USC Edward R. Roybal Institute on Aging

Cultural Competence and recovery in mental health

William A. Vega

May 21, 2010

LACDMH Partnership Conference

UCLA

USC SCHOOL OF SOCIAL WORK

Objectives

- Understand the state of the art in cultural competence and the continuing challenges that remain for improving the field
- Understand how development of cultural competence is linked to innovations in mental health care that are both mainstream and culture specific
- Identify impediments to cultural competence information and skills development

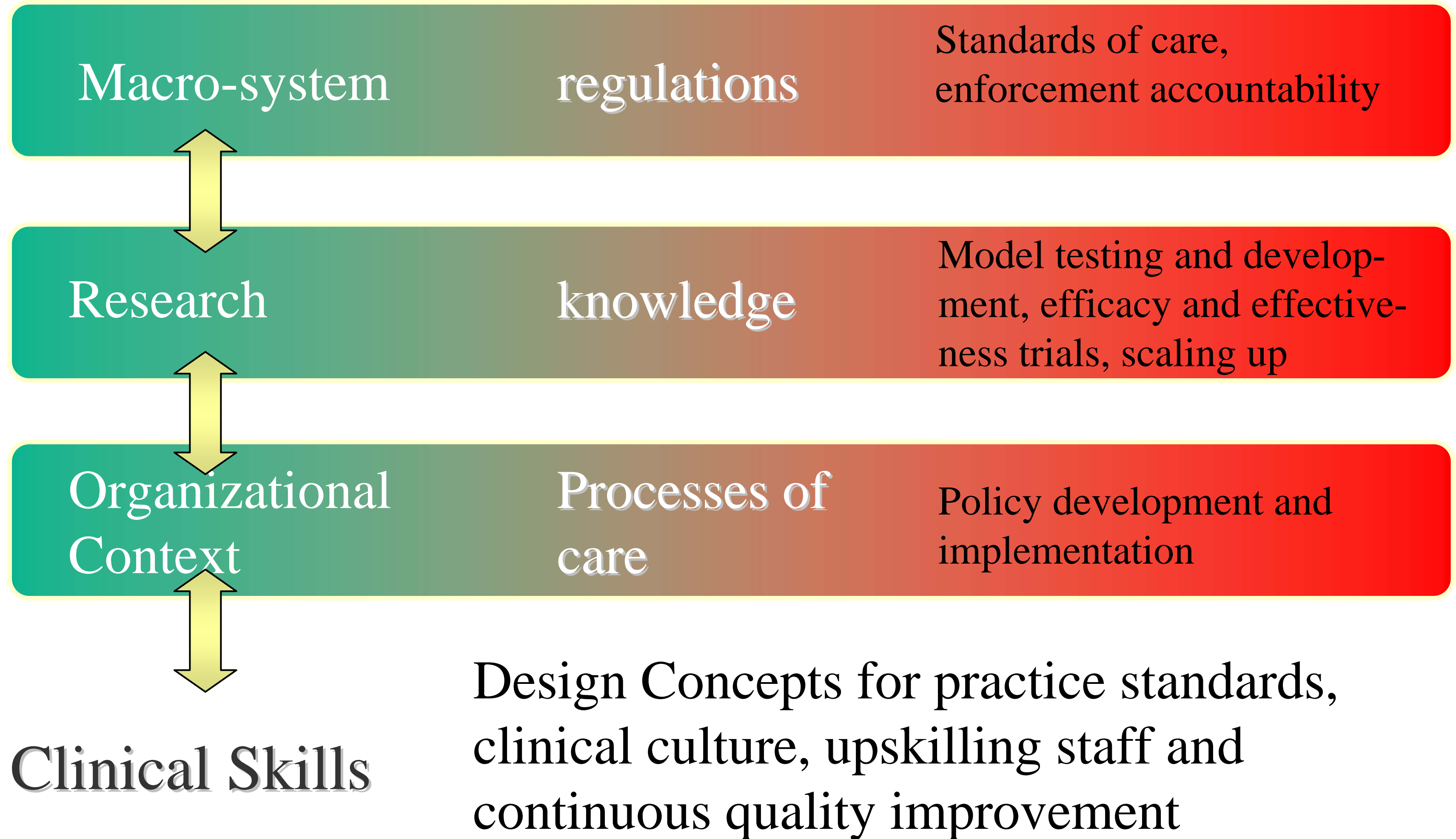
Defining cultural competence

- “a set of congruent behaviors, attitudes, policies and procedures that come together in a system, agency, or among professionals which enable the system, agency or those professionals to work effectively and efficiently in cross-cultural and diverse linguistic situations on a continuous basis”

“The First Law of Improvement”

Every system is perfectly designed to achieve exactly the results it gets.

The Chain of Effect in Improving Cultural Competence



Levels of Activity

- THE REGULATORY COMMUNITY IMPOSING STANDARDS AND ACCOUNTABILITY FOR SYSTEMS OF CARE (INCLUDING FEDS, LICENSURE AND ACCREDITING BODIES)
- THE RESEARCH COMMUNITY PROVIDING THEORY, IMPLEMENTATION MODELS, AND EVIDENCE OF EFFECTIVENESS
- THE INDIVIDUAL AS THE NEXUS OF CULTURALLY COMPETENT (INDIVIDUALIZED) CARE MODELS
- THE HEALTH CARE ORGANIZATION AS THE WEBWORK CONTROLLING ACCESS, PROCESSES OF CARE AND PRACTICE INNOVATIONS, AND OUTREACH TO PATIENTS AND COMMUNITY

Four Levels of Change Required

- Clarifying national aims for improvement
- Changing the care, itself
- Changing the organizations that deliver care
- Changing the environment that affects organizational and professional behavior

Challenges Ahead

- Access to care in a cost-control environment
- Reconfiguring a fragmented health care system
- Poor coordination of payers to providers for safety net populations
- Low visibility and high stigma of mental health providers and treatments
- Low availability of linguistically competent staff or translators
- Low availability of co-ethnic specialists

  - **Current levels of practicing mental health professionals: 29 Hispanics per 100,000 vs. 173 European Americans per 100,000**

Congressional Health Care Reform Legislation 2009

- Cultural and linguistic competence are core elements of the legislation
- Overcoming disparities in quality and access to care are highlighted
- Workforce development component stresses training of minority health professionals
- Mental health parity is retained

President's New Freedom Commission Goals - 2003

- Americans understand that mental health is essential to overall health and functioning
- Mental health care is consumer and family driven
- Disparities in mental health services are eliminated

  Including: high quality culturally competent care, and, improved access to high quality care in rural and geographically remote areas

Commission goals – cont.

- Early mental health screening, assessment, and referral are common practice
- Excellent mental health care is delivered and research is accelerated in four areas: mental health disparities, long-term effects of medications, trauma, and acute care
- Technology is used to access mental health care and information-informatics

Surgeon General's Report: Culture, Race & Ethnicity

- Culture counts!
- Striking disparities in mental health care for racial and ethnic minorities
- Minorities have less access to mental health resources
- Minorities are less likely to receive needed mental health services
- Minorities in treatment receive poorer quality care
- Minorities are underrepresented in mental health research
- Disparities impose a greater disability burden on minorities

Source: USDHHS (2001). *Mental Health : Culture, Race and Ethnicity* – A Supplement to Mental Health: A Report of the Surgeon General

CLAS & SAMHSA Standards

- Culturally and Linguistically Appropriate Standards (CLAS) from the Office of Minority Health, DHHS
  - Provide a comprehensive overview of the components of a culturally competent health care organization
  - Lack implementation guidelines or performance standards
- SAMHSA Cultural Competence Standards for Managed Behavioral Health Care Organizations
  - Provide consensus guidelines developed through a multi-ethnic process
  - Lack implementation guidelines, but provide extensive performance standards for organizations

Language provider capability is assured under Title 6 of the 1964 Civil Rights Act , lax enforcement

Research Issues

Overcoming the gap between practice needs and evidenced based research:

- Diagnosis
- Quality of Care
- Culturally Appropriate Services
- Psychosocial Intervention Development
- Psychopharmacologic Interventions.

Science to Practice

- Era of clinical guidelines, comparative effectiveness and evidence based practices to improve quality of care
- New knowledge applied to actual innovations in interventions and overcoming organizational barriers to care
- Struggle for adoption of new practices – average time to full adoption is 17 to 20 years in health care

Recommendations of recent expert reviews

- Improve and disseminate knowledge about culturally competent care
- Rapid information transfer to practitioners
- Identify and address documented disparities in quality of care
- Increase accountability through monitoring outcomes of care using improved data systems

Diagnosis Research

- **Role of patient and clinician language use in the assessment of PMDs** among Spanish monolingual, bilingual, and English monolingual patients;
- **Effectiveness of properly trained interpreters in the diagnosis of PMDs**;
- **Diagnostic process in different clinical settings** including primary care and specialty mental health care to determine rates and determinants of accurate detection of PMDs;

Diagnosis Research

- **Elements of the diagnostic process associated with systematic misdiagnosis in psychotic spectrum** and mood disorders that are potentially confounded by substance abuse problems, language usage, and cultural idioms of patients who present with putative psychotic symptoms, and,
- **Health literacy related to mental illness and treatment** among diverse ethnic patients and caregivers, and developing and testing models for patient and family education.

Quality of Care and Culturally Appropriate Services

- **Study the role of stigma** as it affects cultural acceptability of services, patterns of access to care, and perceived barriers;
- **Develop new models in the provision of mental health care that try to overcome the linguistic barriers**, and improve understanding of patient conceptions of mental illness, therapies and decision-making models;
- **Study the cultural issues affecting quality and continuity of care for special populations**, including elderly, rural, undocumented and refugee populations, and sexual minorities focusing on discrimination, clinician readiness, and risk for HIV/AIDS;

Quality of Care and Culturally Appropriate Services

- **Study the course and outcome of treatment** for PMDs in relation to cultural features such as patient conception of illness and family response to medications; and,
- **Study the cultural tailoring of existing interventions for Hispanics with PMDs to increase their cultural suitability and integrate them into existing treatment models.**

Psychosocial Intervention Development

- **Examine all aspects of single and multi-family group interventions** for Hispanic families coping with schizophrenia in a multi-site, collaborative effort, using public specialty mental health outpatient resources.
- **Explore the feasibility and efficacy of single-family and multi-family group interventions** for Hispanic families coping with severe and persistent affective, anxiety, and co-morbid disorders.
- **Investigate the comparative efficacy** of culturally and linguistically adapted interpersonal cognitive-behavioral, supportive, group-therapeutic, family therapeutic, and brief psychodynamic psychotherapy.

Psychosocial Intervention Development

- **Examine the receptivity and responses to diverse psychoeducational materials** concerning PMDs delivered through various media.
- **Continue exploration of potential protective factors operative in Spanish speaking families** in diverse U.S sub-cultural groups.

Psychopharmacologic Intervention

- **Conduct genetic linkage (or genome-wide association) studies regarding PMDs** among Hispanics to complement those for non-Hispanic subjects;
- **Expand pharmacogenetic studies in Hispanic subjects** regarding drug metabolizing enzymes as well risks for adverse drug effects, including the metabolic syndrome and diabetes mellitus;
- **Investigate medication adherence** in relation to family and cultural beliefs, perspectives and meanings concerning the use of psychotropic agents;

Psychopharmacologic Intervention

- **Investigate cultural and sub-cultural aspects of diet and herbal preparation use** which may impact efficacy, dose requirements and potential toxicity for psychotropic agents among Hispanic subjects, and;
- **Insist on the inclusion of adequate numbers of Hispanic subjects to assure statistical validity and generalizability** in both government and industry supported psychopharmacologic research.

Access to Mental Health Care

- **Investigate the feasibility of early detection and treatment of PMD's in childhood and adolescence**, including early identification of prodromal psychosis in high risk children and adolescents in school, juvenile justice, and detention facilities;
- **Investigate the feasibility and effectiveness of using innovative models, like telepsychiatry services, telephone based psychotherapy and medication follow-up**, and providing expert consultation and supervision to clinicians with limited experience in the diagnosis/treatment of Hispanics in rural areas.

Access to Mental Health Care

- **Conduct epidemiologic and services studies in adult correctional institutions** to assess the prevalence of PMD and addictive disorders, the adequacy of medical and psychiatric treatment provided in detention, and the coordination of care post-detention;
- **Examine primary care as a site** of treatment, coordinated care, and referral for Hispanics with PMDs;

Access to Mental Health Care

- **Use community-based methods of participatory research to inform the development of new models of community outreach in ethnic low income communities** for supporting families with members who have PMDs, especially special populations such as the elderly, disabled and people living with HIV, to achieve appropriate access and regularity of specialty treatment services.

Focal areas for organizational cultural competence

Culturally Competent Practices:

- Improve access to mental health services for underserved populations
- Keep mental health services consumer centered and consumer driven
- Focus service design to meet the needs of cultural groups, neighborhoods and communities
- Enhance and improve service quality

Source: NYS Office of Mental Health Fact Sheet
on Cultural Competence in Mental Health Services

Definitions of Recovery (English)

Females who received services:

- “To feel better than what I feel now.”
- “Being able to control it.”
- “That I don’t feel anxiety and depression; Don’t feel sad.”
- “There is no recovery but dealing with them [*symptoms*] better.”
- “Not having negative feelings, feeling low, stressed out, anxiety attack; I know I’m not going to be there now or never permanently.”
- “Be able to function; get up and do routine work I used to do; be able to remember, to function, to socially get involved socially.”
- “I’m always going to be recovering from alcohol.”
- “It would be to see signs and deal with it in a healthy way.”
- “Never to have symptoms, recover quickly, not lay in bed for longer than 30 minutes.”
- “Not to do drugs; Their effects and consequences put life on hold.”
- “Not to have suicidal thoughts, not take meds, not see a counselor and having more positive thoughts.”

Definitions of Recovery (English)

Males who received services:

- “Getting better. I don’t know if I could ever recover. Maybe as an old man.”
- “Not 100% but maybe 75%.”
- “Not struggle with the symptoms of depression; not have a rollercoaster of emotions; be content with life and emotions.”
- “Finding the answers would put me at ease.”
- “Being able to live a normal life. Getting through the day without feeling blue, without bad thoughts.”
- “Every day process; always be in recovery. Only when I die I will recover from alcohol/drugs.”
- “Finding the answers would put me at ease.”
- “Get better. Not cured but trying to accept and deal with symptoms.
- “Get myself back into perception – do what I used to do before using sports.”
- “It can go away but comes back. You can deal with it with help at times.”
- “Once you are seeking help, you start recovering but it’s a long process.”

Clarifying scope and methods

- Is cultural competence about “white racism?
- Is it about managing social problems?
- Is it patient-focused or ethnic group focused?
- Are clinicians or administrators the focal targets for change?
- What is the appropriate pedagogy?

Barriers to Implementation of Organizational Cultural Competence

- Cultural competence training needs to incorporate the senior leadership of the agency to be effective.
- There are significant costs to implementing cultural competence training if staff are truly to be engaged in the process.
- Program saturation is important to insuring that the program is fully implemented.

Barriers to Implementation of Organizational Cultural Competence

- There is a dearth of research establishing the impact of cultural competence interventions on improving program quality and success in recruiting and maintaining a diverse patient population.
- Management information systems need to be adapted to identify the differential experiences of diverse client populations.
- Staff in managed mental health care programs are often overwhelmed by productivity demands and paperwork requirements.

CULTURAL COMPETENCE

CULTURAL COMPETENCE:

- Addressing system-level, organizational issues in dealing with a multicultural consumer population
  - Includes cultural sensitivity and cultural diversity
  - Goes beyond attitudes and staffing patterns
  - Includes skills and program elements which enhance services to a diverse consumer population

CULTURAL COMPETENCE CONTINUUM

- ***CULTURAL DESTRUCTIVENESS***
  - Views persons of color as inferior
  - Discrimination open and purposeful
- ***CULTURAL INCAPACITY***
  - Adopts the cultural inferiority premise
  - Discrimination present, but more subtle
  - Unfairness in hiring
  - Condescension towards minority consumers
- ***CULTURAL BLINDNESS***
  - Focus on delivering the same services to all consumers
  - Agency philosophy professes to be unbiased
  - Model of service is designed with the dominant cultural group in mind

CULTURAL COMPETENCE CONTINUUM

- ***CULTURAL PRE-COMPETENCE***
  - Commitment to civil rights and active attempt to better serve minorities
  - Focuses on symbolic efforts in hiring and programs
  - Core of the agency remains the same
- ***BASIC CULTURAL RESPONSIVENESS***
  - Respect for cultural differences
  - Program adaptations that take culture into account
  - Continuing self-assessment on culture-related issues

CULTURAL COMPETENCE CONTINUUM

ADVANCED CULTURAL COMPETENCE

Places culture in "high esteem"

Agency practice supported by:

- Research on cultural competence
- Proficiency among staff in developing culturally competent treatment approaches
- Dissemination of demonstration project findings
- Promotion of improved ties with wider community

Terry Cross. 1988. *Focal Point*

Challenges to cultural competence

- Beyond the ethical premise, is there a strong professional or organizational justification for culture competence?
- What type of evidence is needed to motivate organizations and their leadership?
- Is there a market justification?
- Will it actually help eliminate disparities?
- What do end users believe they can receive of value from cultural competence?
- What elements actually work?
- What are the feasible outcomes?

Receptivity

- Is cultural competence contesting professional culture?
- Elements of professional culture that support legitimacy: (1) rational-scientific method, (2) ethical values of the profession, (3) specialized knowledge, (4) self regulation

The development of evidence

- At this time we have no evidence regarding how much of what type of training will improve practice.
- Training alone is not likely to change practice
- At this time we have limited evidence regarding what types of organizational changes will improve practice
- We have only face validity, and experiments are needed.

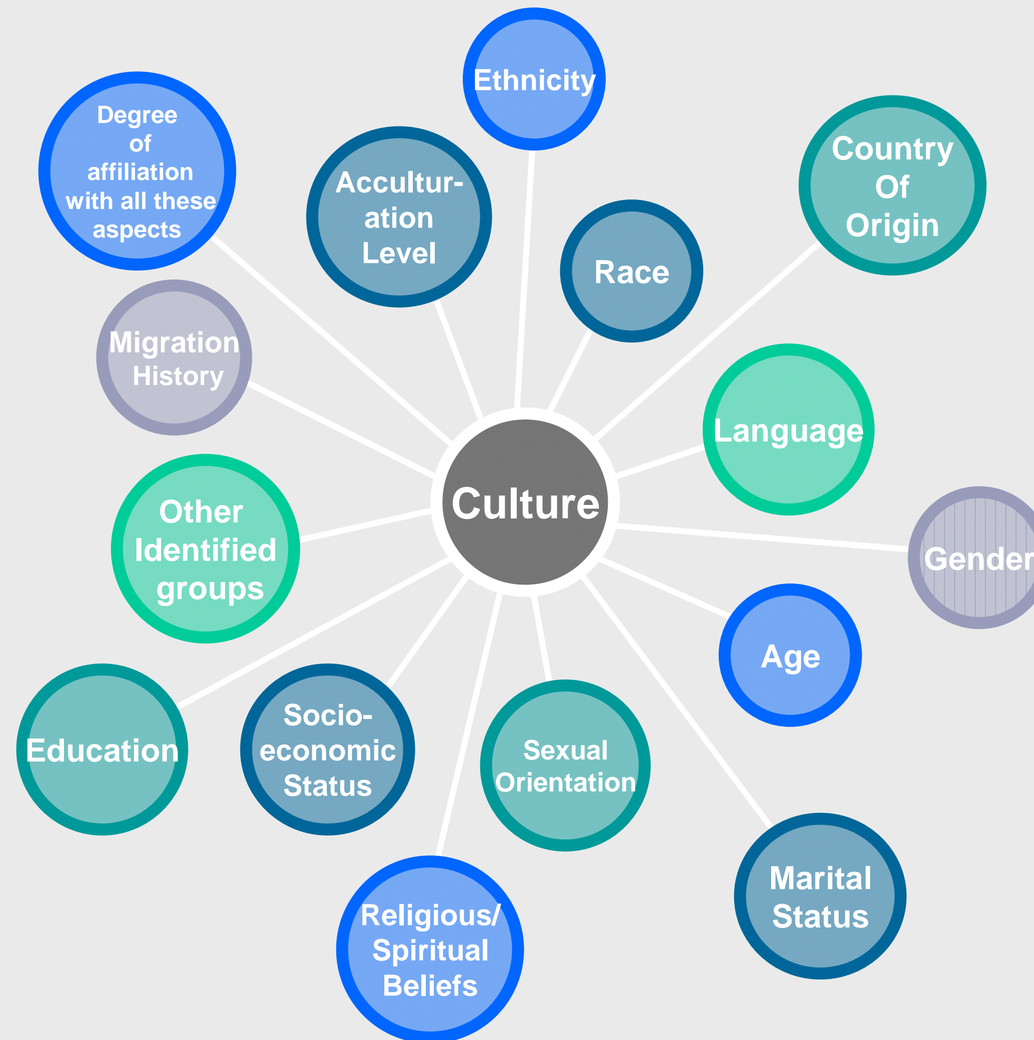
Reframing cultural competence as quality of care

- The capacity to deliver appropriate and effective treatment
- Why are these obstacles?
  - Cost
  - Knowledge
  - Acceptance in professional guilds
  - Overcoming organizational resistance

Improving quality through Individualized care

- Focus on the interaction between provider and patient, particularly that the patient receive the best possible care.
- “Individualized Care” encompasses elements of culture, language, proper diagnosis, evidence-based interventions, and other elements that makes each clinical encounter both culturally appropriate and effective.

Aspects of Cultural Identity



Adapted from: Ton H, Lim RF. The assessment of culturally diverse individuals. In: Lim RF (ed). *Clinical Manual of Psychiatry*. Arlington, VA: American Psychiatric Publishing; 2006:10.

Uniqueness of mental health

- Emphasis on communication accuracy and fidelity of meaning between patient and therapist
- Disorders have multiple idioms, signals are often confusing
- DSM-IV offers insufficient guidance about how to use culture in assessment without further training
- Stigma is strong for individual and family

Mental health services areas impacted by cultural competence

Beliefs about receiving mental health services;

Experiences in seeking mental health services;

Reasons for not seeking mental health services;

Family/support systems;

Perceptual/institutional barriers to mental health services;

Participant's self definition of "recovery."

Family and cultural competence issues

Role of the family in the course of mental illness;

Family’s perceptions of mental illness;

Support of family in managing and treating mental illness.

Cultural Factors

- **Self-definition of cultural identity bears on acculturation of individual, degree of integration with cultural of origin;**
- **Perceptions of how culture influences access to mental health services.**

Knowing your patient: how is cultural relevant?

- Patient disclosure
- Patient engagement
- Cultural nuances in problem presentation
- Social factors

Perspectives of Latino Clients – The Centrality of Language

- Latinos felt that it was important that the clinician could communicate in Spanish. Even those who spoke English, felt there were times when switching to Spanish would get the point across more effectively.
- *"The language is the most important thing. Nothing replaces the language."*
- *"The doctor told my interpreter that I need to learn English."*
- *"I was in a treatment where I was not able to communicate well and that affected the treatment."*

Perspectives of Latino Clients – Understanding Cultural Idioms

- Not only do clinicians need to understand the language in a general sense, they need to understand the specific meanings of cultural idioms that people use to describe their emotional problems
- *"I told my doctor that my nerves were bothering me a lot and he didn't understand."*

Perspectives of Latino Clients – Understanding Cultural Idioms

- Not only do clinicians need to understand the language in a general sense, they need to understand the specific meanings of cultural idioms that people use to describe their emotional problems
- *"I told my doctor that my nerves were bothering me a lot and he didn't understand."*

Perspectives of Latino Clients – Being Able to Share Emotions

- Latinos felt like they and clinicians needed to be able to share their emotions with each other; they needed a personal connection.
- *"Therapists can cope if you are mentally imbalanced, but can't cope if you pour your heart out. The best way to deal with emotion is with emotion."*

Perspectives of Latino Clients – Collectivism is Not Dependence

- Extended family is central in Latino culture. There is a tendency for intensive involvement with family to be viewed as dependence and to judge it negatively.

- *"Therapists need to understand the value systems of the culture because what may seem to be an unhealthy dependence, you know, may be just a natural value like, you know, a culture that prizes collectivism. We belong all to the bigger group as opposed to just being very independent."*

Cross-Cutting Concerns – The Stigma of Mental Illness

- All of the clients emphasized the challenge of dealing with the stigma of mental illness from family and the broader community
- *"We need to educate our families more and churches about mental illness and what it means – a lot of stigma's out there about exactly what it means when they say you're crazy. … I think mental health professionals need to get out there into the community more… and talk to people directly… It's not just television and the media. …*

Cross-Cutting Concerns – Clients are Raising the Cultural Issues

- During assessment, clients reported that it was often their role to educate the clinicians about the larger issues in their lives and to make the connections between cultural issues and their mental health problems.

Therapists Need to Understand Their Own Values

- *"The actual therapist should understand his or her own values. I mean, what you walk in the room with. Because if you understand that as a factor, then, you know, it kind of puts things in perspective when dealing with other people. You don't assume, you know? You just see yourself as one of many. And you kind of have better control of your own assumptions and stereotypes and gut reactions that you would have."*

The Seven Primary Domains of Measuring and Reporting Cultural Competency are:

1. Leadership
2. Integration into Management Systems and Operations
3. Patient-Provider Communication
4. Care Delivery and Supporting Mechanisms
5. Workforce Diversity and Training
6. Community Engagement
7. Data Collection, Public accountability and Quality Improvement (QI)

Recommendations for moving forward

- We need much more focused research on ethnic issues
- Need to go beyond rhetoric – need policy commitment
- Ethnic issues need to be depoliticized – "quality of care"
- Provide "crisp" (not rare and exotic) examples in training materials, practical guidelines, "vignettes" in key areas in clinical training, and train clinicians using case consultation
- Build the pipeline for greater diversity in workforce
- Clarify and enforce federal regulations about language and cultural competence
- Provide feedback, rewards, accountability mechanisms for health care organizations