

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

Chapter 1

INTRODUCTION

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

Systems of care for children's mental health is a specific community of service designed to meet the needs of children with serious emotional disturbance and their families (Saxe, 1998; Stroul & Friedman, 1986). Given that children are already an exceptionally vulnerable group of society, it is important to consider the impact of culture in serving children suffering from mental health disorders. Census data indicate that the population growth of children and adolescents is extremely diverse. It is estimated that by the year 2005, 40% of the population of children and adolescents in this country will be of color ("Embracing the Dynamics of Difference," 1997). The Surgeon General's Report on Mental Health (U.S. Department of Health and Human Services [USDHHS], 1999) indicated that the "fundamental components of effective service

delivery include integrated community-based services, continuity of providers and treatments, family support services (including psychoeducation), and *culturally sensitive services* [emphasis added]" (p. 455).

Cultural competence is a key philosophical value of the systems of care movement (Stroul & Friedman, 1986), and the federal branch of the United States government supporting this movement is challenging communities to implement and measure cultural competence at both practice and systems levels (USDHHS, 2001). However, determining the best method for assessing cultural competence is a difficult task when the researcher is uncertain about what she/he is to observe. Terms used to describe culturally competent work, and models developed for implementing and assessing culturally competent practice, have proliferated across disciplines over the past two decades. Fong (2001) identified fourteen terms, some reflecting models for practice, used in social work alone. Ironically, as social work increasingly strives to incorporate cultural competence into its curriculum, the Social Work Dictionary includes no definition of the concept (Wells-Wilbon & McDowell, 2001). Social work's professional journals have offered little guidance, as they have included minimal attention to issues of diversity and multiculturalism over the past twenty-five years (Lum, 2000). The lack of clarity around the conceptual meaning of cultural competence leads one to question the constructs underlying the models advanced and the measurement instruments developed based on those models.

The proposed study explores the viability of a participatory, mixed-method approach to assessing cultural competence in four different communities implementing children's mental health systems of care across one southwestern state. The study attempts to compare conceptualizations of cultural competence from individual community perspectives with current

theoretical conceptualizations of the construct and examine the results for measurement implications.

Statement of the Problem

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

Current national data indicate that one out of every five children will need mental health services at some point before reaching adulthood. The Surgeon General’s Report on Mental Health (U.S. Department of Health and Human Services, 1999) indicates that approximately 21 percent of U.S. children ages 9-17 have a diagnosable mental or addictive disorder.

Approximately 9 to 13 percent of all children suffer with serious emotional disturbances. While disciplines and other interest groups vary on the specific definition of serious emotional disturbance (Friedman, Kutash, & Duchnowski, 1996), systems of care often use a variation of the definition put forth by the Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Mental Health Services (CMHS). SAMHSA/CMHS (n.d.) define a child or adolescent with serious emotional disturbance as one who has a diagnosable emotional, behavioral, or mental disorder that severely disrupts his/her daily functioning at home, in school, or in the community.

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

Pulling these services together requires staff who can successfully navigate the multiple service systems, while individualizing work with youth and families. This specialized *wraparound* service delivery approach (Burchard & Clarke, 1990; VanDenBerg & Grealish, 1998) requires knowledge at many levels of service implementation. The wraparound model

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

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

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

In addition to cultural issues related to people of color, Hernandez, Isaacs, Nesman, and Burns (1998) discuss the relationship between poverty and youth with mental health needs going unmet. Children and youth of color are greatly impacted by the conditions of society, including poor economy, lack of health care provision, and discrimination, to name but a few. The range of youth affected by social conditions is compounded by the number of immigrants and refugees who live in poverty in the United States. These societal conditions impact the emotional and psychological well being of children and youth of color ("Embracing the Dynamics of Difference," 1997).

Yet another aspect of cultural difference is related to geography. Rural communities face a different set of challenges and barriers in providing needed mental health services than do inner

city communities (Cutrona, Halvorson, & Russell, 1996). Residents of rural, urban, and suburban communities all address similar needs, but the solutions they develop must address the unique geographic characteristics of their communities.

With cultural competence playing such an integral role in systems of care designs, monitoring development of cultural competence within systems is a critical component of evaluation. Identifying the essential components of culturally competent care and their relationship to outcome is critical, as no empirical data is currently available to determine these relationships (USDHHS, 2001; Human Resources and Services Administration, 2001).

Although a number of cultural competence measurement instruments were developed across disciplines over the last decade (Hernandez, Gomez, & Worthington, 2001; Roizner, 1996), most of them are not compatible with the systems of care philosophy. Most measures currently available were developed through traditional scale development approaches (DeVellis, 1991; Springer, Abell, & Hudson, 2002), reflecting a top-down, expert-driven model of measurement development (Rogler, 1999). In contrast, a participatory, professional/family partnership approach to developing services, policy, and evaluation is fundamental to systems of care philosophy. Thus, the philosophy calls for a bottom-up approach to conceptualizing and assessing cultural competence. Current measures are not structured for flexible community conceptualizations of the construct.

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

methods for assessing a construct that is constantly evolving at multiple levels within a service community.

Purpose of the Study

The purpose of the proposed exploratory study is to implement and examine the viability of an innovative approach to examining cultural competence in children's mental health systems of care. Concept Mapping, as developed by Concept Systems, Inc. (Trochim, 1989), will be used in four separate systems of care communities, two urban and two rural, for this cross-sectional exploration. Concept Mapping is a participatory structured conceptualization process that uses a mixed-method approach to understanding multiple ideas from multiple participants. The study will generate conceptualizations of cultural competence from the perspectives of individuals participating in the specified service communities. The conceptualizations generated through the comparison study will be further examined for their congruence with the assumptions underlying current definitions, models, and measures of cultural competence.

The study is grounded in a combination of cultural/intercultural and communicative integration theories (Gillin, 1948; Green, 1999; and Spitzberg, 1989), which focus on the interaction/relational aspects of exchange of meanings. To actualize the principles and values behind systems of care philosophy, the cultures of all participants must be recognized and integrated into the system's development. The primary mode of this recognition occurs through processes of communication. Previous research on the values of social work students indicated incongruence between student values and those of the social work profession, especially related to issues of poverty and welfare recipients (Haynes, 1993). Given the dominance of a Euro-White worldview in the structures of social service systems, such conflicts in value systems

would certainly influence a social worker's capacity for engaging in culturally competent communication and practice.

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

On a practical level, the study seeks to assist local communities in establishing a baseline from which their local mental health systems can monitor the development of cultural competence. Participants will quantitatively attribute value to their own ideas, producing a form of measurement to provide local communities a means for assessing adherence to the systems of care model at service delivery and policy levels. Another practical purpose for the study is to assist communities in gathering information necessary for developing technical assistance and training plans to address issues related to cultural competence. Experience from a pilot study that this author conducted using this approach indicated that concrete training needs across the system can be identified for application in system development.

Research Questions

1. To what extent are there differences and similarities in conceptualizations of cultural competence among groups of participants across four systems of care communities?
2. Do systems of care community assessments (individually and collectively) support current assumptions and theoretical conceptualizations of cultural competence?

3. Do community conceptualizations of cultural competence support the usage of generalized measures of cultural competence?
4. Is Concept Mapping methodology a viable approach to assessing cultural competence in individual communities?

Significance for Social Work and Children's Mental Health

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

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

and “balance its reductionistic tendencies with the knowledge that the whole is greater than the sum of its parts” (p. 1064-1065).

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

Why begin this section of significance to social work with an outline of what another discipline is doing to address issues of culture? Social work often lags behind the curve on issues and trends found important by its sister disciplines. Three specific examples are pertinent for this discussion. First, social work’s efforts to establish its research knowledge base of evidenced-based treatment, especially in the area of mental health, have been extremely belated (Austin, 1998; Task Force on Social Work Research, 1991; Zlotnik, Biegel, & Solt, 2002). Secondly, social work continues to experience slow recognition and incorporation of participatory research and evaluation approaches into its curriculum and research practices (Altpeter et al., 1999; Davis, T. in press). Finally, there is a recognized neglect by social work professional journals to include publications related to cultural diversity (Lum, 2000). The tendency of slow development around critical issues has tremendous influence on how professionals both inside and outside of social work view the capacities of our field. Since a majority of mental health services are conducted by social workers, these specific examples may lead one to question the preparation of its mental health practitioners for working with culturally diverse children and families.

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

The proposed study attempts to offer social work an alternative lens for viewing issues related to culture and cultural competence. This lens will contribute in three substantial ways. The study will first provide some additional insight into current definitions and conceptualizations of the cultural competence construct. Secondly, the findings will provide a means for examining the content validity of current cultural competence measures. Finally, the study's method contributes to social work's knowledge base of research methodologies. Potocky-Tripodi & Tripodi (1999) called upon social work researchers to "develop their own [research] methods, or modify existing ones, to suit the profession's unique purposes" (p. 124) especially as they relate to the interface between the person and the environment. As this research examines the cultural interface between families and service systems, it has the further

potential of adding a culturally appropriate alternative method for measuring cultural competence.

Limitations of the Study

There are several limitations to this study that need to be addressed. Given the exploratory purposes of the study, the research does not include an in-depth review of the relationship between personal/cultural values and cultural competence, although the theory grounding the study provides a values framework for conceptualizing cultural competence. The choice to include a values-based theoretical framework is based on the personal epistemological fit with the researcher, the emphasis on values within systems of care and wraparound philosophies, and on the integral relationship among social work values, ethics, and culturally competent practice.

Another limitation of the study centers on the sample. The systems of care being studied are in early developmental stages, thus there are only a small number of families currently being served across communities. This state of the systems development limits the potential for a large number of families to be included in the research. Efforts are being made to increase the numbers of families by broadening the definition of the system of care community to include families being served in at least two of the partnering agencies, but not enrolled in the wraparound service delivery. Because this is an exploratory study, the researcher did not want to expand participation beyond the system of care participants. Such attempts might risk jeopardizing future efforts of individual communities to involve new partners if the research does not produce results consistent with the practical objectives of the research.

Due to the exploratory purposes of this research, the findings from the study will not be generalizable to any specific population or community. The sample is limited to systems of care

within one state. Although communities are being encouraged to gather the greatest number of diverse participants that reflect the targeted populations of their systems of care, there is a possibility that the sample may not be large enough to examine differences between specific ethnic groups within a community. Comparisons between groups is a goal and process of the Concept Mapping methodology, and is a noted need in cultural competence research (Mason, Benjamin, & Lewis, 1996).