Cultural Competence and Quality of Care: Issues for Mental Health Service Delivery in Managed Care

Jennifer S. Abe-Kim, Loyola Marymount University
David T. Takeuchi, University of California, Los Angeles

Models of mental health service delivery in managed care have evolved without considering the needs of ethnic minorities in any systematic manner. Consequently, these new systems may pose additional barriers to access and treatment. In this article, the impact of the health care crisis on mental health service delivery to ethnic minorities in terms of access, cost, and quality of care issues in managed care systems is explored. A quality-of-care framework is used for addressing the notion of *cultural competence as a critical dimension of quality of care* for ethnic minority populations. Research in minority mental health and quality of care is integrated in order to explore how various structures, processes, and outcomes in managed care systems (e.g., cost containment structures for controlling the supply and demand of mental health services, utilization management and gatekeeping processes) may impact mental health service delivery to ethnic minorities. Cultural competence is conceptualized as a critical component of quality care for ethnic minority populations.

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Initiatives to reform the manner in which health and mental health services are delivered have captured a large portion of this country's public policy agenda. The impetus for health care reform measures is driven by critical deficiencies in our present system and has become a national "health care crisis" (Frank, 1993). Health care in the United States is 40% more expensive than in any other developed nation (Schieber & Poullier, 1991), consuming an increasingly greater share of the national economy. Because of rising costs, health care has become largely unaffordable for a substantial portion of the American population. The current health insurance system does not provide many Americans with adequate relief from the high cost of health care. It has been estimated that approximately 37 million Americans possess neither public nor private health insurance coverage (Mechanic & Aiken, 1989). This lack of insurance is not due to welfare or disability; about 85% of the uninsured are low- income working families. Despite the tremendous economic investment in the health care system, Americans rank lower on a number of health indicators relative to other developed countries that are spending far less per capita on health care (Kiesler, 1992; VandenBos, 1993).

At the state and federal levels, some consensus seems to have emerged that universal access to health care must be included in any attempt to reform the health care system (Frank, Sullivan, & DeLeon, 1994; VandenBos, 1993). Beyond universal coverage, however, very little agreement is evident in how much health care, and in what form, is appropriate for a national health plan (VandenBos, 1993). Managed care, however, appears to be an "inescapable element" of health care delivery today (Appelbaum, 1993). As a generic term, *managed care* simply refers to a variety of practices designed to reduce health care costs through eliminating unnecessary treatments and procedures. In these managed care models, holding service providers accountable for the treatment approaches undertaken, as well as the types of treatment rendered, is a major strategy for cost containment. Dem-

Address correspondence to Jennifer Abe-Kim, Department of Psychology, Loyola Marymount University, 7900 Loyola Blvd., Los Angeles, CA 90045–8045.

onstration of "medical necessity" has become the key criterion for determining access not only to health care, but also to mental health services (Glazer, 1992), despite what Glazer (1992) notes as the lack of clear biological bases undergirding the concept of medical necessity in mental health. Accordingly, the subsequent capacity to fully consider the manner in which system, cultural, and psychosocial factors affect mental health is severely constrained (McKinlay, 1996; Neighbors, Jackson, Campbell, & Williams, 1989; Vega & Murphy, 1990).

The increasing pervasiveness of managed care systems represents a fundamental shift in the structure of mental health service delivery. Yet the impact of these changes on how mental health services are delivered to ethnic minority populations is largely unknown. To address these issues, we propose creating linkages between research on minority mental health issues with issues in access, cost, and quality of care in mental health service delivery. A critical aspect of these proposed linkages is the conceptualization of cultural competence as a critical aspect of "quality" care to ethnic minority populations. In this article, we examine these linkages in the managed care contexts that have evolved in response to the spiraling cost of health and mental health care. Accordingly, we aspire to provide a framework for the provision of culturally competent services to ethnic minorities within these managed care settings.

EVOLUTION OF MANAGED CARE SYSTEMS

Before 1920, health care was largely a personal financial responsibility (VandenBos, Cummings, & DeLeon, 1992). Between 1945 and 1960, health insurance became increasingly available, to the point where about 70% of the population had some type of health coverage through private insurance companies (VandenBos, 1993). During the 1960s, the federal government became the single largest payer of health costs through the institutions of Medicaid and Medicare, leading to a dramatic increase in public funding and delivery of mental health services (Simon, 1989). With the deinstitutionalization movement, however, the care provided in public institutions decreased, with a corresponding increase in the care provided by community-based programs (Bickman & Dokecki, 1989).

At the same time, the private sector began to emerge as a formidable entity. For instance, while deinstitutionalization reduced the use of state hospital beds by 75%, the number of for-profit, private psychiatric hospital beds more than tripled (Simon, 1989). This process of privatization involves the private sector delivery, production, or management of services traditionally provided by the public sector (Simon, 1989). Indeed, the major providers of long-term care to chronically mentally ill patients are no longer located in the public sector, but in two private sector industries (Shadish, 1989), nursing homes (Cicchinelli et al., 1981) and board-and-care homes (Segal & Aviram, 1978). Generally, as privatization of mental health service delivery has evolved, there has been a dramatic increase in the development of large private corporations that own or manage mental health and substance abuse service delivery (Perkey, 1989). As Perkey (1989) observed, mental health has become "big business." The for-profit motivation of these corporations has shifted the landscape of health and mental health service delivery, in the attempt to curtail the rising costs of health services and to maximize their own profits. As a result, the managed care model has emerged as the chief alternative to the fee-for-service (FFS) model of health care (Newman & Bricklin, 1991), stimulated, in part, by federal legislation aimed at encouraging the growth of managed care organizations around the country [e.g., Health Maintenance Organization Act of 1973 (1987)].

The federal government plays a major role in the financing of mental health services. By 1990, public financing of mental health services accounted for approximately 59% of all expenditures for mental health services (Rice, Kelman, & Miller et al., 1990). In addition, state and local governments bear a far greater share of the cost for mental health care, compared with the cost of general health care (Tischler, 1990). This imbalanced burden makes state and local mental health services highly vulnerable to cost-containment initiatives by other parts of the public sector (e.g., federal government), as well as the private sector (Tischler, 1990). As public support and financing have eroded, the public sector has increasingly turned to managed care approaches to contain the rising costs of mental health service delivery. In fact, the adoption of these managed care approaches has resulted in a blurring of the distinction between public and private sectors. At present, a complex, unwieldy financing system has evolved that includes both public and private payors and public and private providers of mental health care. Their overlapping and conflicting roles only serve to underscore the importance of balancing access, cost, and quality-of-care concerns in the provision of mental health services (Frank & McGuire, 1996).

Although the overriding goals of public policy emphasize access to cost-effective quality care (Kiesler & Morton, 1988), the actual implementation of these goals presents a different picture. The health care crisis helps to underscore the complex nature of the relationship between health care policy and mental health service delivery. Kiesler (1992) points out how the structure of mental health service delivery has followed health care policy. For instance, methods of reimbursement reflect a technological bias where procedural services are favored over cognitive services, and inpatient services are favored over outpatient services (Glick, Showstack, Cohen, & Klar, 1989). Indeed, inpatient treatment now accounts for over 70% of the mental health dollar in the United States (Kiesler, 1992). This may be partly due to the fact that it is easier for health insurers to pay a single charge for hospitalization than to pay various charges for a variety of outpatient medical, social service, and housing agencies (Glick et al., 1989). Ironically, the mental health services that are most easily reimbursed, such as inpatient services, are those that demonstrate the least effectiveness and are the most expensive (Kiesler, 1992). Reimbursement for other types of psychological interventions, such as preventive care, screening and assessment, rehabilitation and rehabilitative psychotherapy, and long-term chronic care, in contrast, are limited or nonexistent (Appelbaum, 1993). This imbalance results in a highly inefficient allocation of health care resources, with most of the resources going toward expensive procedures with little value (Frank, 1993), rather than toward preventive care and care for chronic conditions, which are most needed by the "least wealthy 40% of the population" (Kiesler, 1992, p. 1077).

Current efforts to reform the health care system have served to underscore the continuing extraordinary lack of parity between health and mental health benefits (Mechanic, 1993). Federal legislation [e.g., Health Maintenance Organization Act of 1973 (1987)] requires only limited coverage of mental health services for health maintenance organizations (HMOs; e.g., short-term outpatient evaluative services and crisis intervention mental health services for up to 20 visits per year) compared with mandated coverage of non-mental health care services (Newman & Bricklin, 1991). Most federally qualified HMOs offer 30 inpatient days for mental health treatment as part of their benefits as well, although they are not required to do so (Newman & Bricklin, 1991). Mental health benefits have also been a target of aggressive cost-control strategies by insurance and managed care companies in that they are often "carved out" from physical health care benefits. Contracts are negotiated to allow a separate mental health managed care firm to provide or administer the mental health benefit (Reidy, 1993). Often these tactics may result in further degradation of benefits (Hersch, 1995), as well as potential discontinuity of care (Reidy, 1993).

MENTAL HEALTH SERVICE DELIVERY TO ETHNIC MINORITIES

Over the past 25 years, the United States has undergone a dramatic change in the composition of its population. It is estimated that by the early 21st century about one third of the population in the United States will consist of racial and ethnic minority groups (Jones, 1991). These demographic shifts can be attributed to the various changes in laws and policies that have led to over 10 million people migrating to the United States in the past 20 years. This figure represents one fourth of the population gain made in the United States during this time period. Over 80% of these new immigrants have settled in large urban areas such as New York, Miami, Los Angeles, Boston, San Francisco, and Washington, DC (Muller, 1993). The large population increase due to immigration parallels a similar type of increase that occurred in the early part of this century. The major difference between these two periods is that in the early 1900s immigrants came primarily from Europe and Canada; the recent immigration has come primarily from Asia and Latin America (Portes & Rumbaut, 1990).

There is ample evidence that race, ethnicity, and associated constructs such as nativity and acculturation levels are important in understanding who gets sick, where and how they are diagnosed and treated, and how effective interventions are in reducing symptoms and improving quality of life (Burnham et al., 1987; Geary, Brown, Milburn, Ahmed, & Booth, 1989; Kuo, 1984; McIntosh, 1984; Moscicki, Locke, Rae, & Boyd, 1989; Rumbaut, 1989; Somervell, Leaf, Weissman, Blazer, & Bruce, 1989; Sue & Sue, 1987; Wells, Golding, Hough, Burnham, & Karno, 1989). A number of excellent reviews have already examined the epidemiology of mental health problems (National Center for Health Statistics, 1980;

Vega & Rumbaut, 1991), psychotherapy (Atkinson, 1986; Neighbors et al., 1989; Sue, Zane, & Young, 1993), and service delivery (Snowden & Cheung, 1990; Takeuchi & Uehara, 1996) among ethnic minority populations. We shall not engage in a repetition of these summaries but suggest that these reviews generally support several themes. Ethnic minorities in the United States may (a) experience a disproportionate burden of health illnesses and disease compared with White Americans (Meinhardt, Tom, Tse, & Yu, 1985–1986; Mirowsky & Ross, 1989; Raskin, Crook, & Herman, 1975; Simon, Fleiss, Gurland, Stiller, & Sharpe, 1973; Warheit, Holzer, & Schwab, 1973), (b) encounter the greatest number of barriers to accessing health and mental health services (Aponte & Barnes, 1995; Corin, 1994; Durvasula & Sue, 1996; Lopez, 1981; Mayeno & Hirota, 1994; Mollica, Blum, & Redlich, 1980; Sussman, Robins, & Earls, 1987), (c) have the fewest financial resources to obtain appropriate services (Corcoran & Vandiver, 1996; Kim, McLeod, & Shantzis, 1992; Westermeyer, 1991) and are subsequently overrepresented in the numbers of Americans who are uninsured or underinsured (Commonwealth Fund, 1995; Crow, Smith, McNamee, & Piland, 1994; Scheffler & Miller, 1989; Wells, Manning, Duan, Newhouse, & Ware, 1986), and (d) may experience lower quality of care when they do receive health and mental health services (Council on Ethical and Judicial Affairs, American Medical Association, 1990; Lawson, Hepler, Holladay, & Cuffel, 1994; Mukherjee, Shukla, Woodle, Rosen, & Olarte, 1983; Neighbors et al., 1989; Snowden & Cheung, 1990; Snowden & Holschuch, 1992; White-Means, 1995). Additionally, the managed care models that have evolved in response to the health care crisis have not considered the needs of ethnic minorities in any systematic manner, so these new systems may pose new barriers to access and treatment. Yet, because individuals have fewer options to seek alternative care, managed care systems have a greater responsibility to create alternatives to expensive care that are congruent with the preferences, cultures, and values of clients (Cuffel, Snowden, Masland, & Piccagli, 1994). Indeed, some critical issues regarding managed care service delivery to ethnic minorities (Newman & Bricklin, 1991) have been raised in the areas of training of personnel to deal with minority populations, quality assurance with ethnic minority populations, and the need for legislation that affects ethnic minorities (American Psychological Association, 1986).

Accordingly, policy and program changes have been advocated to make the mental health system more "multicultural" or more sensitive and responsive to the needs of ethnic minorities. The breadth of these recommendations has been extensive and has led to a number of interventions that attempt to make services more accessible and treatment more effective for ethnic minority groups. Recommendations to make services more "culturally responsive" or "culturally sensitive" have made us aware that sociocultural differences among groups can lead to (a) difficulties in performing valid psychological assessments (Jones & Thorne, 1987), (b) differential or discriminatory forms of treatment (Yamamoto, James, & Palley, 1968), (c) therapist preferences for client characteristics that place ethnic minorities at a disadvantage (Schofield, 1964), and (d) client preferences for treatment (Sue & Zane, 1987).

Traditionally, the problems attributed to cultural insensitivity were partly due to the incongruence between the characteristics of the mental health system and the minority culture (Rogler, Malgady, & Rodriguez, 1989). That is, assessment instruments, clinicians, practices, and policies in mental health programs and systems did not adequately address the needs of minority clients. Often, this dissimilarity is suspected of leading to poorer treatment outcomes among minorities. Although the construct has gained popularity in the past decade, the operationalization of cultural sensitivity has remained a "black box" (Sue, Fujino, Hu, Takeuchi, & Zane, 1991; Takeuchi & Uehara, 1996). Moreover, systematic research that critically evaluates whether cultural responsiveness actually results in increased access, better quality of care, and more positive outcomes for ethnic minorities is lacking. By conceptualizing cultural sensitivity in terms of the linkages between structural factors, process variables, and outcomes in providing mental health services, we may also focus on broader cost, access, and quality issues that will help to open and define the contents of this black box.

Moreover, researchers examining quality-of-care issues have developed methodologies that can be used as a foundation to investigate the notion of *cultural competence as a critical dimension of quality of care* with ethnic minority samples. At the same time, research on the evaluation of the quality of mental health services can also benefit from the inclusion of culturally diverse samples. For instance, a primary goal in quality-of-care studies is to develop explicit criteria to assess "acceptable" clinical practice. In instances where existing knowledge about effective practices is limited, it may be feasible to identify criteria indicating poor quality (or practices to avoid). While these explicit criteria may provide a basis to judge the treatment given to patients, they may easily neglect the fact that sociocultural factors are critical in defining care, especially in mental health where process and outcomes are more difficult to quantify than medical criteria. Efforts to standardize criteria bear an implicit assumption that the standards are reliable and valid for specific ethnic and racial subpopulations. This assumption may be premature because we lack a large body of empirical literature that documents how health and illness are stable or at variance across multiple ethnic groups. It is more likely that cultural groups vary in their sense of what constitutes health and illness and what factors contribute to a meaningful quality of life. Cultural factors also affect patient-physician interactions, which can play a critical part in the assessment of quality (Sue & Zane, 1987). Assessments that ignore these issues can results in systematic errors in diagnosis and measurement of quality care in treatment processes and outcomes (McKinlay, 1996). Such errors have been well documented and include the diagnosis of more Blacks than Whites as schizophrenic, and judgments that individuals of lower socioeconomic status are more seriously disturbed than individuals from higher socioeconomic brackets (Sleek, 1996).

ISSUES IN THE EVALUATION OF QUALITY

From a mental health perspective, *quality* can been conceptualized in many ways. At the level of individual treatment, Menninger (1977) proposes an interactionist definition of quality as the "goodness of fit" between the problem requiring therapeutic attention, the desired outcome or goal of treatment, and the effectiveness of the treatment approach, as perceived by the patient, as judged by service providers, and as verified by outcomes studies (Rodriguez, 1989). In contrast, Byalin (1992) borrows a definition of quality from the industrial literature, viewing quality as "conformance to requirements, not as goodness" (Crosby, 1984, p. 64). This perspective takes the position that a performance standard of "zero defects" is desirable. To enhance quality from this perspective, the approach is to create systems that emphasize prevention of problems, rather than to intensify efforts to correct problems, such as monitoring and supervision. Other definitions of quality break the concept down into several components (Vuori, 1980): (a) maximal quality—the application of the most current knowledge and techniques available, (b) optimal quality—the allocation of scarce resources in a purposeful manner that minimizes waste, and (c) logical quality—the efficiency with which information is used to arrive at a decision. In perhaps the most widely used definition of quality in the field, however, Donabedian (1978) conceptualizes quality in terms of structure (or the environment of care), process (or the content of care), and outcome (or the results of care).

Quality: Assessing Structure

In Donabedian's (1978) framework, a structural review examines the resources that are necessary to provide care, whether facilities, services, or staffing. It provides the most indirect measure of quality because it does not provide information on what actually happens with patients (Liptzin, 1974); however, it is the easiest aspect of quality to actually quantify and measure. Traditional methods of ensuring quality—such as controlling entry into professional schools and training programs and screening through standardized licensing exams—generally fall into this category, because they impact staffing arrangements. But structural assessment also involves the evaluation of equipment, space, clinical records, financial management, organizational design, and method of quality assurance, in addition to staffing patterns and staff credentials (Savitz, 1992).

Quality: Assessing Process

A process evaluation entails a comparison of the actual service delivery with explicit criteria or normative standards (Cohen, 1988). Accurate assessment of the process of care requires the identification of the critical components that represent important decision points in the care of the patient (Wells and Brook, 1989). Process variables include patient access to care, diagnostic procedures, referral, treatment, and patient compliance, as well as the identification of all components of mental health care (partial hospitalization, family services, ambulatory programs, etc.), that provide effective treatment (Savitz, 1992). As Wells and Brook (1989) note, however, we do not know what components of process are meaningfully related to either subsequent process components or to eventual outcomes. For process criteria to be valid, it must be demonstrated that improvements in the process of care are linked to improvements in outcome (Brook, Kamberg, & Lohr, 1982).

Various terms have been developed to assess quality in the process of care. *Criteria* are statements that define appropriate clinical care (Fauman, 1990). They represent elements of the process of care that represent a certain level of quality of care (i.e., ranging from poor to acceptable to good). An example of a criterion related to continuity of care, for instance, is the requirement that a patient receive treatment in an outpatient setting within 30 days of being discharged from inpatient treatment. *Standards* represent the degree of adherence to criterion that represent acceptable quality-of-care levels. In the previous example, if follow- up treatment in outpatient settings is routinely scheduled for such patients, then the standards for acceptable care are being met for this criterion. Other examples of standards may be that (a) no more than 30% of clinical records will lack a treatment plan, (b) 90% of patients who are taking lithium carbonate will be evaluated in person at least once every 2 months, or (c) 95% of patients will be offered an appointment within 3 working days (Savitz, 1992). Standards are difficult to set. If they are set too high, it may lead to unrealistic expectations and a sense of failure among staff. If they are set too low, acting as a floor of treatment, they may inadvertently become the prevailing level of care (Savitz, 1992). In general, criteria and standards developed to define and assess quality care are considered the hallmark of quality-of-care studies (McGlynn, Norquist, Wells, Sullivan, & Liberman, 1988). Quality-of-care research focuses on the (a) development and validation of criteria, (b) operationalization of quality in terms of these criteria, and (c) implementation and evaluation of quality of care in terms of valid criteria and standards (McGlynn et al., 1988).

Despite their importance, the development of criteria and standards is complicated by the fact that there is such a diversity of providers, with different assessment and treatment methods, priorities, settings, and so on. From a conceptual perspective, criteria may be defined from several different perspectives (Fauman, 1990). Criteria may be defined according to *referents*, that is, according to the condition, diagnosis, or treatment in question, and by *source*, specifically, whether criteria are developed through normative means (e.g., the judgment of experts) or empirical means (e.g., a survey of actual clinical practices among professionals). More often than not, criteria referenced by source are labeled as *implicit* or *explicit*. Implicit criteria are normatively based; they are based on the assumption that all the specific factors that influence a particular case are weighed so that a competent assessor can make the judgment of what he or she would have recommended under the circumstances (Donabedian, 1978). Consequently, quality-of-care judgments based on implicit criteria rely on the assessor's expert clinical experience, rather than any predetermined criteria (Fauman, 1989). Explicit criteria, in contrast, are predetermined, and are supposed to represent "acceptable" practice. At one extreme, this may involve the judgment of what leading experts would consider to be the best practice (which is essentially a normatively based approach), while at the other extreme this may represent the average practice of service providers in the community (which may reflect a more empirically derived approach; Donabedian, 1978).

Peer review processes are often inconsistent, depending on whether process criteria used are implicit or explicit in nature. In order to ensure the reliability of explicit criteria, for instance, Cohen (1988) notes that (a) the criteria must be specific, (b) records or treatment reports must contain sufficiently specific process information, and (c) reviewers must be trained in the application of these criteria. Similarly, quality assessment based on implicit criteria tends to be time consuming and unreliable unless performed by extremely skilled and motivated assessors. Reviewers using implicit criteria often show great variability in their interpretation of patient conditions, often by theoretical orientation (Brook et al., 1982; Cohen & Holstein, 1982; Pizzirusso & Cohen, 1983). For example, psychodynamic reviewers are often more positive in evaluations of long-term psychodynamic therapy compared to non-psychodynamic reviewers (Cohen & Oyster-Nelson, 1981). The fact that there are reviewer orientation effects suggests that there may be an inherent bias in peer review systems based on implicit process criteria. Beyond the bias in peer review systems, however, the wide variability in therapeutic procedures depending on the personal qualities of the therapist, unrelated to competence or even orientation, and the limited validity of psychiatric diagnoses make it difficult to evaluate the efficacy or outcome of treatment (London & Klerman, 1982).

Another major concern in the assessment of process is confidentiality. Typically, process measures involve some form of peer review strategies, including record audits, direct observation of staff activities, observation of the patient's condition, or exams to test staff knowledge (Zusman & Ross, 1969). Rodriguez (1988) notes that no other area raises such basic ethical and legal problems as the threatened loss of privacy historically protected in the therapist-client relationship. Due to these concerns, treatment records have become notoriously unreliable sources of information. Many practitioners deliberately keep limited records of treatment in order to protect the confidentiality of their clients, but even without this tendency, psychiatric terminology is often vague. Practitioners do not routinely link specific treatment goals to defined symptoms and behaviors, psychological processes, severity of dysfunctions, or need for the level of care provided (Rodriguez, 1988). Thus, fundamental concerns about the basic quality of information available in treatment records have not been resolved.

Quality: Measuring Outcomes

An assessment of outcome entails an evaluation of the effects of treatment on patient outcome (Cohen, 1988). Put another way, outcomes generally indicate the effect of process variables on patient status, whether the results are therapeutic or are complications of treatment. A focus on outcome may appear attractive as an index of quality because outcome measures would appear to assess what benefit the patient received from *all* aspects of treatment. However, it is problematic to determine *which* aspect of treatment brought about the observed outcome for a given patient, since distinguishing between provider input, the nature of the disorder, and characteristics of the patient is often impossible (Mirin & Namerow, 1991; Savitz, 1992). Savitz (1992) observes that, despite the provider's input, generally the severity of a patient's illness largely determines the outcome.

Outcomes of treatment may include measures of patient satisfaction, as well as changes in mental status, interpersonal functioning, and social performance (Savitz, 1992). Patient satisfaction often is ignored as an outcome, yet may be the best indicator that a patient's goals for care were met (Steffen, 1988). Vuori (1987) believes that patient satisfaction is an important measure of quality but is undervalued by providers who do not traditionally value patient opinions. Although the formation of outcome criteria would ideally involve both patient and provider input (Savitz, 1992), in general, outcome criteria require some refinement before they achieve "operational status" in quality assessment programs (Mattson, 1984, p. 608). Grant (1982) points out that a major problem with an emphasis on outcomes is that it is possible to obtain a zero effect or less than optimal effect on the patient as an outcome, yet this unsatisfactory outcome may have nothing to do with the quality of care provided.

In fact, McAuliffe (1979) argues that outcomes are less direct manifestations of quality compared with process criteria. Process data can be collected closer in time to the actual service provision than can outcome data. It is also less expensive to collect (Mattson, 1984). Thus, a central challenge is to identify process measures that can be used as proxy indicators for eventual outcome, and to link improvements in the process of care to improvements in patient outcome (Mattson, 1984). Even though some medical studies indicate that carefully derived process criteria are predictive of medical outcomes (Hastings, Sonneborn, Lee, Vick, & Sasmor, 1980; Mates & Sidel, 1981), mental health outcomes are more difficult to quantify. In reality, the choice of whether to conduct process or outcomes studies is often bound to the nature of the data and data collection techniques that are available (Brook et al., 1982). Unfortunately, many times the nature of the data is fairly limited.

Evaluation of Quality: Institutional Context

Efforts to assess and ensure that quality of care is high involve quality assurance activities. Yet few studies have actually linked quality assurance activities to changes in process or outcome of care, so it has not been established that quality assurance programs actually improve quality of care. The objectives of quality assurance programs are to evaluate the quality of mental health services delivered, and to provide corrective or educational feedback to remedy detected deficiencies in service quality (Cohen, 1988). The first goal requires assessment of quality in these settings. The second goal involves corrective feedback, which often takes the form of various educational measures, increased monitoring and supervision, and improving documentation (Crosby, 1984; Mattson, 1984). Mattson (1984) points out, however, that this may not be enough; rather, effecting change in the system should be a major charge of quality assurance activities. The lack of documented effectiveness of many quality assurance systems may be due, in part, to a failure to conceptualize quality assurance as a problem of organizational and behavioral change (Luke & Boss, 1981). Crosby (1984) views patterns of error as a system failure that requires the improvement of the operating systems, rather than intensifying error-correcting efforts, such as monitoring and supervision.

This perspective is significant, as it alters a view of quality assurance departments as serving an "internal policing function" (Byalin, 1992, p. 458) to a view in which quality assessment departments lead institutional efforts to modify operational systems. Quality assessment departments thus are not simply responsible for catching errors, but for continually improving systems.

Evaluation of Quality: Community Context

Some mental health researchers have expanded the traditional domain of quality-of-care research to include "the conceptualization, measurement, and assessment of the outcome, process, and structure of both the health delivery system and the context in which it operates" (McGlynn et al., 1988, p. 157). This definition represents an adaptation of Donabedian's (1978) classic scheme, to emphasize the broader context in which care is delivered. Specifically, McGlynn et al. (1988) propose that community and client population attributes that may influence the process and outcome of care are vital to gaining a full understanding of the health care delivery system context. These attributes include both (a) characteristics of the institutions providing care and the providers delivering care, and (b) characteristics of the community and the patients potentially benefiting from care. The notion that systems of mental health service delivery should be developed around the needs of the population in the target community served is probably most articulated among community mental health centers (Lebow, 1982), as well as a few innovative models at a statewide level. For instance, Minnesota has instituted integrated service networks (ISNs), or delivery systems, that stress the delivery of high-quality services relying upon a primary care system. These systems bear an added responsibility to monitor the health of the communities served, including members of the community who do not necessarily participate in the programs (Frank et al., 1994). The ISN model places primary emphasis on the relationship of the health care system to the community (Frank, Sullivan, & DeLeon, 1994) and has the potential to extend health system networks into underserved areas.

In expanding the definition of the structure of care to the community level, the target population includes not just treated patients, but untreated patients, which allows the examination of how access is gained to these systems, and the implications of not obtaining access (McGlynn et al., 1988). Equal access exists when services are distributed according to need, rather than race, family income, or other demographic variables (Aday & Anderson, 1981; Aday, Anderson, & Fleming, 1980). From this perspective of "similar treatment for similar cases," a person's ethnicity, income, or other factors should not determine the quality of care received; treatment is provided in the same way for the same disorders across different groups.

McGlynn et al.'s (1988) expansion of Donabedian's (1978) framework also facilitates the examination of the role cultural and racial factors may play in a client's ability to access mental health care and obtain appropriate and effective mental health services. The authors also observe that language and cultural barriers may pose significant barriers to the delivery of care, and have important implications for the quality of care provided. We will examine these potential sources of difficulty in the structures, processes, and outcomes associated with managed care systems, as well as their impact on the access, cost, and quality of services to ethnic minority populations.

QUALITY AND MANAGED CARE STRUCTURES

Models of Service Delivery

There are at least four basic models of service delivery within managed care systems: (a) traditional indemnity programs allow patients to select their own providers who are reimbursed on a fee-for-service (FFS) basis but with preauthorization, pretreatment, or other review requirements; (b) preferred provider organizations (PPOs) restrict the providers that patients may select, and may select providers on the basis of their willingness to use lower- cost procedures and to cooperate with cost-control measures (Appelbaum, 1993; Dorwart, 1990; Tischler, 1990); (c) HMOs in which care is provided by a fixed system of designated providers with fixed costs associated with each type of procedure; and (d) point-of-service (POS) treatment networks, which allow the patient to decide, at the point of service delivery, whether to use a network or non-network service provider (Patterson, 1993). Although HMOs are more restrictive in consumer choice relative to indemnity programs, PPOs, and POSs, there are a variety of HMOs, such as staff, group, network, and independent practice associations (IPA), that range quite widely in the degree of consumer flexibility allowed (Cuffel et al., 1994).

Providers who work in staff HMOs are salaried staff working 100% of their time for the HMO. In this case, the HMO and the insurance company are part of the same organization. In group HMOs, providers are clustered in multispecialty areas that comprise a larger medical group. This medical group works closely with an insurance company in providing services to enrollees. The arrangement between the Kaiser Health Plan and Permanente Medical Group (Kaiser-Permanente), one of the largest and oldest HMO providers, is an example of a group HMO. Staff and group HMOs are considered relatively "closed" systems, since individuals outside the plan do not have access to provider services, and enrollees do not have the option of obtaining services outside the plan (Winegar, 1992). IPA and network plans, in contrast, are more loosely organized and often offer greater access to individuals in the community, whether they are enrolled in the HMO or not. In IPAs, providers are screened and selected for provider panels. In exchange for agreeing to several conditions (e.g., some form of discounted fee for HMO enrollees, adherence to an HMO's standards, and participation in quality control), HMOs refer enrollees to providers. As a consequence, an HMO using the IPA model offers services that are geographically scattered and more community based. In addition, HMO enrollees typically comprise a majority of the patient base for IPA providers. In contrast, a network HMO model involves an HMO contracting with individual providers to provide services; in this case, HMO enrollees typically comprise only a small proportion of total patients seen by the provider (Winegar, 1992). Finally, a key difference between HMOs and PPOs is that in PPOs consumers are encouraged to go to selected providers but have the option of seeking services from out-of- network choices. If they do so, however, they incur a greater degree of cost-sharing than if they had sought services within the plan (Cuffel et al., 1994). In contrast, in all HMO plans, providers are preselected by the HMO and the consumer does not have the choice of going to providers outside the HMO. Finally, the newest model to emerge is the POS treatment network system. Similar to PPOs, the patient may choose between a contracted network provider or a non-network provider, with greater cost-sharing incurred by the patient with use of the non-network provider. In POSs, however, the timing of this choice is more flexible, in that it may occur at the point at which services are needed (Patterson, 1993).

These different varieties of managed care systems vary in consumer choice, flexibility, and cost-sharing arrangements. The organizational structures are geared toward providing high-quality services, or services that are appropriate in intensity, amount, and type (Cuffel et al., 1994), at minimal cost. The distinction between the different types of managed care systems, however, becomes very important in examining quality within systems. For instance, staff model HMOs have a small number of providers who share their workspace, can be directly monitored, and often share similar professional values (Savitz, 1992). In contrast, an IPA model involves a large network of providers that are loosely connected and geographically scattered. In this model, providers may or may not comply with standards, even though they may have professed values consistent with managed care practices.

The ideal that quality of care entails efficient and appropriate care provided at minimal cost underscores all these systems. In turn, cost containment can be accomplished by managing the *demand* for services or by limiting the *supply* of services available to enrollees. Specifically, insurance systems structure patients' incentives to demand care, while reimbursement systems structure providers' incentives to supply care (Ellis & McGuire, 1990). Consequently, the containment of costs in managed care is accomplished through regulating supply and demand for services through a health payment system containing two parts: insurance coverage and reimbursement systems (Ellis & McGuire, 1990).

Cost Containment Structures: Managing Demand

Rodriguez (1989) notes that benefit redesign and structuring utilize employee co-payment as a means of controlling help-seeking behavior and demand for services. This strategy may backfire, however, if demand is too tightly regulated. Individuals may not seek help until their problems are more serious and treatment is more expensive, leading to higher hidden costs (Rodriguez, 1989). On one hand, then, insurance coverage should be generous enough to discourage excessive delays in help-seeking behavior. On the other hand, numerous studies indicate that utilization of mental health services is much more "elastic" in response to price and changes in insurance coverage, compared to the utilization of health services (Frank & McGuire, 1986; Horgan, 1986; Taube, Kessler, & Burns, 1986; Watts, Scheffler, & Jewell, 1986). This price elasticity reflects a greater tendency for mental health consumers to utilize a higher quantity of services simply because the price is cheaper (e.g., due to low co-payments or generous insurance coverage). Outpatient psychotherapy visits, in particular, tend to demonstrate greater price elasticity compared to other sectors of specialty mental health services (Horgan, 1985; McGuire, 1981; Taube et al., 1986). Consequently, the elasticity of demand for mental health services discourages insurance companies from providing too-generous coverage for mental health needs, as there exists a strong perception that such coverage may lead to excessive utilization rates and higher costs for delivering services. Indeed, economists refer to this inclination as "moral hazard" (Ellis & McGuire, 1990; Mechanic, 1993). Mechanic (1993) argues against moral hazard, and the use of these cost barriers to manage demand for services (with the exception of outpatient psychotherapy), maintaining that patients are reluctant to use mental health specialty services and that people with high levels of need are naturally constrained from seeking care due to fear of being stigmatized.

The implications of these payment structures for service delivery to ethnic minorities are not adequately recognized in the mental health literature. For instance, a distinction needs to be made between the *demand* for services and *need* for services. While *demand* has been viewed in terms of the "press of individuals" upon the managed care system, Dorwart and Epstein (1992) define *need* in terms of "clinical manifestations of illness that meet established criteria and indications for medical treatment" (p. 13). The distinction between these two concepts is particularly important in examining the utilization patterns of ethnic minorities. In cases where utilization of services is interpreted as an index of need, rather than demand, Asian Americans and Latin Americans would appear to have a lower need for mental health services and African Americans and Native Americans would appear to have a greater need for mental health services (Sue, Zane, & Young, 1991, 1993). Yet this depiction, as discussed in earlier sections, is not an accurate reflection of reality because need and demand are independent constructs. Epidemiologic studies indicate that many individuals in the general population meet criteria for psychiatric disorders but don't receive any specialty mental health services (Robins et al., 1984; Shapiro et al., 1984). So, individuals in a given community may experience a high need for care, but this need may not necessarily translate into a high demand for services.

Crow et al. (1994), for instance, examined the results of multiple epidemiological surveys, and determined that race was a critical variable affecting the use of outpatient mental health services. They reported that non-Whites (African American and Hispanic respondents) were 50% less likely to use outpatient services than Whites. No data were available on use of outpatient services among Asian Americans and Native Americans. Nevertheless, race appeared to be a significant predictor of the *probability* of use and, to a lesser extent, of the *intensity* of use. Probability of use may reflect demand for services, which may be reduced by a patient's inability to pay or lack of insurance, while intensity of use, or actual utilization patterns, may be influenced by provider's method of service delivery. Yet even when these factors are controlled, ethnic differences may still persist. Scheffler and Miller (1989), for instance, found that demand for mental health services among African Americans, Hispanics, and Whites represented "vast differences" between ethnic groups, despite identical insurance coverage (p. 202).

Further complicating this picture, just as low demand may not be indicative of low need, high levels of demand may not always necessarily reflect high levels of need. The elasticity of demand for mental health services has been found to vary across income groups, with the lower income groups demonstrating the highest price elasticity (McGuire, 1981; Watts et al., 1986). For instance, utilization of mental health services is higher under Medicaid coverage, with Medicaid beneficiaries averaging more visits compared to non- Medicaid clients (Taube et al., 1986). Schinner, Rothbard, and Hadley (1992) point out the difficulty in interpreting whether this pattern suggests moral hazard (in which case, high demand does not indicate high need) or higher risk of psychiatric crisis and greater service needs (in which case, high demand reflects high need or "true demand").

Insurance companies can also control demand by targeting membership to groups perceived to have low utilization rates. Companies may target membership for firms with white-collar workers, assuming they will have less serious problems than firms with predominantly blue-collar workers, or may locate their HMO facilities in attractive suburbs, rather than an older city location (Dorwart & Epstein, 1992). There are at least two major implications of insurance companies' practices of targeting membership to desirable (e.g., low health risk) communities for ethnic minority populations. First, ethnic groups with traditionally low utilization rates may be targeted as desirable populations to cover. Asian Americans and Hispanic Americans, for instance, typically manifest low demand for services. Companies may maximize their profits by providing coverage to these populations, particularly if they do not engage in any outreach activities to promote utilization of services. As noted before, however, these practices may backfire, as individuals may not present for treatment until their symptoms are fairly severe, and they may cost more to treat in the long run.

A second major implication is that insurance companies may be motivated to avoid or exclude ethnic minority groups that are perceived as high risk populations. "Adverse selection" occurs when a target population includes a disproportionate enrollment of insurance risks who are poorer or more prone to suffer more loss or make more claims than the average risk (Feldman & Fitzpatrick, 1992), which would raise the costs of providing care. This term is typically used to describe the situation that occurs when high-end users of mental health services are able to purchase the plan that provides maximal coverage for their treatment (Frank & McGuire, 1986; Horgan, 1986). Adverse selection is most likely to occur when coverage for treatment of mental health disorders varies widely, and consumers are faced with a variety of insurance options (Frank & McGuire, 1986). It is not as likely to occur with limited options for coverage. Yet those who are more likely to utilize services heavily because of greater vulnerability to adverse health and mental health conditions due to poverty, immigration, age, and so on, may also be perceived in terms of adverse selection; consequently, coverage for these groups is also contraindicated from an insurance company's perspective.

The pattern that emerges is clear. The fact that alternative models of health and mental health care service delivery are proliferating does not, in itself, change the availability of and access to needed services for many segments of the general population. Furthermore, an important issue for ethnic minority populations is whether adverse selection may inadvertently serve as a proxy for ethnicity, particularly for ethnic populations that may be overrepresented among the poor and/or viewed as overutilizing services.

Cost Containment: Managing Supply

Reimbursement strategies have evolved from a traditional model of reimbursement (e.g., fee- for-service) based on calculations of charges for "usual, customary, and reasonable costs" for professional procedures and other health service charges, to alternative models of reimbursement that pass financial risk to consumers or to providers. For beneficiaries, such strategies include raising deductibles and co-payments, or imposing penalties for lifestyle-related conditions by limiting benefits or increasing premiums. For providers, alternative strategies primarily center around instituting prospective payment systems. These systems are effective in rendering hospitals and health care organizations accountable for the types of health care services rendered.

There are two basic types of prospective payment mechanisms. These mechanisms are classified according to their scope of coverage or "bundling of services" (Lehman, 1987). The use of diagnosis-related groups by Medicare, for instance, bundles services according to diagnoses and/or treatment approaches taken by health care institutions (e.g., by episode of illness). That is, payment is based on a prearranged reimbursement for each episode of illness within a given diagnostic group, so that the provider knows beforehand the limits of reimbursement for each patient, once a diagnosis is given (Lehman, 1987). For mental health disorders, psychiatric diagnoses alone do not appear to have much power for predicting use of treatment resources, such as length of hospital stay (Knesper, Belcher, & Cross, 1988). Yet, the identification of factors that can more accurately predict use of services and intensity of treatment is critical to formulating service delivery contracts between third-party payors and service providers (Crow et al., 1994).

Such contracts are central to the implementation of the second type of prospective payment mechanism referred to as *capitation*. Capitation has three critical elements: (a) care is prepaid with a predetermined fixed price, (b) the provider is at financial risk if expenditures exceed payments, and (c) payment is tied to a specific population of capitated patients (Mechanic, 1993). In this mechanism, services are bundled according to period of time, rather than episode of illness, as prepayment is provided for the comprehensive care of a capitated population during a given period of time (usually a 1-year period). Negotiations for defining the parameters of the covered population, and the development of feasible estimates to determine the optimal coverage to provide per covered individual (Crow et al., 1994; Ellis & McGuire, 1990), are critical to ensuring adequate access to mental health services and appropriate high-quality service delivery. Typically, adverse selection is viewed as complicating the interpretation of utilization data, as the observed population utilization rates may exceed the "true" rates that would be observed if a random sample had equally generous benefits (Frank & McGuire, 1986). Yet for ethnic minority populations, it is not clear whether the differential rates of utilization among ethnic groups suggest that we engage in "risk-adjusted" capitation strategies. Such strategies would assume that high utilization rates reflect higher true rates (due to higher need) in a particular population, and do not reflect the complicating effects of adverse selection. Yet, at the same time, risk-adjusted capitation strategies might also result in lowered coverage for ethnic populations that utilize services at low rates. The implications of such strategies are being explored in research on capitation strategies for high-risk populations (Snowden, 1995, 1996)

Many high-risk populations, such as the chronically mentally ill, are seen for treatment in the public sector. Yet capitation in the private sector works differently than in the public sector due to the nature of the target population. In fact, Mechanic and Aiken (1989) point out that the advocacy of capitated approaches for individuals with chronic mental illness is somewhat paradoxical. In the private sector, individuals with low need balance out the needs of high-service users, pooling risks across a wide range of individuals. Indeed, HMOs are usually not equipped to deal with the range of problems that the chronically seriously mentally ill present. For these individuals, who are not likely to receive the attention they need in typical HMO structures (Schlesinger, 1986), payors hope to ensure that they will in fact receive the care needed, by tying a budgeting approach to a specific population of patients (Mechanic & Aiken, 1989). Advocates for capitation in services for the severely mentally ill hope to achieve two goals using capitation: (a) to consolidate multiple funding streams in order to develop a spectrum of services that will provide continuity of care, and (b) to encourage more responsibility and accountability among providers for care of the oft-neglected chronically mentally ill, by tying payment to the care of this specific population (Mechanic & Aiken, 1989).

QUALITY AND MANAGED CARE PROCESSES

Processes of care in mental health have been conceptualized as "those events that affect or are intended to affect the course of a disease and its impact on the patient" (McGlynn et al., 1988, p. 163). Quality in processes of care has traditionally been viewed in terms of the appropriate care (e.g., intensity, type, and duration) that is used to treat a mental health disorder. Of course, the extent to which these features may be monitored or regulated will vary according to the structure of the managed care system. For example, if a provider is part of a preferred provider plan, the relationship of the payor to the provider will be less influential than if the provider is a participant in an IPA. Notwithstanding these distinctions, the cost-containment strategy that has the most direct influence on processes related to patient care across all managed care structures is utilization management (Tischler, 1990).

Utilization Management Processes

After a patent gains entry into a managed care system, judgments regarding the appropriateness of care provided are made at various points in treatment through utilization management programs. These programs have several goals (Scheffler, Sullivan, & Ko, 1991): (a) to contain costs by eliminating unnecessary procedures, (b) to direct patients to the most appropriate level of care, and (c) to produce behavior change in providers and patients through education and training that will result in lowered utilization and cost of services. In addition, utilization management mechanisms can basically be classified by the timing of judgments made regarding the appropriateness of care relative to the delivery of care (Scheffler et al., 1991). For instance, preadmission certification occurs before care is actually provided, while concurrent review and discharge planning occur while the patient is undergoing treatment. Retrospective review and denial of payment policies occur after a patient has completed treatment. Finally, individual case management programs occur at all phases of treatment (Scheffler et al., 1991).

The distinction between concurrent utilization review and individual case management often appears blurred, as both programs examine the appropriateness of the treatment plan, appropriateness of subsequent care, complications of treatment, and progress toward discharge and termination of treatment. Whereas concurrent utilization review generally tends to monitor the treatment process and provide approval for payment for further treatment at different review points, case management can be more focused and aggressive, targeting specific conditions, settings, or clinicians (Tischler, 1990). In this instance, managers may target cases that involve significant treatment complications, or cases that fail to demonstrate improvement in clinical status. Such activities may involve much more contact between service provider and case manager, compared with the contact between service providers and concurrent utilization reviewers. Not surprisingly, case management is often perceived as being intrusive (Tischler, 1990), and is an aspect of managed care that is particularly resented by service providers.

For ethnic minorities, the provision of "culturally responsive" treatment by a therapist, may no longer be adequate, because the therapist has relatively limited authority in the management of treatment in managed care settings. The management of treatment by case managers and concurrent utilization reviewers means that the therapist-client relationship, traditionally perceived in terms of dyadic influences and dynamics, is invariably subject to these "intrusive" influences. For instance, if a therapist wanted to use a translator during treatment sessions, or include family members in the treatment process, he or she might not receive authorization to do so, unless case managers and concurrent utilization reviewers were also sensitive to cultural factors that might influence the treatment process.

The effect of cultural factors in evaluating a patient's response to treatment must also be considered by staff at all levels. Corcoran and Vandiver (1996) note that managed mental health care providers need to deal with many immigrant patients from a collective perspective, by being prepared to deal with all levels of kin, nuclear and extended. For instance, LeClere, Jensen, and Biddlecome (1994) note that families play important health- related functions for immigrant refugee clients, including (a) pooling resources to pay for care, (b) socializing children into patterns of health care behavior by modeling illness and help-seeking behaviors, and (c) relying on relatives to provide instrumental and informational support to guide health care decisions. In addition, observations regarding patients' level of compliance, symptom changes, medication effects/side effects, and complications of treatment that may be necessary in order to assess treatment response may not be so straightforward for many ethnic groups. Asian American patients, for example, may not tell service providers that they haven't taken their medications out of concerns for preserving "face." In addition, standards for appropriate dosage levels of medication may need to be reconsidered, as ethnic differences in optimal dosages of psychotropic medications have been found (Lin, Nuccio, & Anderson, 1994).

Before any treatment commences, all patients must undergo preadmission certification procedures in order to gain access to treatment. This process takes into account "medical/psychiatric, level of functioning, socioenvironmental, and procedural factors" (Tischler, 1990, p. 967). Many managed care systems are structured so that specifically designated primary care physicians (PCPs) are responsible for determining whether a patient's condition meets criteria necessary to gain access to treatment. The use of these "gatekeeping systems" has important implications for service delivery to ethnic minority patients.

Gatekeeping Processes

In most HMOs, PCPs serve as gatekeepers to the system by determining whether a "medical necessity for care" exists (e.g., through preadmission certification) and deciding what form of service would be most appropriate for treatment. Criteria for medical necessity typically include the following components (Tom, 1995): (a) distress or disability that results from an appropriate DSM-IV diagnosis (e.g., schizophrenia, affective disorders, anxiety disorders, and some personality disorders); (b) the purpose of proposed treatment is diminishing the distress and disability; (c) the distress or disability is not responsive to primary care–based treatment; and (d) the beneficiary is expected to benefit from treatment. Treatment "benefit" may be defined in positive terms (e.g., significant diminishment of distress or disability) or in negative terms (e.g., the expectation of significant deterioration in important areas of functioning in the absence of treatment; Tom, 1995). If medical necessity for services is established, gatekeeper physicians may refer patients to specialists, including psychiatrists, psychologists, and other mental health service providers. The gatekeeping role underscores the centrality of the PCP as the entry point and principal controlling influence on all health care use (Eisenberg, 1985).

For ethnic minorities, where the stigma of seeking mental health services is of particular concern and often a significant barrier to treatment, seeing a PCP rather than a mental health specialist might actually increase the acceptance of mental health referrals. In addition, because the delivery of mental health services is much closer to primary care medicine, comorbidities and medical etiologies associated with psychiatric disorders may be more likely to be detected (Dorwart & Epstein, 1992). Yet, there are serious limitations to these systems, as well. For instance, Gottlieb and Olfson (1987) found that PCP gatekeepers often demonstrated limited diagnostic and referral skills, did not recognize mental disorders, and were unaware of treatment options. In addition, some gatekeepers may be subject to risk- pooling arrangements that may offer them financial incentives for keeping specialty referrals low (Martin, Price, & Richardson, 1989). In these arrangements, funds from a risk-sharing account established for the gatekeeper may be used to cover hospitalization, drugs, specialty, ancillary, and other referral costs (excluding catastrophic costs) for a specified patient population. Any deficits or surpluses remaining in the account at the end of a year are then divided between the gatekeeper and the insurance company. To the extent that providers are financially liable (or able to maximize their profits) in risk-sharing arrangements, the volume of referrals that the provider is motivated to make is correspondingly reduced, and the greater the need for surveillance of possible underuse (Eisenberg, 1985). Indeed, the appeal of gatekeeping systems for third-party payors is that they may reduce the cost of services by limiting specialist visits (Martin et al., 1989). Buie (1987), however, notes that this arrangement may also put unassertive or depressed patients at a disadvantage in securing the types of services they may require.

Tom (1995) points out how the use of criteria for medical necessity in gatekeeping systems may block ethnic minority access to treatment. He identified several factors that may limit the use of such criteria, including (a) cultural limitations of the DSM-IV, (b) language barriers, (c) misdiagnoses, and (d) cultural determinants in the expression of symptoms of mental illness (i.e., somatization of symptom expression). Assessment of medical necessity requires clear communication between provider and patient. Yet, gatekeepers may not be attuned to different cultural modes of expression and communication regarding mental health concerns among ethnic minorities. For instance, what would happen if an older African American woman who was clinically depressed presented with a variety of nonspecific somatic symptoms, and yet tended to minimize her psychological concerns when asked? Or a young Latin American client reported hearing his dead grandmother speak to him? Would these clients receive referrals for mental health services? Would a gatekeeper physician be able to discriminate between cultural influences on communication and behavior and symptoms indicating the presence of psychopathology? Some research suggests that there is reduced use of mental health specialty services when gatekeeping systems are in place (Martin et al., 1989). There may be particular cause for concern with ethnic minorities, as obtaining specialty care was reported to be a major problem for 18% of ethnic minority adults, compared with 8% of White adults according to the Commonwealth Fund (1995) *National Comparative Survey on Minority Health*. In fact, Rodriguez (1989) points out that "through the processes of benefit denial and beneficiary silence, gatekeeper systems pose real and potential threats to access and quality in mental health services" (p. 260). Nevertheless, we do not have any data on how gatekeeping arrangements currently affect access to mental health services for ethnic minority populations.

QUALITY AND MANAGED CARE OUTCOMES

Treatment outcomes have been described in terms of the effect that mental disorders have on patients and their ability to cope with the ensuing limitations (McGlynn et al., 1988). This impact may refer to nonhealth as well as health outcomes, and to intermediate as well as long-term outcomes of treatment. Although treatment outcome research has traditionally focused on changes in clinical status and symptomatology (Mirin & Namerow, 1991), quality of life and patient satisfaction have also been identified as important variables to assess as outcome variables (McGlynn et al., 1988; Mirin & Namerow, 1991). As stated before, however, very little research has been carried out on the quality of treatment received and subsequent outcomes in managed care settings (Tischler, 1990).

A few studies have examined patient outcomes in fee-for-service (FFS) versus managed care settings. Wells, Manning, and Valdez (1990) compared mental health outcomes for families randomly assigned to a prepaid group practice versus comparable FFS insurance plans in Seattle. The found no statistically significant or clinically meaningful differences for overall mental health status as well as for psychological distress (e.g., anxiety and depression) and psychological well-being between the two groups, and concluded that the less intensive style of treatment in the prepaid group practice was not associated with worse mental health outcomes. These results were consistent with the result of an earlier study (Ware et al., 1986) that found no differences in global mental health status between HMO and FFS participants. While a larger proportion of HMO participants received much less intensive form of psychotherapy than FFS participants over a period of several years, HMO participants were also more likely to receive some outpatient mental health treatment than their FFS counterparts. Thus, the authors note that although differences in styles of treatment (e.g., probability of inpatient vs. outpatient mental health services) occur across systems, these differences may cancel each other out in mental health outcomes.

Not all studies indicate an absence of differences between programs. An examination of recidivism under managed care plans found that individuals who visited an HMO or who received services through a case-managed plan were more likely than individuals receiving service through FFS plans to return to an employee assistance program within 3 months with a second request for care (Fishel, Janzen, Bemak, Ryan, & McIntyre, 1993). The results of this study should be interpreted with caution, however, as patients were not randomly assigned for services, and the data obtained were limited, with no information on original diagnoses or the nature of the second request for care.

It is not surprising that with the paucity of knowledge regarding the impact of managed care on the quality of services and outcomes of treatment within managed care settings, very little is known about the care received by ethnic minorities in managed care settings. In one study, Diehr, Williams, Martin, and Price (1984) made ethnic and racial comparisons in examining utilization patterns across FFS, HMO, and IPA models of care. They found that non-Whites (African Americans and Asian Americans were classified together) were less likely to use services than Whites in the IPA plan, and had fewer sessions than Whites in both IPA and HMO plans. In another study, both the probability of use and the intensity of use were lower for African Americans than for Whites, across both an HMO and FFS plan (Williams, Diehr, Drucker & Richardson, 1979).

Perceptions of differential quality of care for poor, largely ethnic minority patients have been observed in medical settings among family practice residents (Price, Desmond, Snyder, & Kimmel, 1988). For instance, 62% of the residents in one study felt that the quality of care poor patients received was not equivalent to the care other patients received (Price et al., 1988). Half of these residents reported that the poor patients seen were typically ethnic minorities (i.e., Black and Hispanic). In addition, 45% of the residents agreed that patient dumping, or transferring patients from one hospital to another because of inability to pay, was very common. Indeed, after the initiation of prospective payment systems and changes in Medicaid benefit design, an increase in the number of patients transferred to state and county mental hospitals was noted elsewhere (Frank & Lave, 1985; Rupp, Steinwachs, & Salkever, 1984). In addition, other studies have supported the belief that patient dumping involves an inordinate number of ethnic minorities (Brider, 1987; Himmelstein, Woolhandler, Harnly et al., 1984).

Measures of outcomes with ethnic minority populations have been quite limited. First, there have been virtually no controlled psychotherapy outcome studies with ethnic minorities that have compared groups of treated and untreated ethnic minority clients (Sue et al., 1993). Second, much of the research that has been conducted on outcomes of treatment for ethnic minority clients has only used indirect measures of outcome, such as utilization rates, premature termination, length of treatment, and Global Assessment of Functioning scores (O'Sullivan, Peterson, Cox, & Kirkeby, 1989; Snowden & Cheung, 1990; Sue et al., 1991). These indicators may be useful, but are quite limited. Finally, although many "ethnic-specific" services have been developed, we do not yet have any information about the impact of these services on actual outcomes. Part of the problem may be that the specific processes that make these services more "culturally responsive" have not yet been empirically identified and linked to potential outcomes. At the same time, much has been written on cultural competence in actual assessment and clinical treatment of ethnic minorities (Aponte, Rivers, & Wohl, 1995; Comas-Diaz & Griffith, 1988; Dana, 1993).

CONCLUSIONS

Traditionally, research on mental health service delivery to ethnic minority populations has examined many issues at different levels of care, including cultural sensitivity in psychotherapy and experiences within specific settings, such as inpatient hospitalization experiences, as well as systemic issues such as utilization rates, help-seeking behavior, and premature termination rates. To a large extent, these issues remain critical for managed care systems, as well. With various mechanisms for regulating the demand for services in a membership population and the supply of services offered to such a membership, however, a key starting point for examining the quality of mental health care provided to ethnic minorities in these systems is to examine access to care. The quality-of-care literature often assumes that individuals have already obtained access into a given health care system, and assessment of quality is initiated at the point at which they have already entered the system. Yet for ethnic minorities, adequate access into managed care systems has not yet been demonstrated and cannot be assumed. Consequently, the processes occurring in the gap between the mental health needs of a particular community and subsequent entry into a mental health system need to be more clearly articulated. What is clear is that the mere presence of alternative mental health service delivery systems in the form of managed care will not, in itself, ensure that the mental health needs of ethnic minority populations will be met more effectively than through traditional systems. In this article, critical issues in the access, cost, and quality of mental health services delivered to ethnic minorities in managed care systems were identified in order to provide a framework for cultural competence in these systems. Such systems must operationalize cultural competence across the structure, process, and outcomes of mental health service delivery in order to provide quality services to ethnic minority populations. In addition, the conceptualization of the mental health care delivery context must be expanded to include the community and target population being served. In doing so, the critical missing links between the community being served (e.g., need and demand for services) and the institution providing services (e.g., through access to services) may be addressed.

At a policy level, many systems are already purportedly striving toward developing greater access to services, a central feature of high quality of care. Explicit in the Hill-Burton Construction Act (1946) was the notion that services were to be provided to all who were unable to pay for services, and that these services would be available to all who reside in a particular geographic vicinity. In the 1960s, issues of access became an emphasis in federal health policies and were reflected in legislation designed to reduce financial, geographical, organizational, and other barriers to care through increases in facilities, personnel, and research funding (Falcone & Hartwig, 1991). What has not been addressed is why, even with financial access and the gains that have been made in the mental health system (O'Sullivan et al., 1989), many ethnic groups still do not utilize services adequately because of other equally prohibitive barriers, including barriers related to language and culture.

Although demand and utilization of services that are lower than the true need for services in a given community may be appealing to third-party payors in the short run, they ultimately result in higher cost services in the long run. For Asian Pacific American populations, for instance, reports of low utilization for health and mental health care, as well as preventive care (i.e., prenatal services, cancer screening, etc.), are accompanied by statistics that suggest they are more likely to use emergency rooms over other sources of care (which is one of the most costly forms of care), and by data that indicate when they do utilize mental health services, they are more severely disturbed (Mayeno & Hirota, 1994; Durvasula & Sue, 1996). Consequently, when they do present for mental health services, their problems tend to be much more serious and cost more to treat. This overlaps with trends in our national health policy, with its emphasis on higher-end services such as inpatient hospitalization, and use of full-service hospitalization rather than partial hospitalization or outpatient services, and its neglect of preventive services or access to care. Mental health policy has traditionally paralleled this path, such that outpatient services are neglected in favor of inpatient services, and very little attention is paid to prevention programs. This results in higher costs when individuals do require psychological intervention and utilize services.

Managed care systems counteract this tendency by limiting services to a predefined membership and aiming for efficiency of care without unduly sacrificing quality of care. Preventive care and wellness programs become cost effective in that they address issues before they become high-cost, physical and psychological syndromes. With efficiency as a goal that is regulated through various utilization management mechanisms such as preauthorization certification, concurrent utilization review, and case management, managed care systems contain ever-spiraling costs of providing mental health services. However, many of the services for which there is the greatest demand, such as serious chronic mental disorders and alcohol and substance abuse programs, are often excluded from insurance benefits packages. Thus, although managed care systems are generally successful in containing costs, covered services tend to exclude problems that are the most needed and the most costly, leaving wide gaps in care.

For ethnic minorities, the proliferation of managed care systems has the potential for more culturally sensitive and effective service delivery, even as it threatens to exclude ethnic minorities from receiving the benefits of these changes in service delivery. On the one hand, the increased coordination between health and mental health services—particularly in staff and group HMOs—may reduce the number of individuals who "fall through the cracks" once they are in a controlled system. The potential increase in the credibility and acceptance of mental health interventions through its (a) association with primary care physicians, and (b) more limited and focused goals for treatment, may also help counteract the stigma of mental health services for many ethnic minority populations. The association with primary care physicians may actually be consistent with some ethnic groups' holistic conception of health; that is, mental health cannot be neatly separated from physical health. In addition, Savitz (1992) points out how a managed care system, with a clearly defined and limited population, is in an excellent position to inform and educate members in order to enhance access to services (including outreach to special populations). In cases where a gatekeeper system discourages appropriate utilization of services, the system of access may be changed to fit the needs of the population. For instance, a system could allow direct access of members to a mental health clinician, or self-referral, although there is some fear that a high increase in utilization (e.g., moral hazard) would result from such a move (Schneider-Braus, 1992). In any case, it may be useful to use specially trained gatekeepers to coordinate assessment and referral process since appropriate intervention and treatment depend on accurate diagnosis and effective treatment plan (Savitz, 1992). Of course, this assumes that ethnic minority populations will have adequate access into these systems. Because a disproportionate number of ethnic minorities are underinsured or uninsured, encounter more barriers to accessing health and mental health services, and have fewer financial resources to obtain services compared to their White counterparts, assumptions about access to managed care need to be carefully considered.

On the other hand, the involvement of third-party payors through utilization management mechanisms adds another level of complexity to the notion of culturally sensitive interventions. For example, even if a service provider is highly skilled in providing culturally sensitive treatment to a diverse range of patients, the intervention may be derailed despite his or her best efforts, if case managers and concurrent utilization reviewers do not also recognize the impact and legitimacy of cultural influences on the treatment process. In order to provide quality services, managed care administrators as well as service providers must recognize the importance of these cultural factors. Furthermore, awareness of cultural influences (i.e., in the help-seeking process, symptom expression, communication styles, conceptualization of mental health problems, etc.) is particularly important in a system that involves utilization management mechanisms such as preadmission certification, concurrent utilization review, and case management to make judgments regarding the need for treatment and the appropriateness of treatment provided. In addition, because managed care systems designate care providers, and patients can only choose providers who are part of the system, patients are completely reliant on providers who may or may not be sensitive to ethnic issues. In light of the concern that utilization management techniques such as gatekeeper systems and financial at-risk arrangements may pose, it is distressing that the focus of research on the impact of utilization management activities is solely on the efficiency of care provided, rather than also examining the impact of such activities on the quality of care provided, in terms of mental health outcomes (Tischler, 1990).

Finally, for ethnic minority populations, quality of care cannot occur without incorporating cultural competence as a central feature of quality. While we need more conceptual and empirical work in defining the dimensions of cultural competence, managed care systems offer an heretofore unavailable opportunity to examine systemic factors that impact service delivery to ethnic minority populations. In a closed system, quality may be operationalized and examined at all levels of intervention and in different aspects of the system. In such a system, the daunting yet worthwhile challenge of trying to operationalize, monitor, and recalibrate processes to reflect cultural competence may be undertaken. Ultimately, this challenge may prove to be both cost effective in terms of providing services more efficiently, and necessary as it will promote quality in service delivery to ethnic minorities in managed care systems.

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REFERENCES

Aday, L. A., & Anderson, R. M. (1981). Equity of access to medical care: A conceptual and empirical overview. *Medical Care, 19*(Suppl. 12), 4–27.

Aday, L. A., Anderson, R., & Fleming, G. V. (1980). *Health care in the U.S.: Equitable for whom?* Beverly Hills, CA: Sage.

American Psychological Association. (1986, May 1–3). Board of Ethnic and Minority Affairs, *Minutes*. Washington, DC: American Psychological Association, Public Interest Directorate.

Aponte, J. F., & Barnes, J. M. (1995). Impact of acculturation and moderator variables on the intervention and treatment of ethnic groups. In J. F. Aponte, R. Y. Rivers, & J. Wohl (Eds.), *Psychological interventions and cultural diversity* (pp. 19–39). Needham Heights, MA: Allyn and Bacon.

Aponte, J. F., Rivers, R. Y., & Wohl, J. (eds.). (1995). *Psychological interventions and cultural diversity.* Boston: Allyn and Bacon.

Appelbaum, P. S. (1993). Legal liability and managed care. *American Psychologist, 48,* 251–257.

Atkinson, D. R. (1986). Similarity in counseling. *The Counseling Psychologist, 14,* 319–354.

Bickman, L., & Dokecki, P. R. (1989). Public and private responsibility for mental health services. *American Psychologist, 44,* 1133–1137.

Brider, P. (1987). Too poor to pay: The scandal of patient dumping. *American Journal of Nursing, 87,* 1447–1449.

Brook, R. H., Kamberg, C. J. & Lohr, K. N. (1982). Quality assessment in mental health. *Professional Psychology, 13,* 34–39.

Buie, J. (1987). Evidence of HMO flaws mounting. *American Psychological Association Monitor, 18(9),* 45.

Burnham, M. A., Hough, R. L., Escobar, J. I., Karno, M., Timbers, D. M., Telles, C. A., & Locke, B. Z. (1987). Six-month prevalence of specific psychiatric disorders among Mexican Americans and Non-Hispanic Whites in Los Angeles. *Archives of General Psychiatry, 44,* 687–694.

Byalin, K. (1992). The quality assurance dilemma in psychiatry: A sociological perspective. *Community Mental Health Journal, 28,* 453–459.

Cohen, L. H. (1988) Research on mental health quality assurance. In G. R. Stricker and A. R. Rodriguez (Eds.), *Handbook of quality assurance in mental health* (pp. 65–79). New York: Plenum Press.

Cohen, L., & Holstein, C. (1982). Characteristics and attitudes of peer reviewers and providers in psychology. *Professional Psychology, 13,* 66–73.

Cohen, L., & Oyster-Nelson, C. (1981). Clinicians, evaluations of psychodynamic psychotherapy: Experimental data on psychological peer review. *Consulting and Clinical Psychology, 49,* 583–589.

Comas-Diaz, L., & Griffith, E. E. H. (Eds.). (1988). *Clinical guidelines in cross-cultural mental health.* New York: John Wiley and Sons.

Commonwealth Fund. (1995, March 20). *National comparative survey on minority health.* Commonwealth Fund.

Corcoran, K., & Vandiver, V. (1996). Culturally competent practice in a managed care environment. In *Maneuvering the maze of managed care* (pp. 143–187). New York: Free Press.

Corin, E. (1994). The social and cultural matrix of health and disease. In R. E. Evans, M. L. Barer, & T. R. Marmor (Eds.). *Why are some people healthy and others not? The determinants of health of populations* (pp. 93–132). Hawthorne, NY: Aldine de Gruyter.

Council on Ethical and Judicial Affairs, American Medical Association (1990). Black-White disparities in health care. *Journal of the American Medical Association, 263,* 2344–2346.

Crosby, P. B. (1984). *Quality without tears: The art of hassle-free management.* New York: McGraw-Hill.

Crow, M. R., Smith, H. L., McNamee, A. H., & Piland, N. F. (1994). Considerations in predicting mental health care use: Implications for managed care plans. *The Journal of Mental Health Administration, 21,* 5–23.

Cuffel, B. J., Snowden, L., Masland, M., & Piccagli, G. (1994). *Managed mental health care in the public sector.* Berkeley, CA: Institute for Mental Health Services Research.

Dana, R. H. (1993). *Multicultural assessment perspectives for professional psychology.* Boston, MA: Allyn and Bacon.

Diehr, P., Williams, S. J., Martin, D. P., & Price, K. (1984). Ambulatory mental health services utilization in three provider plans. *Medical Care, 22,* 1–13.

Donabedian, A. (1978). The quality of medical care: Methods for assessing and monitoring the quality of care for research and for quality assurance programs. *Science, 200,* 856–864.

Dorwart, R. A. (1990). Managed mental health care: Myths and realities in the 1990s. *Hospital and Community Psychiatry, 41,* 1087–1091.

Dorwart, R. A., & Epstein, S. S. (1992). Economics and managed mental health care: The HMO as a crucible for cost-effective care. In J. Feldman & R. J. Fitzpatrick (Eds.), *Managed mental health care: Administrative and clinical issues*. Washington, DC: American Psychiatric Press.

Durvasula, R., & Sue, S. (1996). Severity of disturbance among Asian American outpatients. *Cultural Diversity and Mental Health, 2,* 43–51.

Eisenberg, J. M. (1985). The internist as gatekeeper. *Annals of Internal Medicine, 102,* 537–543.

Ellis, R. P., & McGuire, T. G. (1990). Optimal payment systems for health services. *Journal of Health Economics, 9,* 375–396.

Falcone, D., & Hartwig, L. C. (1991). Congress and health policy: The legacy of reform and retrenchment. In T. J. Litman & L. S. Robins (Eds.), *Health politics and policy* (2nd ed., pp. 116–134). Albany, NY: Delmar.

Fauman, M. A. (1989). Quality assurance monitoring in psychiatry. *American Journal of Psychiatry, 146,* 1121–1130

Fauman, M. A. (1990). Monitoring the quality of psychiatric care. *Psychiatric Clinics of North America, 13,* 73–88.

Feldman, J., & Fitzpatrick, R. J. (Eds.). (1992). *Managed mental health care: Administrative and clinical issues*. Washington, DC: American Psychiatric Press.

Fishel, L., Jazen, C., Bemak, F., Ryan, M., & McIntyre, F. (1993). A preliminary study of recidivism under managed mental health care. *Hospital and Community Psychiatry, 44,* 919–920.

Frank, R. C., & Lave, J. R. (1985). The impact of Medicaid benefit design on length of hospital stay and patient transfers. *Hospital and Community Psychiatry, 36,* 749–753.

Frank, R. G., & McGuire, T. G. (1986). A review of studies of the impact of insurance on the demand and utilization of specialty mental health services. *Health Services Research, 21,* 241–265.

Frank, R. G., & McGuire, T. G. (1996). Introduction to the economics of mental health payment systems. In B. L. Levin & J. Petrila (Eds.), *Mental health services: A public health perspective* (pp. 23–37). New York: Oxford University Press.

Frank, R. G., Sullivan, M. J., & DeLeon, P. H. (1994). Health care reform in the States. *American Psychologist, 49,* 855–867.

Geary, L. E., Brown, D. R., Milburn, N. G., Ahmed, F., & Booth, J. (1989). *Depression in Black American adults: Findings from the Norfolk Area health study*. Washington, DC: Institute of Urban Affairs.

Glazer, W. M. (1992). Psychiatry and medical necessity. *Psychiatric Annals, 22,* 362–366.

Glick, I. D., Showstack, J. A., Cohen, C., & Klar, H. M. (1989). Between patient and doctor: Improving the quality of care for serious mental illness. 193–202

Gottlieb, J. F., & Olfson, M. (1987). Current referral practices of care providers. *Hospital Community Psychiatry, 38,* 1171–1181.

Grant, R. L. (1982). Quality assurance in community mental health centers: Why it may not be working. *Quality Review Board, 8,* 3–7.

Hastings, G., Sonneborn, R., Lee, G., Vick, L., & Sasmor, L. (1980). Peer review checklist: Reproducibility and validity of a method for evaluating the quality of ambulatory care. *American Journal of Public Health, 70,* 222–228.

Health Maintenance Organization Act of 1973, 42 U.S.C. [SECTION] 280(c), 300(e)(1)(c)–(6)(a), 300(e)(1)(d), 300(e)(1)(b) (1987).

Hersch, L. (1995). Adapting to health care reform and managed care: Three strategies for survival and growth. *Professional Psychology: Research and Practice, 26,* 16–26.

Himmelstein, D. U., Woolhandler, S., Harnly, M. et al., (1984). Patient transfers: Medical practice as social triage. *American Journal of Public Health, 74,* 494–497.

Horgan, C. M. (1985). Specialty and general ambulatory mental health services. *Archives of General Psychiatry, 42,* 565–572.

Horgan, C. M. (1986). The demand for ambulatory mental health services from specialty providers. *Health Services Research, 21,* 291–319.

Jones, E. E., & Thorne, A. (1987). Rediscovery of the subject: Intercultural approaches to clinical assessment. *Journal of Consulting and Clinical Psychology, 55,* 488–496.

Jones, J. M. (1991). Psychological models of race: What have they been and what should they be? In J. D. Goodchilds (Ed)., *Psychological perspectives on human diversity in America* (pp. 3–46). Washington, DC: American Psychological Association.

Kiesler, C. A. (1992). U.S. mental health policy: Doomed to fail. *American Psychologist, 47,* 1077–1082

Kiesler, C. A., & Morton, T. L. (1988) Psychology and public policy in the "health care revolution." *American Psychologist, 43,* 993–1003.

Kim, S., McLeod, J. H., & Shantzis, C. (1992). Cultural competence for evaluators working with Asian-American communities: Some practical considerations. In M. A. Orlandi (Ed.), *Cultural competence for evaluators: A guide for alcohol and other drug abuse prevention practitioners working with ethnic/racial communities* (pp. 203–260). Rockville, MD: U.S. Department of health and Human Services, Office of Substance Abuse Prevention.

Knesper, D. J., Belcher, B. E., & Cross, J. G. (1988). Variations in the intensity of psychiatric treatment across markets for mental health services in the United States. *Health Services Research, 22,* 797–819.

Kuo, W. H. (1984). Prevalence of depression among Asian-Americans. *Journal of Nervous and Mental Disease, 172,* 449–457.

Lawson, W. B., Hepler, N., Holladay, J., & Cuffel, B. (1994). Race as a factor in inpatient and outpatient admissions and diagnosis. *Hospital and Community Psychiatry, 45,* 72–74.

Lebow, J. (1982). Models for evaluating services at community mental health centers. *Hospital and Community Psychiatry, 33,* 1010–1014.

LeClere, F. B., Jensen, L., & Biddlecome, A. E. (1994). Health care utilization, family context, and adaptation among immigrants to the United States. *Journal of Health and Social Behavior, 35,* 370–384.

Lehman, A. F. (1987). Capitation payment and mental health care: A review of the opportunities and risks. *Hospital and Community Psychiatry, 38,* 31–38.

Lin, K.-M., Nuccio, I., & Anderson, D. (1994). Studies of drug response in multiethnic populations. *Applied Clinical Trials, 3,* 36–41.

Liptzin, B. (1974). Quality assurance and psychiatric practice: A review. *American Journal of Psychiatry, 131,* 1374–1377

London, P., & Klerman, G. L. (1982). Evaluating psychotherapy. *The American Journal of Psychiatry, 139,* 709–717.

Lopez, S. (1981). Mexican-American usage of mental health facilities: Underutilization reconsidered. In A. Baron, Jr. (Ed.), *Explorations in Chicano psychology* (pp. 139–164). New York: Praeger.

Luke, R. D., & Boss, R. (1981). Barriers limiting the implementation of quality assurance programs. *Health Services Research, 16,* 305–314.

Martin, D R., Price, D. P., & Richardson, W. C. (1989). Effect of a gatekeeper plan on health services use and charges: A randomized trial. *American Journal of Public Health, 79,* 1628–1632.

Mates, S., & Sidel, V. (1981). Quality assessment by process and outcome methods: Evaluation of emergency room care of asthmatic adults. *American Journal of Public Health, 71,* 687–693.

Mattson, M. R. (1984). Quality assurance: A literature review of a changing field. *Hospital and Community Psychiatry, 35,* 605–615.

Mayeno, L., & Hirota, S. M. (1994). Access to health care. In N. W. S. Zane, D. T. Takeuchi, & K. N. J. Young (Eds.), *Confronting critical health issues of Asian and Pacific Islander Americans* (pp. 347–375). Thousand Oaks, CA: Sage.

McAuliffe, W. E. (1979). Measuring the quality of medical care: Process versus outcome. *Milbank Memorial Fund Quarterly-Health and Society, 57,* 118–131.

McGlynn, E. A., Norquist, G. S., Wells, K. B., Sullivan, G., & Liberman, R. P. (1988). Quality of care research in mental health: Responding to the challenge. *Inquiry, 25,* 157–170.

McGuire, T. G. (1981). *Financing psychotherapy: Costs, effects, and public policy.* Cambridge, MA: Ballinger.

McIntosh, J. L (1984). Suicide among Native Americans: Further tribal data and considerations. *Omega: The Journal of Death and Dying, 14,* 215–229.

McKinlay, J. (1996). Some contributions from the social system to gender inequalities in heart disease. *Journal of Health and Social Behavior, 37,* 1–26.

Mechanic, D. (1993). Mental health services in the context of health insurance reform. *The Milbank Quarterly, 71,* 349–364.

Mechanic, D., & Aiken, L. H. (1989). Capitation in mental health: Potentials and cautions. *New Directions in Mental Health Services, 43,* 1–116.

Meinhardt, K., Tom, S., Tse, P., & Yu, C. Y. (1985–1986). Southeast Asian refugees in the "Silicon Valley": The Asian Health Assessment Project. *Amerasia, 12,* 43–65.

Menninger, R. W. (1977). What is quality care? *American Journal of Orthopsychiatry, 47,* 476–483.

Mirin, S. M., & Namerow, M. J. (1991). Why study treatment outcomes? *Hospital and Community Psychiatry, 42,* 1007–1013.

Mirowsky, J., & Ross, C. E. (1989). *Social causes of psychological distress.* New York: Aldine.

Mollica, R. F., Blum, J. D., & Redlich, F. (1980). Equity and the psychiatric care of the Black patient, 1950–1975. *Journal of Nervous and Mental Disease, 168,* 279–286.

Moscicki, E. K., Locke, B. Z., Rae, D. S., & Boyd, J. H. (1989). Depressive symptoms among Mexican Americans: The Hispanic health and nutrition examination survey. *American Journal of Epidemiology, 130,* 348–360.

Mukherjee, S., Shukla, S., Woodle, J., Rosen, A. M., & Olarte, S. (1983). Misdiagnosis of schizophrenia in bipolar patients: A multiethnic comparison. *American Journal of Psychiatry, 140,* 1571–1574.

Muller, T. (1993). *Immigrants and the American city.* New York: New York Century Press.

National Center for Health Statistics. (1980). *Basic data in depressive symptomatology: U.S. 1974–1975* (DHHS Publication No. PHS 11-216). Washington, DC: U.S. Government Printing Office.

Neighbors, H. W., Jackson, J. S., Campbell, L., & Williams, D. (1989). The influence of racial factors on psychiatric diagnosis: A review and suggestions for research. *Community Mental Health Journal, 25,* 301–311.

Newman, R., & Bricklin, P. M. (1991). Parameters of managed mental health care: Legal, ethical, and professional guidelines. *Professional Psychology: Research and Practice, 22,* 26–35.

O'Sullivan, M., Peterson, P., Cox, G., & Kirkeby, J. (1989). Ethnic populations: Community mental health services ten years later. *American Journal of Community Psychology, 17,* 17–30.

Patterson, D. Y. (1993). Twenty-first century managed mental health: Point-of-service treatment networks. *Administration and Policy in Mental Health, 21,* 27–33.

Perkey, B. (1989). Public and private responsibility for mental health services. *American Psychologist, 44,* 1148–1150.

Pizzirusso, C., & Cohen, L. (1983). Psychologist's evaluations of psychodynamic psychotherapy: A peer review analogue experiment. *Professional Psychology, 14,* 57–66.

Portes, A., & Rumbaut, R. (1990). *Immigrant America: A portrait.* Berkeley: University of California Press.

Price, J. H., Desmond, S. M., Snyder, F. F. & Kimmel, S. R. (1988). Perceptions of family practice residents regarding health care and poor patients. *The Journal of Family Practice, 27,* 615–620.

Raskin, A., Crook, T. H., & Herman, K. D. (1975). Psychiatric history and symptom differences in Black and White depressed inpatients. *Journal of Consulting and Clinical Psychology, 43,* 73–80.

Reidy, W. J. (1993). Staff model HMO's and managed mental health care: One plan's experience. *Psychiatric Quarterly, 64,* 33–44.

Rice, D. P., Kelman, S., Miller, L. S., et al. (1990). *The economic costs of alcohol and drug abuse and mental illness 1985.* Washington, DC: ADAMHA Office of Financing and Coverage Policy.

Robins, L. N., Helzer, J. E. Weissman, M. M., Orvaschel, H., Gruenberg, E., Burke, J. D., & Regier, D. A. (1984). Lifetime prevalence of specific psychiatric disorders in three sites. *Archives of General Psychiatry, 41,* 949–958.

Rodriguez, A. R. (1988). An introduction to quality assurance in mental health. In G. Stricker & A. R. Rodriguez (Eds.). *Handbook of quality assurance in mental health* (pp. 3–36). New York: Plenum Press.

Rodriguez, A. R. (1989). Evolutions in utilization and quality management: A crisis for psychiatric services? *General Hospital Psychiatry, 11,* 256–263.

Rodriguez, A. R. (1992). Management of quality, utilization, and risk. In J. Feldman & R. Fitzpatrick (Eds.), *Managed mental health care: Administrative and clinical issues* (pp. 83–97). Washington, DC: American Psychiatric Press.

Rogler, L. H., Malgady, R. G., Costantino, G., & Blumenthal, R. (1987). What do culturally sensitive mental health services mean? The case of Hispanics. *American Psychologist, 42,* 565–570.

Rogler, L. H., Malgady, R. G., & Rodriguez, O. (1989). *Hispanics and mental health: A framework for research.* Malabar, FL: Krieger.

Rumbaut, R. G. (1989). Portraits, patterns, and predictors of the refugee adaptation process. In D. W. Haines (Ed.), *Refugees as immigrants: Cambodians, Laotians, and Vietnamese in America* (pp. 138–82). Totowa, NJ: Rowman & Littlefield.

Rupp, A., Steinwachs, D., & Salkever, D. (1984). The effect of hospital payment method on the pattern and cost of mental health care. *Hospital and Community Psychiatry, 35,* 456–459.

Savitz, S. A. (1992). Measuring quality of care and quality maintenance. In J. Feldman & R. J. Fitzpatrick (Eds.), *Managed mental health care: Administrative and clinical issues.* Washington, DC: American Psychiatric Press.

Scheffler, R. M., & Miller, A. B. (1989). Demand analysis of mental health service use among ethnic subpopulations. *Inquiry, 26,* 202–215.

Scheffler, R. M., Sullivan, S. D., & Ko, T. H. (1991). The impact of Blue Cross and Blue Shield Plan utilization management programs, 1980–1988. *Inquiry, 28,* 263–275.

Schieber, G. J., & Poullier, J. P. (1991). International health spending: Issues and trends. *Health Affairs, 10,* 106–116.

Schinner, A. P., Rothbard, S. D., & Hadley, T. R. (1992). A prospective management approach to the delivery of public mental health services. *Administration and Policy in Mental Health, 19,* 291–308.

Schlesinger, M. (1986). On the limits of expanding health care reform: Chronic care in prepaid settings. *Milbank Quarterly, 64,* 189–215.

Schneider-Braus, K. (1992). Managing a mental health department in a staff model HMO. In J. Feldman & R. J. Fitzpatrick (Eds.), *Managed mental health care: Administrative and clinical issues.* Washington, DC: American Psychiatric Press.

Schofield, W. (1964). *Psychotherapy: The purchase of friendship.* Englewood Cliffs, NJ: Prentice Hall.

Segal, S. P., & Aviram, U. (1978). *The mentally ill in community based shelter care.* New York: Wiley.

Shadish, W. R. (1989). Private-sector care for chronically mentally ill individuals. *American Psychologist, 44,* 1142–1147.

Shapiro, S., Skinner, E. A., Kessler, L. G., Von Korff, M., German, P. S., Tischler, G. L., Leaf, P. J., Benham, L., Cottler, L., & Rigier, D. A. (1984). Utilization of health and mental health services: Three epidemiologic catchment area sites. *Archives of General Psychiatry, 41,* 971–978.

Simon, L. S. (1989). Privatization and the mental health system. *American Psychologist, 44,* 1138–1141.

Simon, R. J., Fleiss, J. L., Gurland, B. J., Stiller, P. R., & Sharpe, L. (1973). Depression and schizophrenia in hospitalized Black and White mental patients. *Archives of General Psychiatry, 28,* 509–512.

Sleek, S. (1996). Ensuring accuracy in clinical decisions. *American Psychological Association Monitor, 26(4),* 30.

Snowden, L. (1995, November). *Cost assessment and capitation.* Paper presented at the third annual Cultural Competence and Mental Health Summit, San Jose, CA.

Snowden, L. (1996). *Mental health system reform and ethnic minority populations.* Manuscript in preparation.

Snowden, L., & Cheung, F. K. (1990). Use of inpatient mental enrollees in a prepaid group practice plan and an independent practice plan. *Medical Care, 17*, 139–151.

Winegar, N. (1992). *The clinician's guide to managed mental health care*. Binghamton, NY: Hawarth Press.

Yamamoto, J., James, Q. C., & Palley, N. (1968). Cultural problems in psychiatric therapy. *Archives of General Psychiatry, 19*, 45–49.

Zusman, J., & Ross, E. (1969). Evaluation of the quality of mental health services. *Archives of General Psychiatry, 20*, 352–357.

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