



Cultural Competency: Measurement as a Strategy for Moving Knowledge into Practice in State Mental Health Systems

FINAL REPORT
September 2004

National Technical Assistance Center
for State Mental Health Planning (NTAC),
National Association of State Mental Health Program Directors (NASMHPD)



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Introduction

The implementation of cultural competence is often given a low priority, not necessarily from any lack of good intentions, but often because of other crises or priorities that are given more attention. The following recommendations are premised on the notion that the implementation of cultural competence is not a compartmentalized, adjunct activity but that it is a critical management and quality-of-care concern that must permeate the entire system. Based on discussion at two Experts meetings, *Cultural Competency: Strategies for Moving Knowledge into Practice in State Mental Health Systems* (June, 2002) and *Cultural Competence Measures for State Mental Health Agencies* (February, 2003), this report outlines the rationale for implementing cultural competence, the approaches to implementation, including the measurement of cultural competence as a strategy, and steps that a state mental health commissioner/director can take to move the cultural competence agenda from research into practice. These steps were used to develop a State Mental Health Agency Cultural Competence Activities Assessment that was tested on state mental health commissioners/directors. Based on their input, revisions were made to this instrument. This report includes this cultural competence measure for refinement and testing in state mental health systems.

Rationale for Cultural Competence

1. Cultural Competence = Quality of Care

The Surgeon General's Report on Mental Health (1999) points out that all Americans do not share equally in the hope for recovery for mental illness:

Even more than other areas of health and medicine, the mental health field is plagued by disparities in the availability of, and access to, its services. These disparities are viewed readily through the lenses of racial and cultural diversity, age and gender (p. vi).

A supplement to the Report, *Mental Health: Culture, Race and Ethnicity*, documents the existence of several disparities between racial and ethnic minorities, and whites:

- Minorities have less availability of, and access to, mental health services.
- Minorities are less likely to receive needed mental health services.
- Minorities in treatment often receive a lower quality of mental health care.
- Minorities are underrepresented in mental health research.

A major recommendation of this report is that each state mental health system should assess conditions related to cultural competence to examine whether the aforementioned negative consequences of the lack of cultural competence exist in the system. This step is recommended as a starting point before any implementation plan is set in motion.

2. Cultural Competence = Disparity Reduction

Sometimes the complexity of cultural competence—currently embedded in societal values, policies, plans, clinician training, diverse expectations—is so overwhelming that the enormity of the change involved becomes a reason why initiatives related to cultural competence stall before they get started. Rather than be weighed down by the complexity, states could focus on activities that reduce existing disparities. An approach to cultural competence as disparity reduction may not only be more specific and manageable but also may have immediate payoffs in terms of quality improvement.

3. Cultural Competence = Risk Management

In some states, disparities and the lack of cultural competence have resulted in lawsuits and legal action. To address cultural competence is to preempt the possibility of such actions.

4. Cultural Competence = Parity (within the mental health system)

Parity is consistent with the value base of the mental health system. Just as strong arguments have been made for mental health having parity with physical health, the same arguments apply to ensuring that access and outcomes for people needing the mental health system are equitable and have parity.

5. Cultural Competence = Linguistic Competence

One necessary aspect of cultural competence is linguistic competence and access. Persons with limited English proficiency (LEP) (including those who are deaf or hard of hearing and prefer to use sign language) need to have access to bi-lingual staff or qualified interpreters and translators. A qualified mental health interpreter is sufficiently fluent in both target and source languages so that they are able to accurately interpret to and from either language using any specialized vocabulary needed. The language needs and preferences of persons should be monitored and included in data sets.

6. Cultural Competence = A Fundamental Social Responsibility

Besides the “business” case for cultural competence, its implementation reflects the fundamental value base of the public mental health system, which is committed to

being responsive to individual needs and preferences. As the current population of minorities grows, cultural diversity will be mainstreamed. Mental health systems, like other health and social service systems, will need to incorporate cultural competence to be responsive to a segment of the population that is growing and which, in some geographic areas, will collectively be the “majority” population.

Models for Implementing Cultural Competence

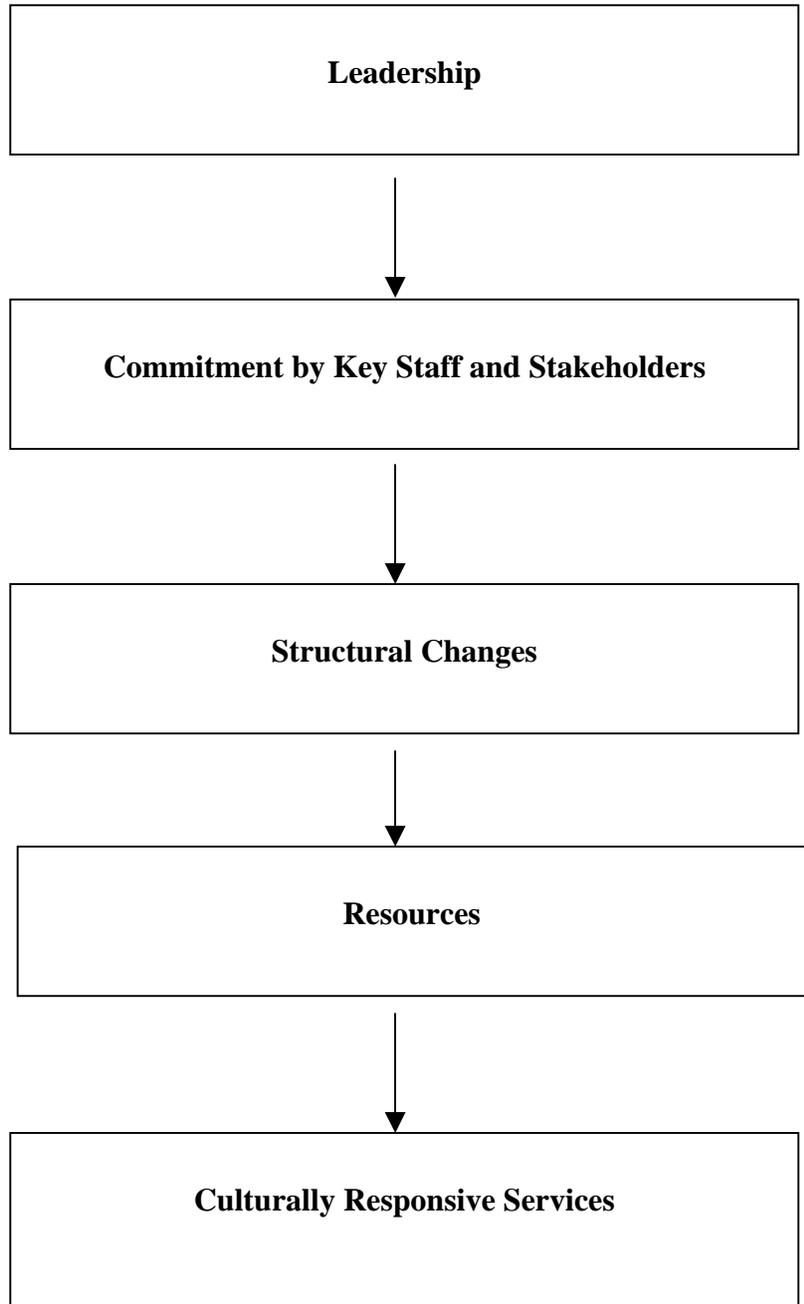
Implementing cultural competence is a complex, “non-linear,” multi-level process involving not only interactions at different levels within the system but also interactions with the community and other social service agencies as well. Within the mental health system, important areas related to cultural competence are: policies/plans, human resources development, and services. The different levels within the system that need to be addressed include the “authority”–or policymaking–level (state or local), the level of the organizational entity providing services, and the level of the individual clinician or provider. Each of these levels will need to be affected to bring about coherent, systemic and sustained change related to cultural competence. That is, cultural competence is a goal for professionals, agencies and systems.

For example, the California model establishes standards and plan requirements for Mental Health Plans in achieving cultural and linguistic competency. These standards include:

- Population Assessment
- Organizational and Provider Assessment
- Access Standards
 - Language Accessibility
 - Written Materials
 - Responsiveness of Special Mental Health Services
- Quality of Care Standards
 - Consumer and Family Role
 - Evaluation, Diagnosis, Referral
 - Competence in Client Culture
- Quality Management
 - Penetration/Retention
 - Service Capacity
 - Continuous Quality Improvement Plan

To develop such standards, there should be broad acceptance of cultural competence as both a goal and a developmental process by the key stakeholders who are involved. A simplified model of action was developed at the NTAC-sponsored Experts meeting to provide a possible framework for actions by Commissioners. A chart representing the model is presented in Figure 1.

Figure 1. Model for Action on Cultural Competence



The figure represents a model for action and is not a model of how system-wide cultural competence occurs. The premise is that the Commissioner must lead the process and garner the commitment of key staff and stakeholders. Organizational and structural changes are needed to underline this commitment. Depending on the priorities identified (e.g., language access), resources will need to be allocated. Then, specific services may need to be developed so that they are responsive to specific cultural or ethnic groups.

Measurement as a Change Strategy

An important aspect of the change strategy is measurement and data analysis. Measurement is important because it is an objective mechanism for documenting current realities and does not depend on anecdote, subjectivity or politics. Another critical aspect is that measurement allows for monitoring changes over time so that the impact of interventions can be monitored. In fact, measurement in and of itself can stimulate change by providing a road map for policy makers.

A key to promoting cultural competence and monitoring change associated with implementation of initiatives is the capacity to collect and analyze data that provides ongoing information regarding equitable treatment to diverse populations within a state.

The routine analysis of such data can provide critical information on disparities in treatment and general access to mental health services. Another critical component is the development of key performance indicators. Data produced through these indicators help provide focus as well as explicit information regarding expected outcomes. This information then provides input for quality improvement activities.

Embedding cultural competence in a quality-improvement framework helps to ensure that such an initiative is lasting and ongoing, as opposed to an isolated or time-limited activity that is geared to one part of the state mental health system. In this way, cultural competence becomes embedded in the service delivery system—a reflection of the values and beliefs on which the public mental health system was created.

Recommendations for Action

The following recommendations were developed at NTAC's June 2002 Experts Meeting on Cultural Competency and are based on the model previously outlined. These recommendations are intentionally broad-based and are designed to guide SMHA Directors and Commissioners in the development of culturally competent systems of care. They may also guide the development of a menu of baseline performance indicators for states to use toward measuring system readiness and progress.

1. Commissioners should personally lead the cultural competence initiative.

Commissioners should provide a signal to the entire system that cultural competence is a high priority for them. This message should be reiterated and emphasized in various public ways so that it is clear to staff, stakeholders, and the community that cultural competence will receive proper emphasis.

2. Commissioners should develop mechanisms to ensure commitment by key staff and stakeholders, especially in all future programming.

It will be important for Commissioners as part of the leadership function to ensure and expect key staff to transmit this priority and establish exemplary processes and actions that others can emulate.

3. Establish an Office of Cultural Competence.

The workgroup was clear that having additional resources and a dedicated individual who has the support of the Commissioner (i.e., a position on the management team) are key to the promotion of cultural competence. A primary responsibility of this person would be to develop consensus on priorities for action and accountability mechanisms to address cultural competence issues.

4. Form a state-level Cultural Competence Advisory Committee.

This should have broad community representation including consumers, family members, providers and policy makers. An effort should be made to include skeptics as well as stakeholders to ensure well-rounded feedback.

5. Each state should perform an organizational self-assessment.

The self-assessment should include a full review of all existing cultural competence initiatives, as well as population *and* provider assessments. Identifying potential disparities through data analysis and monitoring reports can inform the process.

6. To identify disparities, Commissioners should require analyses related to utilization, performance measures, and outcomes by developing a cultural profile of the populations to be served and of the populations actually served.

Analyses should be done for different sub-populations (children and adolescents, elderly, persons with serious mental illness, homeless, etc.). Analyses should be done specifically on linguistic access and on first interactions with the system (for example, examine persons with only one contact with the system by race/ethnicity).

7. Develop a system-wide Cultural Competence Plan.

This plan should address actions at all levels and incorporate cultural competence as a critical component in key management activities including planning, quality management, contracts and staff training.

8. A key aspect of cultural competence is linguistic competence among agency staff, and when necessary, access to qualified mental health interpreters.

When interpreters are in use, providers who only speak English need to be

trained in the effective use of interpreters. Of course, the ideal scenario includes providers who are trained in a variety of languages. Commissioners should also ensure that data related to language proficiency and preferences are developed and available. These data should be used to adapt forms, notices, and educational materials into versions accessible to cultural groups and to determine the statewide need for organized interpreter services.

9. Explore the possibility of implementing standards and developing contractual requirements related to cultural competence and the development of local cultural competence plans.
10. Using the proposed Cultural Competence Plan, identify resources needed for priority activities, including activities related to training, interpreter services and specialized programs. One resource that commissioners may have some control over is the use of Block Grant funds. A certain percentage of Block Grant funds could be allocated for the promotion of cultural competence.
11. Incorporate cultural competence in a quality improvement and accountability framework so that it is an integral component of management and services.
12. NASMHPD should develop an exemplary cultural competence plan while becoming more innovative in this area in a sustained, ongoing manner. NASMHPD should also promote cultural competence through all its divisions and activities.

A Cultural Competence Measure for State Mental Health Agencies

The focus of the February 2003 meeting was on the development of an *action-oriented* measure of cultural competence for state mental health agencies. The focus on action is important: The emphasis is not so much on assessing or rating the cultural competence of a system or the cultural responsiveness or appropriateness of services at the individual or family level but more on progress and actions at the state mental health agency level to move forward with a cultural competence agenda. The emphasis of this initiative is more on answering questions such as: *Is progress being made to advance cultural competence?* and *what needs to happen at the state mental health agency level to promote and sustain cultural competence?* Other questions such as: Are services culturally appropriate and responsive? And how does the system rate on cultural competence? are also important and complement the proposed approach. The emphasis here, however, is on measuring the inculcation of cultural competence and not cultural competence itself.

Using the model and the recommendations for action reviewed in earlier sections of this report as a framework, participants at the meeting reviewed key cultural competence measurement initiatives and proposed, refined, and elaborated the broad-based action categories. This section provides the specificity developed by participants related to each of the major recommendations.

1. Commissioners should personally lead the cultural competence initiative.

- The Commissioner has a personal commitment to cultural competence and has included cultural competence as part of his or her vision for the agency.
- The Commissioner continually identifies cultural competence as a high priority in speeches and other public communications.
- The Commissioner supports key strategies for promoting cultural competence and has assigned staff and resources for their implementation.
- The Commissioner periodically receives reports and checks on implementation of these cultural competence strategies and the accomplishment of intended objectives.

2. Commissioners should develop mechanisms to ensure commitment by key staff and stakeholders, especially in all future programming.

- The Commissioner has developed expectations and objectives for senior management staff to “own” and promote cultural competence.
- The Commissioner includes cultural competence objectives in the performance appraisal of senior management staff.
- The Commissioner advocates for cultural competence in the broader mental health community and in stakeholder organizations.
- The Commissioner is committed to diversity in senior management.

3. Establish an Office of Cultural Competence.

- A person or position exists with overall responsibility for cultural competence.
- The cultural competence position is at the “cabinet” or senior executive level.

- The person responsible for cultural competence has direct access to the Commissioner.
- The Office of Cultural Competence has responsibility for review of major policies and agency products to ensure that cultural competence is included and/or addressed.
- The Office of Cultural Competence has its own budget.

4. Form a state-level Cultural Competence Advisory Committee.

- A cultural competence advisory committee exists.
- The advisory committee includes representatives of all the major race/ethnicity groups in the state.
- The advisory committee includes a person who is deaf or hard of hearing.
- The advisory committee includes consumers and family members of minority groups.
- The Commissioner meets periodically with the advisory committee.
- The committee is responsible for reviewing policies and making recommendations related to cultural competence.
- The committee receives reports related to the implementation status of its recommendations.

5. Each state mental health agency should perform an organizational self-assessment.

- The agency has conducted an organizational self-assessment related to cultural competence.
- The self-assessment was conducted at multiple levels including Central Office, state hospitals, and community mental health centers.
- The organizational self-assessment includes an analysis of state population and demographics.
- The self-assessment includes an analysis of the race/ethnicity/gender of providers and their languages capacities.

- The self-assessment includes a description of how the system promotes cultural competence formally (e.g. hiring practices) and informally (e.g. multicultural events).
 - The self-assessment occurs periodically (at least once every two years).
- 6. To identify disparities, Commissioners should require analyses related to utilization, performance measures, and outcomes by developing a cultural profile of the populations to be served and of the populations actually served.**
- Data elements exist in state mental health agency information systems that reflect the composition of the populations to be served. These include: race; ethnicity; age; gender; poverty level; and languages spoken.
 - Agency monthly, quarterly, and annually reports related to utilization, performance measures, and outcomes routinely include race/ethnicity breakouts.
 - Analyses are regularly conducted to examine disparities in services (medications, rehabilitation, clinical, in-home, etc.)
- 7. Develop a system-wide Cultural Competence Plan**
- A current cultural competence plan exists.
 - The plan should cover all administrative organizational components in its purview. (That is, cultural competence should be a requirement and responsibility at all administrative and organizational levels.)
 - The cultural competence plan specifically addresses disparities identified through analyses.
 - The cultural competence plan has measurable objectives; is reviewed annually; feedback is provided to responsible entities related to the accomplishment of objectives.
 - The cultural competence plan is disseminated widely throughout the system.
 - The cultural competence plan includes the development of culture-specific services.

- 8. A key aspect of cultural competence is linguistic competence among agency staff, and when necessary, access is available to qualified mental health interpreters.**
- Data is available related to the language needs of the population to be served and persons receiving services.
 - Language skills of staff are monitored and updated.
 - Standards exist for qualified mental health interpreters.
 - Provider and service directories are available in key languages.
 - Provider and service directories include information on language assistance available at its organizational components.
- 9. Explore the possibility of implementing standards and developing contractual requirements related to cultural competence and the development of local cultural competence plans.**
- Standards of care specifically address cultural competence.
 - Contracts with local authorities and service agencies include cultural competence requirements.
 - Reporting requirements include break-outs by race/ethnicity.
 - Reporting requirements specifically include activities related to promoting and sustaining cultural competence.
 - Cultural competence is included in quality assurance and quality improvement activities and projects.
- 10. Using the proposed Cultural Competence Plan, identify resources needed for priority activities, including activities related to training, interpreter services and specialized programs. One resource that commissioners may have some control over is the use of Block Grant funds. A certain percentage of Block Grant funds could be allocated for the promotion of cultural competence.**
- Resources are designated specifically for cultural competence training.
 - Resources are designated (or are available) for language and qualified interpreter services.
 - Resources are designated for culture-specific programs and services.

- Resources are allocated statewide for cultural competence training and related services.

In summary, these key activities identified by participants provide specificity to the recommended actions previously proposed. These activities constitute a roadmap for the implementation of cultural competence and are also the basis for a measure related to cultural competence implementation. The inherent assumption is that the more these activities are implemented the more the system moves forward with a cultural competence agenda. These key activities are the basis of the instrument for measuring cultural competence activities in state mental health agencies provided at the end of this report.

Refinement/Testing of Instrument

An initial version of a State Mental Health Agency Cultural Competence Activities Assessment was tested with twenty state mental health commissioners/directors. The commissioners/directors rated their agencies' performance related to the specific activities and provided feedback and recommendations for revisions. Based on these suggestions, the experts involved in the meetings reconvened through conference calls and developed a revised version of the instrument. The final version of the instrument is presented in Appendix A.

The next steps involve the testing and validation of the activities and the instrument. State mental health agencies interested in participating in such an initiative will be identified. The objective will be to pilot, validate and refine the instrument. (With some modifications, this assessment could also be used by other organizations as well. Such organizations could also be involved in this testing initiative.)

Appendix A

STATE MENTAL HEALTH AGENCY CULTURAL COMPETENCE ACTIVITIES ASSESSMENT

**STATE MENTAL HEALTH AGENCY CULTURAL
COMPETENCE ACTIVITIES ASSESSMENT**

STATE: _____

Please enter the appropriate number to indicate the status of the cultural competency activity in your agency.

STATUS CODES
(1 = Not Implementing; 2 = Planning to Implement This Year; 3 = Yes/Currently Implementing)

	<u>Current Status</u>
<p>I. Commissioner’s Personal Leadership</p> <ul style="list-style-type: none"> • The Commissioner consistently identifies cultural competence as a high priority in speeches and other public communications. • The Commissioner has assigned staff and resources for promoting cultural competence. • The Commissioner periodically receives reports to check on implementation of these cultural competence strategies and the accomplishment of intended objectives. 	<p align="center">_____ _____ _____</p>
<p>II. Staff and Stakeholder Commitment</p> <ul style="list-style-type: none"> • The job descriptions of senior management staff include the promotion of cultural competence. • The Commissioner includes cultural competence objectives in the performance appraisal of senior management staff. • The commissioner advocates for cultural competence in the broader mental health community and stakeholder organizations. • Senior management reflects the race/ethnicity demographics of the state. 	<p align="center">_____ _____ _____ _____</p>
<p>III. Responsibility for Cultural Competence</p> <ul style="list-style-type: none"> • A person exists with overall responsibility for cultural competence. (If less than 1 FTE then what percent of FTE: ____) • The cultural competence position is at the “cabinet” or senior executive level. • The person responsible for cultural competence has direct access to the Commissioner. • The person has responsibility for review of major policies and agency products to ensure that cultural competence is included and/or addressed. 	<p align="center">_____ _____ _____ _____</p>

STATUS CODES

(1 = Not Implementing; 2 = Planning to Implement This Year; 3 = Yes/Currently Implementing)

<ul style="list-style-type: none"> The person has control of a budget for cultural competence activities. 	<hr/>
<p>IV. Cultural Competence Advisory Committee</p>	<p><u>Current Status</u></p>
<ul style="list-style-type: none"> A cultural competence advisory committee exists. 	<hr/>
<ul style="list-style-type: none"> The advisory committee includes representative of the major race/ethnicity groups in the state (groups that are 5% or greater of the state population). 	<hr/>
<ul style="list-style-type: none"> The advisory committee includes a person who is deaf or hard of hearing. 	<hr/>
<ul style="list-style-type: none"> The advisory committee includes consumers and family members of the different race/ethnicity groups. 	<hr/>
<ul style="list-style-type: none"> The Commissioner meets periodically with the advisory committee. 	<hr/>
<ul style="list-style-type: none"> The committee is responsible for reviewing policies and making recommendation related to cultural competence. 	<hr/>
<ul style="list-style-type: none"> The committee receives reports related to the implementation status of its recommendations. 	<hr/>
<p>V. Organizational Self-Assessment</p>	
<ul style="list-style-type: none"> The agency has a current (within last two years) organizational self-assessment related to cultural competence. 	<hr/>
<ul style="list-style-type: none"> The self-assessment was conducted at multiple levels including Central Office, state hospitals, and community mental health centers. 	<hr/>
<ul style="list-style-type: none"> The organizational self-assessment includes an analysis of state population and demographics, including poverty level. 	<hr/>
<ul style="list-style-type: none"> The self-assessment includes a workforce analysis of the <ul style="list-style-type: none"> i. race/ethnicity/gender of direct and contracted providers ii. and their languages capacities. 	<hr/>
<ul style="list-style-type: none"> The self-assessment includes a description of how the system promotes cultural competence formally (e.g. hiring practices) and informally (e.g. multicultural events). 	<hr/>
<ul style="list-style-type: none"> The self-assessment occurs periodically (at least once every two years). 	<hr/>
<p>VI. Data Analyses</p>	
<ul style="list-style-type: none"> Data elements exist in state mental health agency information systems that reflect the race/ethnicity composition of the populations to be served. These include: 	
<ul style="list-style-type: none"> i. Race 	<hr/>
<ul style="list-style-type: none"> ii. Ethnicity 	<hr/>
<ul style="list-style-type: none"> iii. Age 	<hr/>
<ul style="list-style-type: none"> iv. Gender 	<hr/>

STATUS CODES

(1 = Not Implementing; 2 = Planning to Implement This Year; 3 = Yes/Currently Implementing)

<ul style="list-style-type: none"> v. Poverty level vi. Languages spoken vii. Country of origin viii. Religion 	<p align="center">_____ _____ _____ _____</p>
	<p align="center"><u>Current Status</u></p>
<ul style="list-style-type: none"> • Agency monthly, quarterly, and annually reports related to utilization, performance measures, and outcomes routinely include race/ethnicity breakouts. • Analyses are regularly conducted to examine disparities in services (medications, rehabilitation, clinical, in-home, etc.) • Results are disseminated to participating organizations. 	<p align="center">_____ _____ _____</p>
<p>VII. Cultural Competence Plan</p>	
<ul style="list-style-type: none"> • A current cultural competence plan exists. • The plan covers all administrative organizational components in its purview. (That is, cultural competence should be a requirement and responsibility at all administrative and organizational levels.) • The cultural competence plan specifically addresses disparities identified through analyses. • The cultural competence plan has measurable objectives. • The cultural competence plan is disseminated widely throughout the system. • The cultural competency plan is reviewed annually. • The cultural competence plan includes the development of culture-specific services. 	<p align="center">_____ _____ _____ _____ _____ _____ _____</p>
<p>VIII. Linguistic Competence</p>	
<ul style="list-style-type: none"> • Data is available related to the language needs of the population to be served and persons receiving services. • Language skills of staff are monitored and updated. • Standards exist for qualified mental health interpreters. • Provider and service are available in key languages. • Provider and service directories include information on language assistance available at its organizational components. • The state mental health agency (SMHA) provides or helps organizations to obtain educational materials translated into the identified languages. • The SMHA provides or helps obtain key administrative and procedural documents in key languages. 	<p align="center">_____ _____ _____ _____ _____ _____ _____</p>

STATUS CODES

(1 = Not Implementing; 2 = Planning to Implement This Year; 3 = Yes/Currently Implementing)

<ul style="list-style-type: none"> • The SMHA maintains or helps develop directories of qualified interpreters. • The SMHA provides or assists organizations in obtaining training materials for clinical staff in the use of interpreters. 	<p align="center">_____</p> <p align="center"><u>Current Status</u></p> <p align="center">_____</p>
<p>IX. Standards and Contractual Requirements</p> <ul style="list-style-type: none"> • Standards of care exist that specifically address cultural competence (e.g. CLAS standards). • Contracts with local authorities and service agencies include cultural competence requirements. • Reporting requirements include break-outs by race/ethnicity. • Reporting requirements specifically include activities related to promoting and sustaining cultural competence. • Cultural competence is included in quality assurance and quality improvement activities and projects. 	<p align="center">_____</p> <p align="center">_____</p> <p align="center">_____</p> <p align="center">_____</p> <p align="center">_____</p>
<p>X. Resources</p> <ul style="list-style-type: none"> • Resources are designated specifically for cultural competence training. • Resources are designated (or are available) for language and qualified interpreter services. • Resources are designated for culture-specific programs and services. • Resources are allocated <u>statewide</u> for cultural competence training and related services. • Resources are allocated specifically to reduce disparities. 	<p align="center">_____</p> <p align="center">_____</p> <p align="center">_____</p> <p align="center">_____</p> <p align="center">_____</p>

Appendix B

**Cultural Competency:
Strategies for Moving Knowledge into Practice
in State Mental Health Systems
June 17-18, 2002
Alexandria, VA**

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**Cultural Competency:
Strategies for Moving Knowledge into Practice in State Mental Health Systems
June 17-18, 2002
Alexandria, VA**

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Appendix C

**Cultural Competence Measures for State
Mental Health Agencies
February 14, 2003
Alexandria, VA**

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National Technical Assistance Center for State Mental Health Planning

Cultural Competence Measures for State Mental Health Agencies

February 14, 2003

Alexandria, VA

Sponsored by:

Center for Mental Health Services,
Substance Abuse and Mental Health Services Administration
National Association of State Mental Health Program Directors

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