

CHAPTER 2

COMMITMENT TO CULTURAL COMPETENCY

WHY INTEGRATE CULTURAL COMPETENCE INTO CALIFORNIA'S PUBLIC MENTAL HEALTH SYSTEM?

The need for California to integrate and infuse cultural competence into California's public mental health system is imperative due to California's changing demographics. The extent of multilingual and multicultural diversity in this state are illustrated in Tables 1 and 2 in the Appendix to this chapter, which provide data on the race/ethnicity and primary language of clients in the State's mental health system in fiscal year 2000-01. In November 2000, the Little Hoover Commission reported that, as California's population has grown in size and diversity, the mental health system has strained to keep up with the need for care (Little Hoover Commission, 2000). Cultural and linguistic barriers to mental health care are particularly significant. The barriers to care can be as simple as not being able to communicate because mental health staff who speak a client's language are not available. The Surgeon General reported that other formidable barriers that discourage racial, ethnic, and cultural populations from using mental health care include cost of services, lack of health insurance, fragmentation of services, culturally mediated stigma or patterns of help-seeking, mistrust of mental health services, and the insensitivity of many mental health care systems (U.S. Department of Health and Human Services, 1999, p. 164).

The Surgeon General's Report, "Mental Health: Culture, Race, and Ethnicity," states "Culture influences many aspects of mental illness, including how patients from a given culture express and manifest their symptoms, their style of coping, their family and community supports, and their willingness to seek treatment" (p. 42). The cultural identities and worldviews of consumers shape health and healing beliefs, practices, behaviors, and expectations. Wellness is uniquely defined by each individual and each cultural group. Clearly, the commitment of the public mental health system to cultural competency is vital to meet the needs of all of its residents and to overcome the unique barriers many racial, ethnic, and cultural communities face.

WHAT IS CULTURAL COMPETENCE?

Cultural competence has been described generally as the ability to appreciate and recognize culturally different people and to be able to work effectively with them (Sue, 1998). As Sue, Zane, and Young (1994) explain, a client's culture is relevant to the provision of mental health services because it affects the assessment, etiology, and symptom expression of mental illness, and it affects the client's treatment preferences. Cross (1989) has defined cultural competence as a congruent set of attitudes, behaviors, and policies that enable a system, agency, or provider to treat culturally diverse clients effectively.

Defining the words "culture" and "competence" will further clarify this concept. "Culture" is the integrated pattern of human behavior that includes thought, communication, actions, customs, beliefs, values, and institutions of a racial, ethnic, religious, or social group. Culture defines the preferred ways for meeting needs. Culture may involve parameters such as ethnicity, race, language, age, country of origin, acculturation, gender, socioeconomic class, disability, religious and spiritual beliefs, and sexual orientation (California Department of Mental Health, 2002). "Competence" implies having the capacity to function effectively within the context of culturally integrated patterns of human behavior as defined by each cultural group (Cross, Bazron, Dennis, & Isaacs, 1989).

A culturally and linguistically competent system of care acknowledges and incorporates the importance of culture, assessment of cross-cultural relations, vigilance toward the dynamics that result from cultural differences, expansion of cultural knowledge, and adaptation of services to meet culturally unique needs (Cross et al., 1989). A culturally and linguistically competent system of care promotes for itself and among its providers the following characteristics:

- ◆ Awareness of the value of diversity and developing adaptation to diversity
- ◆ The capacity for continuous self-assessment
- ◆ Institutionalized cultural knowledge

- ◆ Awareness of the dynamics inherent when cultures interact
- ◆ Congruent behaviors, attitudes, and policies enabling the system, agencies, and mental health professionals to function effectively in cross-cultural institutions and communities (Cross et al., 1989)

SYSTEM LEVEL DESIGN ISSUES

The National Standards for Culturally and Linguistically Appropriate Services (CLAS) in health care were developed with input from a national advisory committee of policymakers, health care providers, and researchers (Office of Mental Health, U.S. Department of Health and Human Services, 2001). The following CLAS standards are intended as guidelines for providers, policymakers, accreditation and credentialing agencies, clients, family members, advocates, educators, and the general community:

1. Health care organizations should ensure that patients/consumers receive from all staff members effective, understandable, and respectful care that is provided in a manner compatible with their cultural health beliefs and practices and preferred language.
2. Health care organizations should implement strategies to recruit, retain, and promote at all levels of the organization a diverse staff and leadership that are representatives of the demographic characteristics of the service area.
3. Health care organizations should ensure that staff at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery.
4. Health care organizations must offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each patient/consumer with limited English proficiency at all points of contact, in a timely manner during all hours of operation.
5. Health care organizations must provide to patients/consumers in their preferred language both verbal offers and written notices informing them of their right to receive language assistance services.
6. Health care organizations must assure the competence of language assistance provided to limited English proficient patients/consumers by interpreters and bilingual staff. Family and friends should not be used to provide interpretation services (except on request by the patient/consumer.)
7. Health care organizations must make available easily understood patient-related materials and post signage in the languages of the commonly encountered group and/or groups represented in the service area.
8. Health care organizations should develop, implement, and promote a written strategic plan that outlines clear goals, policies, operational plans, and management accountability/oversight mechanisms to provide culturally and linguistically appropriate services.
9. Health care organizations should conduct initial and ongoing organizational self-assessments of CLAS-related activities and are encouraged to integrate cultural and linguistic competence-related measures into their internal audits, performance improvement programs, patient satisfaction assessments, and outcomes-based evaluations.
10. Health care organizations should ensure that data on the individual patient's/consumer's race, ethnicity, and spoken and written language are collected in health records, integrated into the organization's management information systems, and periodically updated.
11. Health care organizations should maintain a current demographic, cultural, and epidemiological profile of the community as well as a needs assessment to accurately plan for and implement services that respond to the cultural and linguistic characteristics of the service area.
12. Health care organizations should develop participatory, collaborative partnerships with communities and utilize a variety of formal and informal mechanisms to facilitate community and patient/consumer involvement in designing and implementing CLAS-related activities.

13. Health care organizations should ensure that conflict and grievance resolution processes are culturally and linguistically sensitive and capable of identifying, preventing, and resolving cross-cultural conflicts or complaints by patients/consumers.
14. Health care organizations are encouraged to regularly make available to the public information about their progress and successful innovations in implementing the CLAS standards and to provide public notice in their communities about the availability of this information.

Developing cultural competence is an ongoing process that takes place over time through training, experience, guidance, and self-evaluation. "Towards a Culturally Competent System of Care" (March 1989) describes system components necessary to move toward cultural competence. Each level of the service delivery system contributes to the cultural competence of the mental health system. These levels are consumers and families, policymakers, administrators, and practitioners.

Consumer and Family Member Level

This level recognizes that families are the primary source of care and support for the majority of adults with serious mental illnesses and children with serious emotional disturbances. Efforts to reduce racial and ethnic disparities should include strategies to strengthen families to function at their fullest potential in caring for a relative with mental illness (U.S. Department of Health and Human Services, 2001, p. 168).

Consumers and family members are the reasons why the mental health system exists. In fact, a client-directed approach is one of the most important values of the public mental health system. When the system values the racial, ethnic, and cultural characteristics of individual clients and their family members, it empowers these individuals to contribute to their mental health, well being, and recovery, strengthened by their own communities.

Policymaking level

This level includes any entity having a role in shaping policy, such as the Governor, the Legislature, the State Department of Mental Health, and professional licensing boards. At

the state level, the Legislature should play an active role in establishing cultural competence by enacting laws that require state agencies and counties to implement culturally competent practices and that provide funding to do so.

2.1. Recommendation: The Governor and the Legislature should allocate resources to secondary and postsecondary institutions to train bicultural and bilingual staff.

2.2. Recommendation: The Governor and the Legislature should provide funds for loan forgiveness programs to recruit bilingual and bicultural students into training programs.

2.3. Recommendation: The Governor and the Legislature should provide sufficient funding for counties to recruit, hire, and retain bicultural and bilingual staff.

2.4. Recommendation: The Governor and the Legislature should provide funds to mental health providers to provide ongoing cultural competence training to existing staff.

State Department of Mental Health

The State Department of Mental Health (DMH) also plays a significant role in creating a culturally competent mental health system. It has convened a Cultural Competence Advisory Committee (CCAC), comprised of experts on cultural competence throughout California. The committee is chaired by the Chief of Multicultural Services, who is also a member of DMH executive staff. The CCAC was instrumental in developing the cultural competence plans that DMH requires counties to prepare as part of their mental health managed care plans. (More discussion on these plans is included in Chapter 7, Managed Care.) DMH conducts onsite reviews of the county mental health managed care plans (MHPs) to determine if the goals set forth in the cultural competence plans are being actively addressed. The DMH also collects data on many performance indicators related to service utilization and outcome and analyzes these data by race/ethnicity. Those counties with poor performance can be provided with technical assistance to increase the cultural competence of their service systems. The DMH has also convened a State Quality Improvement Council, which addresses many of the trends that have developed since the implementation of managed care and the onsite review process.

The goal of this committee is to advise the DMH on the performance of the mental health system and technical assistance MHPs need to improve their services.

2.5. Recommendation: The DMH should aggressively monitor the MHPs for compliance with the goals established in their cultural competence plans. Any corrective action plans should be given top priority by both DMH and the MHPs.

Professional and Licensing Boards

Professional licensing boards also have a role to play in improving the cultural competence of the mental health system. Many currently practicing professionals were trained in an era when the importance of cultural competence was not so widely understood. In order to accommodate the mental health needs of California's steadily growing diverse populations, this issue should be given a high priority.

2.6. Recommendation: Licensing boards should include training in culturally responsive treatment in their continuing education requirements.

Administrative Level

This level interprets and administers policy in addition to creating it on the local level. It consists of county mental health departments and community-based agencies. Counties are an important part of creating a culturally competent system. Each county in California is unique in its racial, ethnic, and cultural diversity and is responsible for developing a system of care that meets the needs of its community. Counties provide mental health services directly through county-operated programs or by contracting with community agencies. In addition to complying with the cultural competence plans that counties are required to submit and implement through the MHP, counties can enhance the cultural competence of their service systems in a variety of ways. One way is to provide "ecologically valid services" (Aponte & Johnson, 2000). Ecologically valid services enhance access by being provided in churches, housing projects, and other community facilities used by racial, ethnic, and cultural communities. This approach also makes it easier for members of racial, ethnic, and cultural communities to avail themselves of

services. In addition, counties must facilitate interagency collaboration among social services, health, and mental health agencies to serve racial, ethnic, and cultural populations more effectively (Aponte & Johnson, 2000).

2.7. Recommendation: The county mental health departments should develop effective outreach strategies to locate services where clients of various racial, ethnic, and cultural groups will be most likely to access them.

2.8. Recommendation: The county mental health departments should actively facilitate the interagency collaboration among social services, health, and mental health agencies to serve racial, ethnic, and cultural populations more effectively.

Agencies that provide mental health services to clients of all races, ethnicities, and cultures are called "mainstream agencies." These agencies need to be able to serve clients of all cultures competently. First, they need to hire bicultural and bilingual staff of the racial, ethnic, and cultural groups in their service area (Sue, 1977). Hiring paraprofessionals from the racial, ethnic, and cultural groups being served is another way of meeting this need (Aponte & Johnson, 2000). These agencies also need to offer continuing education to their staff about issues related to serving diverse populations and culturally responsive treatment techniques (Sue, Zane, & Young, 1994). Finally, agencies should structure their services so that they take advantage of natural helping networks and support systems in the community, which can make mental health services more accessible to racial, ethnic, and cultural groups (Aponte & Johnson, 2000).

2.9. Recommendation: The DMH should encourage county mental health departments and the agencies with which they contract to structure services so clients can use natural support systems in their own racial, ethnic, and cultural communities.

Practitioner Level

This level consists of all staff involved in providing services to clients, including clinical, administrative, and clerical staff. The Center for Mental Health Services (2001) has developed standards for provider competencies, which include knowledge, understanding, skills, and attitudes (Center for Mental Health Services, 2001). The

introduction to these standards states, "These guidelines present overall system and clinical standards and implementation guidelines, placing a clear emphasis not only on cultural competence but also on the contribution of cultural competence to quality of care. The standards also reflect generally accepted principles for the best way to provide clinical care for persons with mental illnesses. They also describe expected levels of culturally competent systems and clinical behavior as well as courses of action necessary to achieve culturally competent care. These consensus-built standards also serve as a yardstick against which to measure managed care systems' cultural proficiency in meeting the mental health care needs of the target populations" (p. 1). The standards state that the essential components of core continuing education to ensure cultural competence among clinical staff and to promote effective response to the mental health needs of ethnically diverse individuals must include the following knowledge and skills:

- ◆ Understanding of consumer populations' backgrounds
- ◆ Clinical issues
- ◆ How to provide appropriate treatment
- ◆ Agency/provider role
- ◆ Communicating effectively across cultures
- ◆ Providing quality assessments
- ◆ Formulating and implementing quality treatment plans
- ◆ Providing quality treatment
- ◆ Using one's self and knowledge in the treatment process

2.10. Recommendation: Continuing education training in cultural competence for mental health practitioners must meet the standards published in "Cultural Competence Standards for Managed Care Mental Health Services."

Another type of practitioner has recently been developed, a "cultural broker." The term "cultural broker" was developed by Josie Romero, LCSW, and Evelyn Lee, EdD, members of the Department of Mental Health, Cultural Competence Advisory Committee, to use in training interpreters in behavioral health. Cultural brokers must have intimate knowledge

of their ethnic community, including migration history, cultural values, social and power structures, community healers, and cultural views of health and illness. Cultural brokers must be familiar with the American culture as well as have the ability of make a cultural connection and have rapport with the client. The role of a cultural broker is to interpret with a linguistic and cultural perspective and be able to explain to a clinician why a suggestion from the clinician may or may not be acceptable or realistic to the client.

CONCLUSION

California's commitment to cultural competence should encompass all aspects of the mental health system. As emphasized in the Surgeon General's mental health supplement on culture, race, and ethnicity, the demographic changes anticipated over the next decades magnify the importance of eliminating differences in mental health burden and access to services. Ethnic minority groups are expected to grow as a proportion of the total U.S. population.

Based on findings from the Surgeon General's mental health supplement, programs in this State that deliver culturally, linguistically, and geographically accessible mental health services should be expanded and improved (U.S. Department of Health and Human Services, 2001).

2.11. Recommendation: California should expand research in the areas of epidemiology, evidence-based treatment, psychopharmacology, ethnic- and culture-specific interventions, diagnosis and assessment, and prevention and promotion.

2.12. Recommendation: California should improve access to treatment by providing high quality, culturally responsive, and language-appropriate mental health services in locations accessible to racial, ethnic, and cultural populations.

2.13. Recommendation: California should address barriers to treatment for racial, ethnic, and cultural populations by reducing financial barriers and making services more accessible to ethnic communities and educating ethnic communities about mental illness so that shame, stigma, discrimination, and mistrust will not prevent them from seeking treatment when it is needed.

APPENDIX

Race/Ethnicity	Number	Percent
White	261,270	46.63%
Hispanic	117,375	20.95%
Black	95,583	17.06%
American Native	5,684	1.01%
Filipino	4,909	0.88%
Amerasian	709	0.13%
Chinese	4,865	0.87%
Cambodian	2,953	0.53%
Japanese	1,215	0.22%
Korean	1,996	0.36%
Samoan	304	0.05%
Asian Native	578	0.10%
Hawaiian Native	182	0.03%
Guamanian	180	0.03%
Laotian	2,095	0.37%
Vietnamese	6,917	1.23%
Other Asian/Pacific Islander	7,766	1.39%
Other	8,020	1.43%
Unknown	37,685	6.73%
TOTAL	560,286	100.00%

Table 1: Unduplicated Count of Clients Served by Race/Ethnicity for Fiscal Year 2000-01

Primary Language	Number	Percent
English	434,516	77.55%
Spanish	41,572	7.42%
Vietnamese	6,413	1.14%
Cambodian	2,543	0.45%
Tagalog	1,969	0.35%
Other Chinese Language	1,968	0.35%
Armenian	1,832	0.33%
Korean	1,472	0.26%
Russian	1,256	0.22%
Hmong	1,240	0.22%
Lao	1,231	0.22%
Cantonese	940	0.17%
Mandarin	928	0.17%
American Sign Language	583	0.10%
Farsi	562	0.10%
Japanese	497	0.09%
Mien	390	0.07%
Thai	383	0.07%
Samoan	290	0.05%
Arabic	283	0.05%
Portuguese	208	0.04%
Ilacano	169	0.03%
Other Sign Language	119	0.02%
Hebrew	69	0.01%
Italian	64	0.01%
Turkish	60	0.01%
Polish	60	0.01%
French	54	0.01%
Unknown/Not Reported	48,541	8.66%
Other Non-English	10,074	1.80%
TOTAL	560,286	100.00%

Table 2: Primary Language for Unduplicated Clients Served in Fiscal Year 2000-01

REFERENCES

- Aponte, J. F., & Johnson, L. R. (2000). The impact of culture on the intervention and treatment of ethnic populations. In J. F. Aponte & J. Wohl (Eds.), *Psychological intervention and cultural diversity*. Boston: Allyn and Bacon.
- California Department of Mental Health. (2002). DMH information notice no.: 02-03, *Plan for culturally competent specialty mental health services*. Sacramento, CA.
- Center for Mental Health Services. (2001). *Cultural competence standards in managed care mental health services: Four underserved/underrepresented racial/ethnic groups*. Retrieved, from the World Wide Web: <http://www.mentalhealth.org/publications/allpubs/sma00-3457/intro.htm>
- Cross, T. L., Bazron, B. J., Dennis, K. W., & Isaacs, M. R. (1989). *Towards a culturally competent system of care: A monograph on effective services for minority children who are severely emotionally disturbed*. Washington, D. C.: National Technical Assistance Center for Children's Mental Health.
- Little Hoover Commission. (2000). *Being there: Making a commitment to mental health*. Sacramento, CA.
- Sue, S. (1977). Community mental health services to minority groups: Some optimism, some pessimism. *American Psychologist*, 32, 616-624.
- Sue, S. (1998). In search of cultural competence in psychotherapy and counseling. *American Psychologist*, 53(4), 440-448.
- Sue, S., Zane, N., & Young, K. (1994). Research on psychotherapy with culturally diverse populations. In A. E. B. S. L. Garfield (Ed.), *Handbook of psychotherapy and behavior change* (4th Edition ed., pp. 783-817). New York: John Wiley & Sons.
- U.S. Department of Health and Human Services. (1999). *Mental health: A report of the surgeon general*. Rockville, MD: Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health.
- U.S. Department of Health and Human Services. (2001). *Mental health: Culture, race, and ethnicity -- A supplement to mental health: A report of the surgeon general*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services.
- U.S. Department of Health and Human Services, Office of Mental Health. (2001). *National standards for culturally and linguistically appropriate services in health care*. Washington, D.C.: IQ Solutions, Inc.