reduce the utilization and cost of high users of services that the risks are greater for minorities often over-represented in this group. As new systems and policies for health care are formulated more attention needs to be devoted to the differential impact on minority populations.

WICHE.(1996). Standards for mental health services to Latino populations. West Link: Mental Health Developments in the Western States. 17(2), 12-15.

This article provides a list of standards which include cultural competency, planning, governance, benefit design, quality monitoring and improvement, and decision support and MIS. The article also lists clinical standards as well. These include access, triage and assessment, care planning, treatment services, case management and linguistic support. These standards were drafted by Latino mental health professionals. The document also

lists several disadvantages of managed care for the Latino community including a lack of access and knowledge of how the system works, lack of advocates for access to services, lack of bilingual staff and providers, language barriers, fragmentation of the system and a lack of interest within the health care system. The document also lists several advantages of managed care to include its emphasis on consumer orientation, competition for the Medicaid dollar, flexibility of care option and access to early intervention and preventive care. The issues in this article, although discussed in the context of Latino Americans have general applicability to African American and other ethnic populations.

Weil, T.P.(1994). Managed Competition for the Poor: More Promise than Value? Journal of Health Care for the Poor and Underserved. 5(3), 158-169.

Whitlow, J.(1993). Is Managed Care the Answer for Blacks? Focus. 21(7), 5-6.

A brief overview of issues related to access to services by minority populations. The lack of access to needed services may contribute to an increase in cost of services overall.
The author briefly addresses restrictions and benefits of managed care plans, as well as converting Medicaid users to other forms of managed care plans. The author notes that there is a need to carefully educate the African American community to new ways of responding to and preventing illness. It is predicted that managed care will have a negative impact on those health care facilities that have traditionally served the poor. There may be a corresponding negative impact on African American physicians and support staff who have been employed in these facilities, and who may not be accepted by managed care organizations.

Wilson, I.D.(1994). Increasing the Pool of Minority Providers. Journal of Health Care for the Poor and Underserved. 5(3), 260-268.

G. State and Local Governments and Managed Care for African Americans

Balderrame, C.H.(1995). Surfing the managed care tidal wave. Spokane: Washington State Mental Health Division.
This article indicates that managed care appears to be an accepted national policy as evidenced by the growth of managed care plans in the states. In 1995, 68% of the states reported being involved in managed care plans. One area that is projected to be impacted at the state level as these plans are adopted will be the small community-based agencies that have traditionally provided the bulk of services to minority populations. The author suggests that there are clinical and administrative aspects of managed care that must be considered because of their relevancy to ethnic minorities. Community based organizations that serve minority populations will need to offer individualized care. These tailored services can enhance the quality of life of these populations in a managed care environment. Cultural bias places a significant burden on managed care policies need to provide quality service to minorities. The author indicates that there are few managed care experts in working with minority populations or providers who specialize in service design and delivery for these groups.

California Cultural Competency Task Force. Recommendations for the Medi-Cal Managed Care Program. Sacramento:

This document maintains that current health care systems in California do not overcome all barriers to access and cultural appropriateness for the many ethnic and cultural groups served in the system. A framework for addressing issues and concepts related to cultural competency is provided. This framework covers many dimensions including a definition of cultural competency, community linkages, demographic description of the catchment areas, service elements, recommended standards for data in operational managed care plans and others.

Of note, the concept of cultural competency promoted by this task force is that competency is a process that requires individuals and systems to increase respect for cultural diversity. This effort is designed to increase awareness, acceptance and valuing of diversity. The outcomes expected include more effective communication and the provision of services that are more appropriate and useful to various groups.

The primary recommended standards for data in operational managed care plans include 1) measurement of ethnic/racial demographics of the population served; 2) determination of the degree to which access and appropriate service utilization meets established standards of care, 3) identification of differences in enrollment and service utilization among population groups, and 4) measurement and comparison of outcomes by ethnic/racial groups. Additional data standards recommended include the classification of race and ethnicity that match true diversity of the populations; data classifications should match the level of literacy in the primary language of the catchment areas; data should be collected by catchment area and be inclusive of enrollments/disenrollments, utilization patterns, patient compliance and satisfaction information and statistical reports should include measures of dispersion as well as measures of central tendency.

California Mental Health Directors Association. Cultural Competency Goals, Strategies, and Standards for Mental Health Care to Ethnic Clients. Sacramento.

The Multiethnic Mental Health Consortium.(1986). Culturally Competent Approaches to Ohio Care. Position Paper II. Columbus: Ohio Department of Mental Health.

This paper provides a framework which includes demographic clusters which help customize interventions for ethnic minorities. The paper focuses on building therapeutic alliances with consumers and collaborating with other systems to decrease fragmentation of services.

Ohio Department of Mental Health.(1995). The relationship of managed care to cultural diversity. Working Paper. Columbus: Ohio Department of Mental Health.

This document suggests that managed care environments must develop interventions and strategies to address specific needs in order to minimize high cost services and maximize quality health delivery. The authors note that cultural competency is essential for this

process because any services rendered may be inappropriate, ineffective and potentially damaging to the recipient. The document also suggests that awareness and knowledge of the consumer are important determinants of quality. The report proposes that as the level of cultural knowledge and competency of minority populations increases there is the potential for a decrease in the use of more costly services.

Randall, V.R.(1996). Section 1115 Medicaid Waivers: Critiquing the State Applications. Seaton Hall Law Review. 26, 1069.

San Francisco Department of Public Health.(1996). DMS Cultural Competency Self Assessment Questionnaire. San Francisco: Division of Mental Health and Substance Abuse Services.

The purpose of the questionnaire is to serve as a tool for organizations and programs to assess and review resources, capabilities and methods of providing services to racial, ethnic, and cultural minorities. The intent is to urge organizations and programs to do self studies to assess their ability to provide culturally competent services. The authors provide a definition of cultural competency: a collection of practice skills, attitudes, policies, and structures that enable systems to operate effectively in cross cultural situations.

Watson, S. (1993, June). Health Care in the Inner City: Asking the Right Question. North Carolina Law Review. 71. 1647.

5. Review of Standards and Competencies

This review of the literature, covering the period 1976-1996, did not disclose current materials that identify standards or core competencies for mental health service delivery to African American populations with serious mental illness. This finding holds for the more recent managed care environment as well as the fee for service model/policy that has been in use for decades. Of the existing bibliographies that were reviewed, there were no current articles, books, reports, or studies that focus on African Americans with serious mental illness and the competencies needed by providers in managed behavioral health care. Review of guidelines for care provided by managed care companies also did not reveal core competencies or standards to guide in the delivery of mental health services to this population.

6. Identified Gaps in Standards and Competencies

The most significant finding in this report is the paucity of literature that exists on African Americans with mental illness generally as well as the absence of standards, competencies, or guidelines that can be utilized in managed behavioral healthcare specifically. This absence of attention in the literature and the mental health field generally is the major gap that must be addressed if adequate standards are to be developed to guide curriculum, training, and services in managed behavioral healthcare for this population. The most significant indirect reference in the literature is to the value of cultural competency as the guiding model for service delivery to various populations.

7. Recommendations for Action:

1) Center for Mental Health Service support a working national conference, in conjunction with the Historically Black Colleges and Universities Human Resource Development Project, to develop standards and competencies for service delivery to African Americans with serious mental illness;

2) Encourage the associations of Black Nurses, Psychiatrists, Psychologists and Social Workers to participate in the development of standards and competencies for service delivery to African Americans with serious mental illness;

3) Support the development of a national center/project that explores and conducts research on issues of mental health care services and policy as these impact African American populations and communities within managed behavioral healthcare;

4) Utilize the standards and competencies for service delivery to African Americans as the basis for developing curriculum guidelines for the professions.