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"All professionals in rehabilitation recognize that comprehensive client assessment provides the strategic foundation for the provision of rehabilitation services to persons with disabilities" (Bolton, 2001, p. xiii).

The necessity for "comprehensive" assessment has been compromised internally within the assessment establishment by an erosion of quality assessment training and externally by managed care preferences for brief symptom-focused instruments and insufficient compensated time for adequate assessment services (Dana, 2003, submitted). Moreover, the contemporary climate continues discriminatory assessment with ethnic minorities by minimizing group differences, failure to address test bias, and a paucity of empirically-derived knowledge of these burgeoning populations. Although I have criticized the detrimental effects of managed care cost-containment practices on all consumers (Dana, Connor & Allen, 1996; Dana, 1998a), it is now evident that culturally competent assessment procedures must be embedded in diverse delivery systems to facilitate more relevant, ethical, and equitable services.

Employment of the Multicultural Assessment-Intervention Process (MAIP) model can reduce test bias, minimize diagnostic errors, and legitimize utilization of culturally appropriate ingredients in intervention services (Dana, 1997, 1998b). The original MAIP adapted standard assessment instruments and modified interpretation procedures for multicultural populations (Dana, 1993, 2000, 2003a) by asking pertinent questions and providing relevant information concerning how and when to embed cultural contents at preselected opportunities during the assessment process and

subsequently facilitated informed choice among standard, combined, or culture-specific interventions (Dana, 1998b).

MAIP is applicable to the diagnostic process (Dana, 2001a), for specific ethnic minorities (Dana, 2002a, b; Morris, 2000), in community mental health settings (e.g., Dana, Aragon, & Kramer, 2002a, b), and in Rehabilitation Counseling (Dana, 2001b). MAIP was modified for initial embedding within the Tri-City Mental Health Center (Pomona, CA) by specific procedural steps during *Intake, Match, Clinician Cultural Competence Training, Service Delivery Etiquette*, and *Interventions.*

Intake services include opportunities for gathering screening/history information, evaluating acculturation/racial identity status, and deciding with the client whether client-clinician ethnicity/language/gender match is necessary. Matching was investigated in a series of published studies prior to inclusion in intake procedures. Clinician cultural competency, evaluated as a basis for subsequent in-service training, was determined using the 21-item, four factor (non-ethnic ability, awareness, knowledge, sensitivity) California Brief Multicultural Competency Scale (CBMCS) derived from existing multicultural counseling competency measures administered to 1,244 California public mental health clinicians (Gamst et al., submitted; Der-Karabetian et al., 2003). The CBMCS items, organized by factor, served as content domains for development of an empirically-derived, open-ended training manuals (Dana, 2002c, 2003b) designed to permit incorporation of new knowledge and different presentation styles amenable to employment by a variety of trainers. The revised manual provided the contents for a Multicultural Competence Training Program (Arellano, Morrow, & Huff-Musgrove,

2003) endorsed for subsequent piloting and statewide application by the California Department of Mental Health.

The final steps-*service delivery* and *interventions*- represent promisory notes for continuing the process of embedding MAIP components demonstrating multiculturally competent agency practice. Routine incorporation of culture-specific social etiquette into service delivery of all treatment modalities and interventions provides a comfortable climate for relationship and task-orientation. Treatment modalities that combine standard and culture-specific elements or employ culture-specific components exclusively are in process of development for each population.

In order to facilitate MAIP application, a Consumer Outcome Profile was developed to summarize client intake, treatment, and outcome data including gender, ethnicity, language(s), education, living arrangement, assigned and modal therapist information, diagnosis type, trauma code, program designation, referral source, culture/gender/ language preferences for match, pre-post GAF scores, and scores on a variety of outcome measures for adults or children.

Incorporation of each of these five procedural steps was preceded by research findings. The steps are linked by monitoring clients within the assessment-intervention process and employing intervention evaluation with a variety of outcome measures. The effectiveness of this training program will be examined using pre-post measures of various intervention outcomes with each ethnic client population and controlling for a number of covariates.

A number of other available assessment models, including the assessment portion of MAIP described as "Dana's Six Step Cultural Assessment Model", were carefully

reviewed by Ponterotto, Gretchen, and Chauhan (2001). MAIP provides one demonstration of a comprehensive system of mental health care partially embedded within an agency. MAIP evaluation promises timely data describing benefits and limitations of the model. At this point in time, however, there is dire need for simultaneous applications of other comprehensive models in health and mental health services. For example, the ACES model, describes Access, Client Engagement, Intervention Services, Community Support, and Outcomes (Evans, 2003, November). In contrasting scientific and service objectives, Evans reiterates that practice settings require service delivery systems that can be implemented and evaluated without delay.

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