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POLICY BRIEF 6

CULTURAL COMPENTENCY IN THE DELIVERY OF MENTAL HEALTH SERVICES: IMPLEMENTATION ISSUES

By: **Vetta L. Sanders Thompson**, Ph.D., Associate Professor, Department of Psychology, University of Missouri - St. Louis and Fellow, Public Policy Research Center

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8001 Natural Bridge Road
St. Louis, Missouri 63121-4499

The last two decades have witnessed increased attention to multicultural issues; such as minority utilization, language barriers, provider diversity, etc. in mental health service delivery. The motivation to address these issues is related to two facts. First, demographic projections suggest that by the year 2050, half of the United States population will be Hispanic, African American, Asian American/Pacific Islander, and American Indian/Alaska Native (Basic Behavioral Science Task Force of the National Advisory Mental Health Council, 1996). One third of the country will consist of recent immigrants or first and second generation Americans, many of whom will have limited English proficiency. Census data indicate that Hispanics are the fastest growing population in the United States and are expected to become the largest ethnic group in the country. In addition, there is considerable diversity within ethnic/racial designations (Chambers, Siegel, Haugland, Aponte, Bank, Blackshear, Chow, & Grantham, 1998). For example, the designation Asian American represents 40 ethnic groups, speaking 30 different languages. American Indian is a category that consists of hundreds of tribes with different histories, languages, and practices (Chambers, et al., 1998). Individuals of Hispanic descent are united by a common language system, but are of diverse nationalities with varying histories and cultural systems. African Americans living in the US may also differ on the basis of regional background and nationality.

The mental health industry has recently focused on effective and efficient mental health services. This has led to increased interest in treatment outcomes. There is a desire to assure that the services offered to multicultural populations lend themselves to appropriate utilization and positive outcomes. Current research and knowledge suggest that mental health service delivery systems, and the treatment procedures they offer, have failed in this regard (Arthur, 2000; Chambers, et al., 1998). Ethnic/racial group members are admitted more frequently for in-patient hospital treatment, particularly on an involuntary basis. Admissions of ethnic/racial group members to state hospitals have been estimated to be three times the rate of European Americans. Studies report greater use of emergency services, higher dropout rates for outpatient mental health services, delay entering into the mental health system until conditions become intense and/or chronic, and an under utilization of community mental health services of all kinds (Arthur, 2000; Chambers, et al., 1998).

To date, the interest in cultural competency has focused more on individual practitioners than organizations and institutions. However, practitioners' ability to exhibit cultural sensitivity and competence may be limited by the policies and practices of an organization. Multiple policy and implementation issues must be addressed before cultural competency can be achieved. For the purpose of this discussion, cultural competency refers to attitudes, the process of knowledge acquisition, behaviors and skills relevant to service delivery, policies and procedures that assist mental health practitioners in effective and efficient delivery of services cross/multiculturally (Basic Behavioral Science Task Force of the National Advisory Mental Health Council, 1996). Organizations exhibit cultural competency by adaptation of services to meet the needs of cultural groups (Arthur, 2000). Service provision might be modified based on cultural patterns, language, values, and socioeconomic factors. From an organizational stand point, there are two

levels of concern: administrative (e.g. a state mental health or managed care entity) and the provider network comprised of individual providers or groups of providers.

Overview

The earliest organized policy review, standards development, and service revision efforts addressing cultural competence were completed in 1989 by the National Technical Assistance Center for Children's Mental Health and Georgetown University (Chambers, et al., 1998). New York, Ohio and California were the earliest states to address the need for culturally sensitive language activities. In 1993, California conducted a review of the mental health needs and concerns of constituent populations that led to recommendations for standards of cultural competence in a variety of mental health domains, including access to care, plan memberships, qualifications for interpreters, staffing, compliance with standards, and consumer satisfaction.

In fiscal years 1994-1995, 1996-1997, the Ohio Department of Mental Health funded nine programs to encourage the provision of cultural sensitivity training to the state's mental health community and develop nontraditional and culturally sensitive service delivery strategies. In 1998, an evaluation of these efforts was initiated. In June of 1996, SAMSHA/ CMHS (Substance Abuse and Mental Health Services Administration/Community Mental Health Services) convened a "Managed Care and Ethnic Minorities" work group. The findings of the work group were incorporated into standards of cultural competence in managed mental health care issued by SAMSHA/CMHS (Chambers, et al., 1998). Overall standards for cultural competence, implementation steps, performance indicators, and outcomes were identified.

Early efforts at and evaluations of the implementation of culturally competent services have illuminated issues that should be considered prior to undertaking system change related to cultural competence (Chambers, et. al., 1998; The Technical Assistance Center for the Evaluation of Children's Mental Health Systems, 1996).

- Do all components of an organization, institution feel that there is a need for change (management, staff, and board members)?
- Is the administration and senior management committed to cultural competency?
- Are adequate resources allocated for institutional change and training processes to occur; e.g. funding, MIS capacity, strong research & evaluation components, access to needed expertise?
- Are there mechanisms for consumer/community input?

Generally, work groups and panels have suggested that the establishment of culturally competent services requires mental health systems to recognize the importance of culture; evaluation of outcome differences across cultural, racial, or ethnic groups; assessment of the special mental health needs of multicultural and linguistic groups; adaptation of services to meet the unique needs and value systems of persons in all groups; extensive out reach to multicultural and linguistic groups with respect to services, prevention strategies, and stigma reduction; ensuring that culturally competent evaluation and outcomes measures exist (Chambers, et. al., 1998; The Technical Assistance Center for the Evaluation of Children's Mental Health Systems, 1996).

Implementation

Cultural competency implementation responsibilities differ by organizational level. The mental health or managed care authority is responsible for asserting cultural competence as a goal; reviewing, revising, and/or developing an organizational mission and mandate that includes diversity and cultural competence. Relevant policies, procedures, and practices must be reviewed and revised to reflect training, personnel practices, programs, and service delivery that facilitate cultural competence. In addition, the mental or managed health care entity must develop training, service delivery, outcome and evaluation standards, and address funding issues (Chambers, et al., 1998).

The provider network must have the capacity to determine the population demographics of the catchment area, assess the unique needs of the diverse populations in its service area, implement needed program and service delivery changes, and provide data required for evaluation and outcome. Specifically, input from diverse members of the community regarding mental health issues and needs should be sought, a culturally competent, diverse mental health work force should be employed and/or trained, plans for culturally competent service delivery, training in cultural competence, as well as review strategies should be established (Chambers, et. al., 1998; The Technical Assistance Center for the Evaluation of Children's Mental Health Systems, 1996).

Regions and catchment areas experience different population patterns that result in different cultural competence implementation issues. Each service area or regions' needs will be unique. A single statewide plan for cultural competence is therefore not feasible. A region with a large Hispanic or Asian population must address basic issues, such a linguistic accessibility. Linguistic accessibility must address access to bilingual mental health care professionals, interpreters and competence and training criteria for interpreters, training for staff using interpreter services, standards for the use of bilingual staff

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or interpreters, and the development of standards and practices related to confidentiality when interpreters are used. In addition, standards for, and the actual translation of assessment instruments, policy and consumer information materials must be accomplished. The issue of cost and who is responsible for funding interpretation and translation services must be addressed. In addition, diverse populations may require specific services to address unique needs. Examples include post traumatic stress disorder and depression treatment for areas with large refugee populations, and alcohol and substance abuse services for American Indian communities (Arthur, 2000; Chambers, et. al., 1998; The Technical Assistance Center for the Evaluation of Children's Mental Health Systems, 1996).

A research study examining the mental health attitudes of African Americans in the St. Louis metropolitan area (Thompson, manuscript in preparation) revealed a preference for providers of similar racial and socioeconomic background. Mental health providers in predominantly African American catchment areas of the region would need to consider this preference and its implication for service utilization and outcomes in cultural competence plan development. Implementation plans might include increased recruitment of African American professionals, employment and/or training of paraprofessionals, as well as an increased emphasis on development of self- help groups. Participants noted a lack of awareness of mental health services and the symptoms associated with mental illness. In addition, the stigma associated with the use of mental health services was noted as a significant barrier to treatment. Cultural competence planning would therefore require an analysis of communication and outreach strategies likely to reduce stigma, and increase knowledge of mental illness and awareness of services. The integration of community resources into the mental health delivery system would be a planning consideration. Funding concerns would focus on the duration of recruitment, training, and outreach efforts.

Summary

The activities of SAMSHA/CMHS and those states that have made substantial progress in the implementation of culturally competent services provide important information and insights about this process. Clearly, establishing culturally competent services, the necessary evaluation, and monitoring of the process are costly and time consuming. However, the commitment to cultural competence can be exemplified through research and evaluation practices. There has been federal support for cultural competence implementation efforts, such as that provided by SAMSHA/CMHS. While this funding may exist to support initial cultural competency efforts, it cannot be expected to maintain these efforts given shifting federal and agency priorities. As a result, state and local government officials — including the governor, legislators, and administrators, non-government funding sources, mental health agencies, and behavioral managed care entities — must be convinced that participation in these efforts will result in more cost efficient delivery of services. This can be most convincingly demonstrated by data substantiating the reduction in the inappropriate use of high cost inpatient and emergency services by ethnic minority clients and positive mental health outcomes for ethnic minority consumers. However, this requires commitment to evaluation at each stage of cultural competence implementation.

REFERENCES AND MATERIAL FOR FURTHER READING

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