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Addressing Mental Health Disparities through Clinical Competence Not Just Cultural Competence: The Need for Assessment of Sociocultural Issues in the Delivery of Evidence-Based Psychosocial Rehabilitation Services

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Abstract

Recognition of ethnic/racial disparities in mental health services has not directly resulted in the development of culturally responsive psychosocial interventions. There remains a fundamental need for assessment of sociocultural issues that have been linked with the expectations, needs, and goals of culturally diverse consumers with severe and persistent mental illness. The authors posit that embedding the assessment of sociocultural issues into psychosocial rehabilitation practice is one step in designing culturally relevant empirically supported practices. It becomes a foundation on which practitioners can examine the relevance of their interventions to the diversity encountered in everyday practice. This paper provides an overview of the need for culturally and clinically relevant assessment practices and asserts that by improving the assessment of sociocultural issues the clinical competence of service providers is enhanced. The authors offer a conceptual framework for linking clinical assessment of sociocultural issues to consumer outcomes and introduce an assessment tool adapted to facilitate the process in psychosocial rehabilitation settings. Emphasizing competent clinical assessment skills will ultimately offer a strategy to address disparities in treatment outcomes for understudied populations of culturally diverse consumers with severe and persistent mental illness.

Keywords

Mental Health; Ethnic Minority; Cultural Competence; Health Disparities; Measurement Scale; Multicultural Competencies

1. Introduction

In response to sustained efforts to offer effective care to persons with severe and persistent mental illness (SPMI) specialty psychosocial rehabilitation programs have been developed

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(Lehman et al., 2004). These programs emphasize recovery focused on an individual's wholeness and wellness, and empower individuals to take an active role in making decisions and making choices regarding their future. Yet, despite increased efforts to tailor psychosocial services to the needs of each consumer (Liberman, Kopelowicz, Ventura, & Gutkind, 2002), ethnocultural disparities in access to and use of these services continue to abound (USDHHS, 2001). Moreover, a small, but growing number of researchers has documented reduced quality of care and poorer outcomes when the impact of sociocultural factors on treatment is not considered (Bae, Brekke, & Bola, 2004; Miranda et al., 2003; Phillips, Barrio, & Brekke, 2001; Telles et al., 1995; Young, Klap, Sherbourne, & Wells, 2001).

In recognition of the intertwined nature of social issues and culture, we define sociocultural factors as those issues arising out of socioeconomic and cultural differences. Sociocultural factors include a variety of social issues associated with ethnic minority status that are difficult to untangle from cultural beliefs and practices (Brekke & Barrio, 1997) and can be more salient determinants of health and functioning than ethnicity or racial background (Kagawa-Singer & Kassim-Lakha, 2003; Pincus, Esther, DeWalt, & Callahan, 1998). These social issues, such as the importance of family and immigration stresses, cannot be fully captured using the single construct of ethnicity, as they can occur irrespective of any particular cultural or ethnic group, but they do co-vary with ethnic minority status in many instances. Recent literature indicates that sociocultural factors are not well integrated into assessment and treatment planning in psychosocial rehabilitation services (PRS). In general, many providers do not value the importance of social factors in the lives of ethnic minority patients (Vega, 2005). Therefore, an essential foundation for developing and implementing culturally-tailored interventions in psychosocial rehabilitation services (PRS) is missing.

In this paper we offer an overview of how sociocultural issues are considered in relation to clinical assessments in evidence-based PRS. We also provide recommendations to facilitate the clinical assessment of sociocultural issues across diverse consumer populations. We present a conceptual framework to link clinical assessment of sociocultural issues to consumer outcomes within evidence-based practice and we introduce an assessment tool to facilitate the process.

2. Importance of Sociocultural Issues in Mental Health Services

Researchers in the medical field have identified several key sociocultural issues that are relevant to the provision of culturally responsive services. These include: salience of family and social support, importance of religion or spirituality, stress of migration, barriers of language or literacy, and impact of socioeconomic factors on independent living and functioning (Carrillo, Green, & Betancourt, 1999). Other sociocultural issues have been identified through theoretical or empirical studies of mental health (Alegria, Takeuchi, & Canino, 2004). Yet, most research among consumers receiving community-based PRS has been conducted without examining the effects of these factors on outcomes (Brekke, Ansel, Long, Slade, & Weinstein, 1999; Brekke & Long, 2000; Brekke, Long, Nesbitt, & Sobel, 1997). A small body of treatment outcome research has examined sociocultural factors among single ethnic minority groups such as: African Americans (Baker & Bell, 1999; Baker, Stokes-Thompson, Davis, Gonzo, & Hishinuma, 1999; Min, Wong, & Rothbard, 2004), Asian Americans (Kim, Snyder, & Lai-Bitker, 1996), and Latinos (Lopez et al., 2004; Ortega & Rosenheck, 2002). Other work that contributes to our understanding of sociocultural issues in the context of PRS is found in studies examining the effects of ethnicity among three or more ethnic groups. These studies compare outcomes for ethnic minority consumers compared to non-ethnic minority consumers (Brekke & Barrio, 1997; Jerrell & Wilson, 1997) or they report specific ethnic variation in outcomes (Bae et al., 2004; Barrio, 2001; Barrio et al., 2003;

Miranda et al., 2003; Sue, Fujino, Hu, Takeuchi, & Zane, 1991; Weisman, Rosales, Kymalainen, & Armesto, 2005).

There are many ways that sociocultural issues affect the provision of mental health services (Bernal & Saez-Santiago, 2006; Hwang, Myers, Abe-Kim, & Ting, 2008; Lopez & Guarnaccia, 2005). Sociocultural issues affect consumers' preference for setting and for achieving treatment goals and outcomes (Green, Betancourt, & Carrillo, 2002). Ethnic disparities in service use vary in accordance to the responsiveness of mental health services to the sociocultural needs of ethnic minorities (USDHHS, 2001; Snowden & Hu, 1997). Individualized services have been linked to better treatment outcomes (Arns & Linney, 1995; Test, 1981). Sociocultural differences between the provider and consumer may also be associated with systematic biases in diagnoses of SPMI across racial and ethnic groups (Whaley & Geller, 2003). Misunderstandings by providers who are not aware of applicable sociocultural issues have an adverse effect on the interaction between providers and consumers (Betancourt & Maina, 2007; Takeuchi, Sue, & Yeh, 1995). Typically, these misunderstandings reflect differences in sociocultural values that impair the development of trust and undermine the treatment relationship (Carrillo et al., 1999; Comas-Diaz, 2006). Assessing presence of sociocultural issues and then setting goals to address consumers' prioritized outcomes is likely to increase the effectiveness of communication (Kagawa-Singer & Kassim-Lakha, 2003) and to strengthen treatment alliance, a key ingredient in determining outcomes for consumers with SPMI (McCabe, Saidi, & Priebe, 2007).

3. Significance of Clinical Assessment in Evidence-Based Psychosocial Rehabilitation

Within community mental health services, there is considerable evidence of a lack of concordance between provider and consumer ratings of unmet needs (Korkeila et al., 2005; Rosenheck & Lam, 1997; Slade, Phelan, & Thornicroft, 1998; Slade, Phelan, Thornicroft, & Parkman, 1996). The gap between consumer goals and actual services may relate to providers' focus on primary treatment needs (e.g., medication management) while consumers report a broader range of needs related to daily living and community support (Barrio et al., 2008; Crane-Ross, Roth, & Lauber, 2000; Korkeila et al., 2005). Lecomte and colleagues (2005) report that consumers most often expressed rehabilitation goals related to improving their financial situation, physical health, cognitive functioning, and symptoms. Consumers rated services as best at addressing their symptoms and worst in helping them address their religious or spiritual needs. Time constraints for services and increasing caseloads may further decrease providers' elicitation of the unique perspectives of their consumers and thus reduce the degree to which consumers are empowered through active participation in their treatment (Crane-Ross et al., 2000). Increasing the congruence between providers and consumers is imperative for EBP (Bellack, 2006) as consumers' report of their needs correlate with their perceived quality of life and treatment outcome (Korkeila et al., 2005; Lasalvia, Bonetto, Tansella, Stefani, & Ruggeri, 2008).

Empirically supported practice requires assessment-based evidence (Ell, 2006). Dixon and colleagues (2000) emphasize the importance of consumer participation in deciding if an evidence-based practice (EBP) is appropriate. Detailed assessment by service providers also supports the development of individually-tailored interventions that can complement manualized treatments (Chandler & Quinlivan, 2000).

4. Culture and Assessment within Evidence-Based Service Delivery

In response to the increasing attention to mental health disparities in outcomes for minorities (Atdjian & Vega, 2005; USDHHS, 2001; Institute of Medicine, 2002) and the growing diversity

of consumers in need of services, there has been a ongoing call for integrating culture into evidence-based practice (Dixon et al., 2001; Lopez et al., 2004; Sue et al., 2006; Weisman, 2005; Whitley, 2007). Sociocultural adaptations to EBP are encouraged based on the assertion that treatment models normed on one population may not be equally effective with other populations (Miranda, Nakamura, & Bernal, 2003; Sue et al., 2006). Based on findings from the Surgeon General's Report (2001), Miranda et al. (2003) advocate for the development and testing of innovative, theoretically-driven culturally-centered approaches that tailor mental health care so that it coincides with specific cultural characteristics of ethnic minorities. Nonetheless, very little is known about the ingredients necessary to culturally adapt an intervention (Bernal & Saez-Santiago, 2006; Lopez & Guarnaccia, 2005). The few efforts that have been made to design culturally relevant treatments emphasize that the intervention be aligned with the expectations, needs, and goals of the cultural group of interest (Miranda et al., 2005). Ultimately, however, all effective treatment is based on a sound assessment of the expectations, needs, and goals of consumers. Tailoring interventions to individuals thus requires that providers be able to assess and respond to key sociocultural issues (Sue, 2006). Further, there is no standardized method for training providers to assess and respond to sociocultural issues in routine practice in PRS.

Mental health practice guidelines recognize that sociocultural issues are integral to assessment of the needs of persons with SPMI (American Psychiatric Association, 1995; American Psychological Association, 2003; National Collaborating Centre for Mental Health, 2002). A more socioculturally-informed assessment may lead to more individualized treatment plans with improved consumer outcomes (Yamada, Barrio, Morrison, Sewell, & Jeste, 2006). Having a method to embed the assessment of sociocultural issues into PRS is one step in designing culturally relevant empirically supported practices. It becomes a foundation on which practitioners can examine the relevance of their interventions for the culturally varying consumers they encounter in everyday practice. It generates the empirical information that can be used to begin to adapt interventions for use across cultural groups, or to support the development of socioculturally-tailored interventions.

4.1. Current Psychiatric Approach to Assessment of Sociocultural Issues

There is a large body of theoretical and empirical literature (e.g. within counseling and clinical psychology and medicine) that attests to the challenge faced by providers in assessing consumers whose ethnic or cultural background differs from their own (Kagawa-Singer & Kassim-Lakha, 2003; Lewis-Fernández & Diaz, 2002; Lopez, 2004; Sue, 2006). Aside from development of ethnic specific guidelines (Council of National Psychological Associations for the Advancement of Ethnic Minority Interests, 2000), the bulk of research that addresses the impact of cultural diversity on assessment is focused on use of standardized psychological instruments (Dana, 2005; Lopez, 2000; Paniagua, 2005; Suzuki & Ponterotto, 2008) or on the formulation of diagnoses (Alarcon et al., 2002; Lewis-Fernández, 1996; Lewis-Fernández & Diaz, 2002; Mezzich, Kleinman, Fabrega, & Parron, 1996). The Cultural Formulation (CF) Model (Group for the Advancement of Psychiatry: Committee on Cultural Psychiatry, 2001; Lewis-Fernández, 1996; Mezzich et al., 1996) summarized in Appendix I of DSM-IVTR (American Psychiatric Association, 2000) represents a thoughtful conceptualization of the role of culture in psychiatric diagnosis and treatment. While components of the CF model may aid assessment of help-seeking preferences and information gathering, the focus is ultimately to minimize misdiagnosis of clinical syndromes. The model is geared for the advanced professional training of psychiatrists, psychologists, and social workers.

4.2. Why Cultural Competence Training has not Influenced PRS Assessment Practices

There is a lack of research on cultural competence training for community-based PRS. In a broad review of 68 studies of cultural competence training throughout the health professions,

Beach et al. (2005) conclude that there is evidence of change in provider short-term skills or behaviors. However, little evidence of the impact of cultural competence training on sustained change in routine provider behavior or on consumer outcomes is available (Beach et al., 2005). Most efforts, made in real world settings, to educate providers in culturally responsive assessment practices and to compare data meeting state requirements within community-based county mental health systems, are not published. Absence of evidence-based standards for culturally responsive clinical assessment in PSR prevents the provision of uniform training programs across agencies, and efforts to train providers in needed skills are not always sufficient to change their assessment skills.

Clinicians tend to perceive cultural competence as a distinct set of skills, rather than as an integrated component of routine clinical care and patient management (Vega, 2005). Vega (2005) argues that 'cultural competence' training must be presented to clinicians in the context of clinical practice and with organizational support if progress is to be made in decreasing ethnic disparities in care. He emphasizes: the need for feedback to clinicians on their integration of culture in their assessment and practice, the opportunity for additional training to clinicians who do not perform to standards, and the need to develop a body of research that investigates the ability of clinicians to change their practice behavior in a meaningful way to include assessment practices (Vega, 2005).

Six other reasons have been noted as to why cultural competence training efforts have not had a great impact on evidence-based care (Beach et al., 2005; Betancourt, Green, Carrillo, & Ananeh-Firempong, 2003; Green et al., 2002; Park et al., 2006; Weisman et al., 2005): (1) Only a narrow range of topics and cultural issues are included. (2) Training is often based on didactic presentation of facts or descriptions of particular cultural or ethnic groups. Discussion of social issues, which intersect with cultural values, beliefs, and attitudes, is often missing. (3) Providers with the greatest need for the training are least likely to attend. (4) Training is designed with little to no input from the consumers being served. (5) Few training programs are based on theory or educational principles on learning or behavior change. (6) Training programs are not designed to consider the organizational factors necessary to sustain changes in provider clinical practice behaviors. With these limitations in mind, we sought to formulate a novel approach of emphasizing clinical assessment skills that might increase the cultural competence of providers. Our initial work led to development of a conceptual framework to guide our assessment approach.

5. Framework Linking Clinical Assessment of Sociocultural Issues to Consumer Outcomes

Figure 1 specifies an overall conceptual framework for assessment of sociocultural issues and the theorized links that may affect consumer functioning within the context of PRS. The constructs included in our framework were selected based on theory and research from the fields of psychosocial rehabilitation, social psychiatry, cross-cultural psychology, counseling and clinical psychology, and allied health. Given a myriad of potential constructs that could influence consumer outcomes, we focus on those related to the sociocultural context within PRS that have been subject to empirical study.

5.1. Multi-faceted Determinants of Consumer Functional Outcomes

Determinants of consumer functional outcomes in PRS are multifaceted and often complex and difficult to disentangle (Hohmann & Shear, 2002). Effective progress toward cultural competent service delivery thus requires attention to variables associated with the consumers, providers, and the organization (Carpenter-Song, Nordquest Schwallie, & Longhofer, 2007; Maternal and Child Health Bureau, 1999). Betancourt and colleagues (2003) assert that among

the multifaceted contributors to treatment outcomes, the interactive relationship between providers and consumers should be considered. Our conceptual framework thus incorporates the multiple determinants of functional outcomes as reflected in the characteristics of PRS providers, consumers, and the interactions of providers and consumers as they operate within community-based mental health service organizations. The implications of the proposed framework for achieving desired consumer functioning stem from the premise that by understanding the linkages among even these select constructs, providers are more likely to facilitate socioculturally appropriate goal setting and treatment planning necessary to guide the delivery of evidence-based services. Socioculturally relevant evidence-based services are designed such that providers engage in behavior reflecting the philosophy of the recovery movement aimed at achieving clinically meaningful improved consumer functioning. These interactions should endorse patient-centered, participatory service delivery (Test, Greenberg, Long, Brekke, & Burke, 2005). We highlight contributing elements that reflect organizational, consumer, and provider/relational constructs within our conceptual framework.

5.2. Organizational Context of Culturally Responsive Evidence-Based Service Delivery

The degree to which the organizational milieu formally and informally supports and encourages culturally responsive assessment and service delivery is central to all encounters between providers and consumers (Kagawa-Singer & Kassim-Lakha, 2003). Efforts to modify organizational characteristics are supported by research indicating that system factors impede or facilitate provision of culturally responsive interventions (Constantine & Sue, 2005; Snowden, 1998; Westermeyer et al., 2002). The tendency for the credentialed, professional staff to be placed in administrative roles, while the less specially trained staff provide direct PRS, is one organizational issue that has been considered in our adaptation of the SCAP. Identification of specific structural and procedural characteristics of organizational cultures and climates that support culturally relevant clinical assessment could inform efforts to develop services that maximize positive consumer outcomes (Aarons & Sawitzky, 2006; Betancourt et al., 2003; Snowden & Yamada, 2005). The organizational context of the service system thus exerts an influence across all other components included in our conceptual framework.

5.3. Consumer Contributors to Desired Functional Outcomes

Consumers' communication style either facilitates sharing of relevant sociocultural experiences or hinders the ability of providers to individualize their interventions (Betancourt & Maina, 2007). Consumers whose cultural orientation reflects an independent self-identity (as opposed to an interdependent view of self) are more likely to verbally engage with providers (Kim et al., 2000). One possible explanation is that persons in individualistic societies, with less strict social norms, tend to be more expressive than persons in more collectivistic cultures (Van Hemert, Poortinga, & Van de Vijver, 2007). Likewise, the influence of the consumer's personality and functioning (Arns & Linney, 1995) is acknowledged as an interactive factor that directly affects provider attitudes and behavior (Couture et al., 2006; Crane-Ross et al., 2000). Researchers have determined that consumer personality may exert an influence on providers' behavior, consumers' satisfaction with their providers, and consumers' adherence to treatment recommendations (Braman & Gomez, 2004; Schouten, Meeuwesen, Tromp, & Harmsen, 2007).

5.4. Provider and Relational Components of the Framework

The important role of the provider in culturally competent service delivery has long been the foundation of models of multicultural competence (Sue & Sue, 2007). The classic tripartite multicultural model (Sue et al., 1982) conceptualizes the clinical impact of the provider's personal attitudes and values around ethnicity, knowledge of world views, and presence of effective skills in working with diverse people (Constantine & Sue, 2005). In the conceptual

framework we place particular attention on the influence of provider awareness. Increasing providers' cultural knowledge, as it relates to PRS, is not addressed in our framework, as the sociocultural complexity of the consumers who receive services and the number of cultures that would need to be studied would likely overwhelm providers. Provider skill has been built into our conceptual framework in terms of assessment of sociocultural issues and establishment of culturally relevant treatment goals. These provider aspects, and the relational elements we also address, are posited to influence the degree of improvement of consumer functioning.

5.4.1. Provider cultural self-awareness—Providers are better equipped to provide culturally relevant evidence-based services if they have an awareness of their own culture (Sue & Sue, 2007). This requires that providers be aware of their own beliefs, values, and biases they bring into clinical encounters (Constantine & Sue, 2005; Kagawa-Singer & Kassim-Lakha, 2003). Self-awareness enables providers to monitor their reactions and emotions so that they do not inadvertently encourage consumers to provide socially desirable responses to the questions posed. Providers' cultural values (different from those of their consumers) have been posited to partially account for the findings of researchers who have observed variations in provider affective behavior depending on the race or ethnicity of the consumers they serve (Schouten & Meeuwesen, 2006). Our conceptual framework further suggests that the degree to which providers are aware of their own and their consumers' sociocultural characteristics directly influences the extent to which sociocultural factors are assessed and considered in routine clinical practice (Guindon & Sobhany, 2001).

5.4.2. Clinical assessment of sociocultural issues—Some providers do not assess key sociocultural issues when conducting clinical assessments. This oversight may be due to a discrepancy between the providers' view of themselves as culturally aware and their lack of skills to translate their awareness into their assessment procedures (Guindon & Sobhany, 2001). Most standardized assessment instruments that could be used to enhance evidence-based service delivery (see McCabe et al., 2007) do not itemize sociocultural issues such as those related to immigration, language barriers, ethnic identity, or stressors related to ethnic minority status. Sociocultural issues related to reference group cultural identities of consumers are especially overlooked by current assessment protocols, even though development of a positive identity is a core element of recovery (Judge, Estroff, Perkins, & Penn, 2008). Reference group identities are often based on group memberships and peer group influences; identities typical of the consumers we work with include 'homeless', 'gang member', 'city girl', 'Christian,' 'Lesbian,' and 'not normal'. These identities may be of equal or greater importance than those based on ethnicity or racial heritage.

Conversely, while qualitative assessments have been recommended as responsive to sociocultural and linguistic variability among consumers (Guindon & Sobhany, 2001), this approach requires providers to be culturally proficient in eliciting and processing open-ended responses. This approach may also be confusing to consumers who are not always able to articulate the complex influences of sociocultural issues in their daily lives. As illustrated through the limited effectiveness of these typical assessment methods, there remains a need for providers to be trained and to have access to specific and clinically relevant sociocultural prompts to guide their questioning. Eliciting relevant sociocultural issues is a foundation that directly influences consumer communication style and indirectly affects the development of a strong treatment alliance, which in turn is a core element in achieving the intermediate and ultimate desired outcomes as illustrated in the flow across the central chain of boxes in our conceptual framework (see Figure 1).

5.4.3. Provider-consumer sociocultural match—Given the interest in identifying the mechanisms underlying the potential importance of provider-consumer ethnic/racial match in enhancing communication and treatment alliance (Karlsson, 2005; Ortega & Rosenheck,

2002; Schouten & Meeuwesen, 2006; Snowden, Hu, & Jerrell, 1995) we have included it in our framework. We also recognize that ethnic/racial match is insufficient to facilitate the formation of a genuine connection between providers and consumers (Lewis-Fernández & Diaz, 2002). There has been recent attention directed to the value of fostering congruent world views and shared systems of meanings between providers and consumers (Lopez, 2000; Lopez, 2004).

5.4.4. Treatment alliance—As noted in the previous sections, sociocultural issues influence the effectiveness of communication between providers and consumers (Betancourt et al., 2003; Eisenberg, 1979). Providers' failure to ask key questions or their inability to thoughtfully integrate general knowledge of socioculture into clinical assessment procedures can influence the extent to which consumers communicate their needs, goals, and preferences for treatment planning (Schouten et al., 2007). Communication style is one major factor in treatment alliance (Kouyoumdjian, Zamboanga, & Hansen, 2003). Establishing this relational bond based on sociocultural aspects of the provider-consumer dyad is consistent with sound counseling practices and is thought to be a powerful component of culturally relevant service delivery (Fischer, Jome, & Atkinson, 1998).

6. The Use of Assessment Tools in PRS

Recovery and consumer empowerment movements have given the consumers' perspective priority over providers' judgment of the most appropriate treatment goals and outcomes (Corring, 2002; Institute of Medicine, 2001). Participation of the consumer in planning and implementing services is integrated into the PRS philosophy as part of the ongoing assessment process (Bellack, 2006). The value of assessment has been recognized in the fundamental principles of psychosocial rehabilitation, that refer to "a treatment philosophy and to a set of assessment and treatment techniques designed to reduce disability and maximize environmental adaptation" (Silverstein, 2000, p. 277). Before that can happen, mental health service providers must become trained in effective methods for assessing sociocultural factors in routine practice. It is generally recognized that the use of multiple standardized questions facilitates patient-physician communication (see Van Os et al., 2004). Lang et al. (2002) reported a 44% increase in accurate consumer report of significant concerns when physicians were trained to ask specific questions to elicit the consumers' perspectives. There are three issues that impede the use of standardized assessments. (1) The standardized assessment tools specific to PRS are often viewed as burdensome or not cost effective (Wallace, Lecomte, Wilde, & Liberman, 2001). Many tools are considered lengthy, complex to score, or narrowly focused (Lecomte, Wallace, Caron, Perreault, & Lecomte, 2004; Silverstein, 2000; Wallace et al., 2001). (2) Most assessment tools are designed as functional outcome measures to monitor treatment outcomes (Van Os et al., 2004), not to assess ongoing barriers or resources that affect progress toward treatment goals. (3) Although some tools include select sociocultural issues (e.g., reciprocal social support, employment status, and independent living arrangements) (Test et al., 2005) reliance on standardized assessment instruments limits a provider's ability to assess individual variation or to capture sociocultural beliefs, values, and practices. A semi-structured, flexible sociocultural assessment tool, that would meet the guidelines for documentation in PRS is needed for use by professionals, paraprofessionals, and consumer staff (Beutler, Goodrich, Fisher, & Williams, 1999; National Institute of Mental Health, 1991).

7. Clinical Implications

7.1. General Tenets of Enhancing Clinical Assessment of Sociocultural Issues

Given the focus on individualized services, there is an even greater need to consider the influence of sociocultural factors on consumer outcomes (USDHHS, 2003). We offer four

recommendations to guide dissemination of sociocultural assessments into psychosocial rehabilitation usual care settings: (1) Consumers and mental health providers must view the assessment as relevant to the goals, needs, and priorities of the individualized evidence-based services they collaboratively design. (2) Items should be written for use with persons of all ethnic and cultural groups, including European Americans and persons identifying with reference groups such as 'homeless,' to eliminate the need for multiple versions of the tool. (3) As each cohort has specific population demands, the tool must be adapted along two dimensions: a) the background of those administering it, (physicians or paraprofessionals or consumer advocates); and b) the target population, (consumers with health concerns presenting to physicians or those with serious and persistent forms of mental illness). (4) Theoretically based provider training is needed to support effective elicitation and response to consumers' sociocultural content (Lopez, 2000). Following these tenets could maximize the relevance of the assessment and facilitate translation of culturally relevant evidence-based procedures into usual care settings.

7.2. Development of a Sociocultural Assessment Protocol for PRS

The guidelines above informed our work to develop an assessment approach suited to psychosocial rehabilitation settings. We wanted our approach to reflect the applicable components of the Cultural Formulation model. These aspects include: (1) a standardized approach to gathering information, (2) case studies to train providers in recognition of sociocultural issues, (3) orientation to all ethnic and cultural groups; (4) inclusion of factors evaluating the intersection of social and cultural influences (i.e., sociocultural issues) (Group for the Advancement of Psychiatry: Committee on Cultural Psychiatry, 2001), and (5) recognition of sociocultural differences in the provider-consumer relationship as a source of problems for diagnosis and treatment (Lewis-Fernández & Diaz, 2002).

We identified an assessment protocol developed by Carrillo et al. (1999) that embodied these five strengths of the Cultural Formulation model. The original protocol (see Table 1) was designed for use in medical settings to enhance physician awareness of sociocultural issues that influence the interaction between patients, physicians, and the health care system with repercussions for health care disparities (Betancourt et al., 2003; Carrillo et al., 1999). We have completed the initial steps to adapt the Carrillo et al. (1999) measure and refer to it as the Sociocultural Assessment Protocol (SCAP) for use in community-based PRS (see Table 3).

Adaptation of the SCAP for PRS was completed based on a literature review undertaken to examine the relevance of the original content and to identify additional sociocultural issues applicable to PRS. We then undertook field work to explore the multiple perspectives of key stakeholders within a large urban, multi-site PRS organization that has a long-standing history of academic-community partnerships and provides EBPs to address functional outcomes through intensive outpatient consumer adult day service programs where many consumers (70% with diagnoses of schizophrenia) participate in socialization and vocational groups and receive mental health services (Brekke, Ansel, Long, Slade, & Weinstein, 1999; Brekke & Long, 2000).

Pilot work included conducting five in-depth "seasoned" provider interviews, two focus group sessions with 6 program managers and 3 senior administrators, and review of the agency's standard intake assessment forms. This work enabled us to consider the extent to which sociocultural factors affect service delivery within the PRS agency, the willingness of providers to raise sociocultural issues, and most importantly, the feasibility of the proposed assessment tool. The findings from this work led us to conclude that: 1) there is a need for specialized training in sociocultural assessment regardless of the ethnicity of the provider, 2) providers view assessment of culturally diverse consumers as a challenge, 3) providers do not routinely inquire about consumers' sociocultural issues, and 4) providers express a need for training

applicable to different sociocultural groups in lieu of a cookbook of facts and statistics for each individual group

To further refine the SCAP content, we reviewed the transcripts of in-depth qualitative interviews with 20 consumers (five from each group: African Americans, Asian Americans, European Americans, and Latinos) attending the same PRS agency (Yamada, Dinh, Barrio, & Brekke, 2007). Our findings suggest a need for careful assessment of the consumers' various social stressors and specific types of supportive relationships. Consumers also expressed a variety of sociocultural issues pertaining to their PRS treatment needs and goals which included their finances and independent living, employment, and relationships with family and significant others. In addition to the expected findings regarding stigma, religiosity, and family support we identified a major theme reflecting a collectivistic style of self-identity and world view. The content discerned from these interviews informed our decision to expand the domains covered by the SCAP for use with consumers in PRS.

As shown in Table 2, we expanded the four original domains proposed for primary care patients (Carrillo et al., 1999) by creating new questions, expanding the Literacy domain to reflect the range of language and communication difficulties expressed in our pilot work, and proposing two new domains. The first proposed new domain "Collective Network" could be used by providers to assess the important role that family and social support systems play in the treatment outcomes of some persons with SPMI (Barrio & Yamada, 2005; Lin & Kleinman, 1988) and the importance of the cultural construct, collectivism/individualism (Hofstede, 2001) for treatment planning, goal setting, and treatment outcomes in mental health and rehabilitation settings (Bae & Brekke, 2002; Brekke & Barrio, 1997; Jezewski, 2001; Stone, 2004). The second domain, "Individualization of Treatment Expectations, Needs, and Goals," consists of questions that may assist providers to tailor treatment goals and outcomes to fit with the consumer's identified needs, values, and self-identities.

Five consumers with SPMI (2 African Americans and 3 European Americans) receiving services from the same agency were then administered the SCAP to assess the preliminary feasibility of using the tool. Use of the probes elicited information about sociocultural factors that were not obvious, but were important to the consumers' goals. The consumers did not appear to have any difficulty understanding or responding to the questions, although additional probes were occasionally needed to encourage a response. The consumers denied any negative feelings about the questions and did not feel that the questions were intrusive. They felt that use of questions from the SCAP would help their providers to be more aware of issues important to them. All of these consumers indicated that they would feel comfortable discussing the issues embedded in the SCAP.

Overall the SCAP domains and probes were very useful in eliciting information relevant to the consumers' treatment goals and unique sociocultural experiences. Based on this initial body of field work, we determined that this version of the SCAP was acceptable to consumers, administrators, and providers. Nonetheless, we continue to refine the SCAP, in terms of balancing its scope of content with the need for efficient administration by a range of providers.

7.3. Guidelines for Use of the SCAP for Clinical Assessment in PRS

Our development of the SCAP has been strengthened by inclusion of input from all relevant stakeholders in PRS (Ricciardi, 2005). Community-based participatory research techniques were used to maximize the relevance of the SCAP content and to improve the feasibility for future uptake of findings into PRS settings (Hohmann & Shear, 2002). We thus share the following guidelines in the spirit of disseminating promising approaches for integrating clinical assessment into evidence-based provision of psychosocial rehabilitation services.

7.3.1. Target Populations to be Administered the SCAP—The SCAP is designed primarily for use with consumers who are receiving services targeting daily functioning in terms of independent living, vocational training, socialization, or community integration. Application of the SCAP for use with other consumer populations would require minor revisions to adapt the content to best support the individualization of other health or mental health services; the core sociocultural issues (e.g., social support, stigma, self-identity) would be appropriate to use across populations and settings.

7.3.2. Applicability of the SCAP across Ethnocultural Groups—As sociocultural issues are relevant to all consumers, providers should not reserve the SCAP for use only with particular cultural subgroups or recent immigrants. The SCAP is designed for use across ethnic and cultural groups, including European Americans and persons identifying with self-selected reference group identities. Very little SCAP content is devoted specifically to recent immigrant populations, as other basic assessment resources are readily available to providers when they encounter such obvious cultural and linguistic differences (see American Psychiatric Association, 2000). Providers may select the most relevant probes to tailor their assessment; for instance, the content assessing linguistic fluency and immigration issues may be skipped when administered to monolingual English speakers born in the United States.

7.3.4. Intended Users of the SCAP—Any provider of PRS may find the SCAP useful, although it may be most beneficial as a structured tool for use by: service coordinators, paraprofessional staff with limited to no formal assessment training, staff relatively new to PRS, and consumer-advocates or peer navigators. Providers endorsing the recovery model of PRS are especially likely to find the SCAP helpful in exploring the sociocultural context likely to impact functional outcomes.

7.3.5. What the SCAP is Intended to Yield for Providers—The SCAP domains and probes are designed to elicit context and core psychosocial information relevant to consumers' treatment goals and unique sociocultural experiences. The SCAP is designed to provide a fairly rich and detailed portrait of the functioning and sociocultural context of a consumer when the provider has little prior knowledge of the psychosocial functioning; or the SCAP probes can be used to elicit information about social and cultural factors that may not be apparent to providers, but are important to shape the goals set by consumers. The process should be kept as natural as possible so that the assessment becomes seamlessly embedded into service delivery without seeming forced and disruptive to formation of a strong treatment alliance.

7.3.6. Targeted Time points for Use of the SCAP—The SCAP can be used in its entirety as a structured interview to conduct a thorough sociocultural history of consumers prior to development of a treatment plan. The ideal use of the SCAP is in conjunction with other routine psychosocial assessments that the agency uses. For example, at one site there is a required assessment that covers living situation, productive activity, interpersonal strengths, and aspects of role performance. The SCAP could then be used to provide additional context and to elaborate on any sociocultural issues that might moderate or affect these outcomes.

7.3.7. Time Required for Administration based on Purpose of Administration—When the SCAP is used in conjunction with other assessment tools, it takes about 20 minutes. Administration time can be reduced depending on the number of domains and items the provider identifies as relevant. It should also be noted that the probes are suggested and can be trimmed if the provider feels an adequate picture of the domain has emerged. When administered without any prior client contact or any other assessment tool, it can require the provider to generate additional probes to obtain sufficient understanding of a consumer's functioning, psychiatric history and prior treatment experiences, and this lengthens the time

required for the SCAP. Administration time will vary with: how familiar the provider is with the consumer's psychosocial functioning (more knowledge requires fewer probes); how satisfied the consumer is with life, current goals, and current services (higher satisfaction can reduce probes); and how specific or specialized the treatment goals will be (e.g., employment specialists may need to assess a narrower range of sociocultural issues).

7.3.8. Prior Training or Specialty Skills Required to Use the SCAP—One strength of the SCAP is that no culturally specific knowledge is necessary to administer it. Consumers' responses to the items directly inform the provider of relevant issues and provide the context needed to individualize service delivery. Training providers to effectively use the SCAP in routine practice is supported by theoretical and empirical data on behavior change and maintenance over time (Majumdar et al., 2005; Soumerai & Avorn, 1990; Thompson O'Brien et al., 1997). Exposure to respected opinion leaders who model effective use of the assessment protocol can be combined with unobtrusive training done using case studies and role plays to increase providers' assessment self-efficacy (Castaldo et al., 2005; Ozer et al., 2004). The authors are currently developing and testing training procedures to facilitate effective use of the SCAP.

8. Conclusions

Sociocultural issues, related to ethnic/racial heritage, or other salient identities, may play a large role in determining satisfaction and quality of life of consumers. It is thus crucial that providers are prepared to include sociocultural issues in their ongoing clinical assessment practice. The ultimate goal of embedding sociocultural issues in clinical assessment procedures is to enhance providers' assessment of consumer expectations, needs, and goals. Achieving this goal may be a crucial step in individualizing evidence-based practice for diverse consumer populations, and in reducing the disparities in the quality of community-based mental health services.

Based on our ongoing program of research and a conceptual framework that includes attention to organizational issues, we have introduced an adapted tool we believe will increase providers' assessment and handling of sociocultural issues in everyday clinical practice in PRS.

We continue to conduct NIMH funded field work to refine this assessment protocol and shorten the time required for administration. A test of the feasibility and acceptability of the SCAP by PRS providers will occur through a randomized pilot trial of a six-session training program, under development as a means to teach providers how to administer and integrate the SCAP into their routine practice. Issues relevant to the sustainability of the SCAP in routine practice are also being addressed.

One other anticipated future direction for developing the SCAP will be to link the content directly to functional outcomes that are the focus of PRS. To facilitate use of the SCAP to assess the context and provide a larger perspective, we plan to integrate items into categories that best address major treatment goals such as employment, independent living, and social functioning. Providers will essentially have assessment flashcards to facilitate use of suggested questions until they understand how sociocultural issues might impact service delivery and ultimately influence the consumer's likelihood of obtaining desired outcomes.

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Figure 1.
Conceptual Framework for Linking Clinical Assessment of Sociocultural Issues to Consumer Outcomes

Table 1
Sociocultural Domains and Probes Originally Developed for Training General Practice Residents: Adapted from the work of Carillo et al. (1999).¹

Social Stressors and Support Network	
-	What is causing the most stress in your life? How do you deal with this?
-	Do you have friends or relatives that help you? Do they live with you?
-	Are you very involved in a religious or social group?
-	Do you feel that God (or spirituality) provides a strong source of support?
Life Control	
-	Do you ever feel that you're not able to afford food, medications, etc.?
-	How do you keep track of appointments/medications?
-	Are you more concerned about how your mental health affects you right now, or how it might affect you in the future?
-	Do you feel that you have the ability to affect your own mental health (or particular condition) or is it out of your control?
-	Do you ever feel that you are treated unfairly by the mental health care system for any reason (e.g. SES, insurance status, race, language)?
Change of Environment	
-	Where are you from? When did you come to this (country/city)?
-	What made you decide to come to this (country, city, town)?
-	How have you found life here compared with in your (country/ city)?
Literacy	
-	Do you have trouble reading your (medication bottles, instructions)?
-	Do you have trouble with reading in general?

¹ Note. Table 1 content is abstracted and modified from Cross-cultural primary care: A patient-based approach by J.E. Carillo, A.R. Green, & J.R. Betancourt, 1999, *Annals of Internal Medicine*, 130, p. 831. Copyright 1999 by American College of Physicians. Reprinted with permission.

Table 2
Sociocultural Assessment Protocol: New domains & probes for psychosocial rehabilitation service delivery.

Social Stressors and Support Network	
-	Has the way others think about people with mental illness caused you any stress?
-	Are there any other ways that you make yourself feel better with you're feeling stressed?
-	Do you care about other people finding out you're receiving mental health services? Have you felt that they treated you differently?
-	Do you have friends or relatives that need your help?
-	Who are the most important people in your life?
-	Has your illness changed who is important to you?
-	How is your sex life? Are you currently involved in a romantic relationship? If you aren't in a relationship-any reason? Any barriers?
Life Control	
-	How is your fun/entertainment affected by money?
-	How do you decide what goals to focus on right now?
-	How much control do you have over your life?
-	How has your health/body been affected by your mental illness?
Change of Environment	
-	Do you have any contact with people from your hometown? How interested are you in staying involved with people from there? Do you visit? How often?
-	Where did you receive services before coming to (provide site)?
-	Have there been any other types of recent changes in your life?
Literacy/Language/Communication	
-	Do you feel comfortable asking for what you need?
-	Are you comfortable sharing your problems with others?
-	Do you have any difficulty discussing your needs related to your illness/condition with your friends or family?
-	If you have a different opinion from any of your providers, how comfortable are you expressing it?
-	Would you like to change your way of speaking or interacting with others?
-	Do you have any trouble talking to people because of your English ability?
-	Does it seem like other people have difficulty understanding you (due to your accent or English ability)?
-	Has your (English) ability affected your ability to get a job or housing or make friends?
Collective Network	
-	How would you define your cultural or ethnic group? Do you feel connected to that group? Is it important to you?
-	How do you define your personal identity?
-	Has anyone influenced how you see yourself or how you feel about yourself?
-	Certain groups of people are important in our lives (for example, mental health consumers, church groups, homeless people, drug/alcohol users, neighbors, AA groups/12-steps). Are any groups "VERY" important to you? Tell me about why this group is VERY important to you. (Repeat for each group.)
-	How important is it to you, to feel a part of [agency] community?
-	Is there anyone in your life who cares what you do or influences what you do and/or where you live?
-	When you think about working, do the opinions of other people influence you? Whose? What type of work do they want you to do?

- How has your mental illness (or symptoms) impacted the important people in your life?
 - How do the important people in your life feel about your receiving mental health services?
 - Do the people important to you have concerns about your health or how you are doing?
-

Individualization of Treatment, Expectations, Needs, Goals

- How do you feel about taking medication?
 - How does work fit into your life? What do you want from a job?
 - What is your ideal place to live? With whom would you want to live? How has it been living with others? How do you feel about the amount of privacy in your current residence?
 - What do you hope will happen if you keep coming for services? What goals might you achieve?
 - What goals have you achieved? What helps or hurts you to meet your goals?
 - What do you wish was different in your life?
 - Is there any other kind of services or treatments that you think would be really helpful for you at this stage?
 - Is there anything else that would be really helpful for you right now?
 - What's going well for you right now?
-

Table 3
The Sociocultural Assessment Protocol: Proposed domains and illustrative probes reflecting core sociocultural constructs.¹

Change of Environment	
-	Where are you from?
-	When did you come to this (country/city)?
-	What made you decide to come here?
-	Do you have any contact with people from your hometown? How interested are you in staying involved with people from there? Do you visit? How often?
-	How have you found life here compared with your former place of residence?
-	Where did you receive services before coming to (provide site)?
-	Have there been any other types of recent changes in your life?
Social Stressors and Support Network	
-	What is causing the most stress in your life? How do you deal with this?
-	Has the way others think about people with mental illness caused you any stress? How do you deal with it?
-	Are there any other ways that you make yourself feel better with you're feeling stressed?
-	Do you care about other people finding out you're receiving mental health services? Have you felt that they treated you differently?
-	Have you ever felt that you have been treated differently/unfairly by the mental health care system/program for any reason (e.g. SES, insurance status, race, language)? In what way?
-	Do you have friends or relatives that help you?
-	Do you have friends or relatives that need your help? Do they live with you?
-	Who are the most important people in your life?
-	Has your illness changed who is important to you?
-	Do you feel that God (or spirituality) provides a strong source of support? How does this support affect you?
-	Are you very involved in a religious or any other social groups?
-	How is your sex life? Are you currently involved in a romantic relationship? If you aren't in a relationship-any reason? Any barriers?
Life Control	
-	How do you keep track of appointments/medications?
-	How is your fun/entertainment affected by money?
-	How do you decide what goals to focus on right now?
-	How much control do you have over your mental health (or particular condition)?
-	How much control do you have over your life?
-	How has your health/body been affected by your mental illness?
Literacy/Language/Communication	
-	Do you feel comfortable asking for what you need?
-	Are you comfortable sharing your problems with others?
-	Do you have any difficulty discussing your needs related to your illness/condition with your friends or family?
-	If you have a different opinion from any of your providers, how comfortable are you expressing it?
-	Would you like to change your way of speaking or interacting with others?
-	Do you have any trouble talking to people because of your English ability?
-	Does it seem like other people have difficulty understanding you (due to your accent or English ability)?

- Has your (English) ability affected your ability to get a job or housing or make friends?

Collective Network

- How would you define your cultural or ethnic group? Do you feel connected to that group? Is it important to you?
 - How do you define your personal identity?
 - Has anyone influenced how you see yourself or how you feel about yourself?
 - Certain groups of people are important in our lives (for example, mental health consumers, church groups, homeless people, drug/alcohol users, neighbors, AA groups/12-steps). Are any groups "VERY" important to you? Tell me about why this group is VERY important to you. (Repeat for each group.)
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 - How do the important people in your life feel about your receiving mental health services?
 - Do the people important to you have concerns about your health or how you are doing?
-

Individualization of Treatment, Expectations, Needs, Goals

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 - What do you hope will happen if you keep coming for services? What goals might you achieve?
 - What goals have you achieved? What helps or hurts you to meet your goals?
 - What do you wish was different in your life?
 - Is there any other kind of services or treatments that you think would be really helpful for you at this stage?
 - Is there anything else that would be really helpful for you right now?
 - What's going well for you right now?
-

Note. Table 1 also contains items modified from Cross-cultural primary care: A patient-based approach by J.E. Carillo, A.R. Green, & J.R. Betancourt, 1999, *Annals of Internal Medicine*, 130, p. 831. Copyright 1999 by American College of Physicians. Reprinted with permission.