



Why Cross Cultural Competency?

The Importance and Need for
Cross Cultural Competency in
Behavioral Health Treatment


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“Behavioral Health clinicians and their staff are in the business of helping and healing. Surely they don’t really need to worry about ‘Cultural Competency’?”

‘Do no harm’ and good intentions – aren’t they enough?

The evidence says ‘No’.



The case for Cultural Competency involves more than respect; it is pivotal to providing competent and effective mental health treatment.

Objectives

The learner should be able to:

1. Name the three types of barriers to behavioral health treatment for racial/ethnic minorities.
2. Give two historical examples of disparity in treatment of a minority racial/ethnic population.
3. Name one of the professional organizational aids for cultural competency.

Report of the Surgeon General

The groundbreaking Report of the Surgeon General of the United States on Mental health published in December 1999 included important findings on the mental health status of racial/ethnic minorities. Key findings included:

- *Ethnic/racial minorities mental health needs continue to be unmet.*
- *An understanding of cultural and sociopolitical factors that affect ethnic/racial minorities is needed.*
- *Cultural Competence in delivery of mental health services is essential to ‘the psychological and physical well-being of persons of color’.*

U.S. Department of Health and Human Services. 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, National Institutes of Health, National Institute of Mental Health, 1999.

The Mental Health Provider and Treatment of Ethnic/Racial minorities

In November 2003 the APA added an emerging finding to the Surgeon General's Report:

'The mental health practitioner is not immune from inheriting the prejudicial attitudes, biases, and stereotypes of the larger society.'

This APA report also found that 'traditional mental health care is often *inappropriate and antagonistic* to the cultural values' of ethnic minorities.

Psychological Treatment of Ethnic Minority Populations, Council of National Psychological Associations for the Advancement of Ethnic Minority Interests, November 2003, p. 4-5.

*Barriers to Treatment for
Minority Ethnic & Racial Groups*



Types of Barriers to Treatment

Patient – Barriers that originate from the patient side

- *This may include barriers such as community stigma and lack of knowledge concerning mental health.*

Provider – Barriers originating on the provider's side

- *Some barriers may include lack of language aids, ignorance or dismissal of cultural expressions and structure, unequipped or untrained staff, and unawareness of personal prejudices/biases.*

Systemic – Barriers that are built into the system of care

- *Lack of meaningful response to inequities, discreet/separated care systems and ineffective coordination of care, low numbers of racially/ethnically diverse providers, and poor implementation of evidence-based and standard of care treatment with minority populations.*

Barriers Common to most Racial/Ethnic Minorities

- Major barriers for African Americans, Asians, Native Americans, and Hispanic/Latinos and other minority persons attempting to access mental health care include, but are not limited to:
 - ✓ *Lack of services*
 - ✓ *Lack of mental health providers of similar racial/ethnic background and in the member's primary language*
 - ✓ *Perceived and Experienced Mistreatment*
 - ✓ *Poor provider patient communication*
 - ✓ *Inadequate and Inappropriate treatment*
 - ✓ *Mistrust of both majority culture providers and systems of care*
 - ✓ *Stigma*
- *While there continues to be a barrier simply in access to care, the next set of slides will review some of the barriers involved when care is available.*

Barriers Related to Provider Race/Ethnicity

- Most racial/ethnic minorities would prefer a practitioner of their same ethnic background, but this is often not available.
 - *Both Hispanics/Latinos and African Americans are large minorities with each at least 17% of the US population, however NAMI found:*
 - ✓ Only 1% of licensed psychologists in the US identify themselves as Latino
 - ✓ 3.7% of psychiatrists identify as African American
 - ✓ 1.5% of psychologists identify as African American
- The percentages for other racial/ethnic minorities are similar.

Barrier of Inadequate Assessment and Treatment



- Multiple research shows that Ethnic minorities with symptoms of depression are often not treated or referred for treatment.
- Bilingual patients have been found to be evaluated differently and undertreated when interviewed in English versus their primary language.
- Ethnic minorities that do begin treatment may drop out at a higher rate, in part due to culturally ignorant or insensitive treatment.

Margarita Alegria, PhD, Pinka Chatterji, PhD, Kenneth Wells, MD, MPH, Zhun Cao, PhD, Chih-non Chen, PhD, David Takeuchi, PhD, James Jackson, PhD, and Xiao-Li Meng, PhD. Disparity in Depression Treatment among Racial and Ethnic Minority Populations in the United States, PSYCHIATRIC SERVICES November 2008 Volume 59 1264-1272.

Miranda J, Duan N, Sherbourne C, et al. Improving Care for Minorities: Can Quality Improvement Interventions Improve Care and Outcomes For Depressed Minorities? Results of a Randomized, Controlled Trial. Health Services Research. 2003;38:613–630.

Examples of Disparities in Treatment

- Review of admission data from inpatient psychiatric facilities shows disproportionately high rates of admission of African Americans, with both Asians and Native Americans also admitted at a higher rate than Caucasians.
- Multiple reviews of NIMH data indicating that African Americans were more frequently diagnosed with severe mental illnesses than their white counterparts found these diagnostic errors were partially due to the diagnostician's lack of cultural competency in interpreting symptom presentation.
- Melfi et al studied Medicaid recipients being treated for depression and found that African Americans were less likely to be prescribed an antidepressant and if needing an antipsychotic they were more likely to receive an injectable than an atypical with fewer side effects.

SAMHSA, *Cultural Competence Standards in Managed Care Mental Health Services: Four Underserved/Underrepresented Racial/Ethnic Groups*, 1998.

Melfi C, Croghan T, Hanna M, Robinson R. *Racial variation in antidepressant treatment in a Medicaid population*. J Clin Psychiatry. 1997;61:16–21

Snowden LR. Bias in mental health assessment and intervention: Theory and evidence. American Journal of Public Health. 2003;93:239–243.

Lower quality, Under-diagnosis or inappropriate services

- Per the National Institutes of Mental Health multiple studies show that, parallel to findings for ethnic disparity in physical health treatment, African Americans, American Indians and Hispanics are less likely to be appropriately diagnosed and treated for mental health and substance use issues.
- Data pooled from the National Institute of Mental Health Collaborative Psychiatric Epidemiology Surveys confirms multiple other studies showing that not only are African Americans under-diagnosed for depression, but when diagnosed they are significantly less likely to receive adequate depression care compared to non-Hispanic whites.

González, H.M., Vega, W.A., Williams, D.R., Tarraf, W., West, B.T., and Neighbors, H.W. *Depression Care in America: Too little for too few*, Archives of General Psychiatry 2010;67(1):37-46

Reported Disparities in Mental Health Treatment (continued)

- Racial/ethnic minorities, when surveyed, identify common negative experiences of mental health treatment
 - Ethnic minorities whose first language is not English report discourteous and even hostile treatment by mental health staff, not explainable by misunderstanding of cultural differences.
 - Mental health providers and their staff are often reported to take an authoritarian and even confrontational communication style with ethnic minorities
 - Treatment often neglects consideration of family, religion, and language needs.

Morales, L. S., Elliott, M. N., Weech-Maldonado, R., Spritzer, K. L., & Hays, R. D. (2001). *Differences in CAHPS adult survey reports and ratings by race and ethnicity: an analysis of the National CAHPS benchmarking data 1.0*. *Health Services Research, 36*(3), 595–617.

Cultural Awareness

Dominant Culture

Greet with a handshake; how are you
Limp handshake = low integrity
Little eye contact - disrespectful
Roaming eye contact with everyone
Laugh when it is funny
Agreeable, therefore you agree with me
Loose fitting 3-piece clothing = formal
Punctuality = respectful
Dining etiquette, knife/fork/spoon
Meat, wide variety, vegetarians
Alcohol based on age, type by class
Visible sole of the shoe acceptable/in chair

Some Other Cultures

Half or full bow, hug, hug and kiss, two cheeks
Limp handshake = respect, humility
Little eye contact = humility, respectful
Disrespectful to male authority or elder
Laugh a lot, for things "not funny"
Agreeable, respect your authority (but don't agree)
2-piece, covered head-toe, color/material
Early = respectful; tardy = rank/attention
Chopsticks, double spoons, fingers
No beef, no scavengers, blessed
Wine for entire family, none, men only
Unacceptable, leave shoes at the door

The Journey Towards Cultural and Linguistic Competency






Mistreatment: Over-diagnosis of serious mental illness

- Schizophrenia and psychotic disorders are consistently over diagnosed in African Americans and Hispanic populations.
- Multiple studies over the past 3 decades conclude that clinician bias has led to a high level of misdiagnosis of schizophrenia African American patients.
- Psychiatrist Michael Smith of the University of California at Los Angeles studied the effects of culture & ethnicity on psychiatry and found that when hospitals diversified their staffs to include Spanish-speaking doctors half of the cases of Hispanics diagnosed as schizophrenic were re-diagnosed as depression.

Michael Gara, William Vega, Stephan Arndt, Michael Escamilla, David Fleck, William Lawson, Ira Lesser, Harold Neighbors, Daniel Wilson, Lesley Arnold, Stephen Strakowski. *Influence of Patient Race and Ethnicity on Clinical Assessment in Patients with Affective Disorders*, Arch Gen Psychiatry. 2012;69(6):593-600.

Vendatam, Shankar. 6/26/2005. *Patient's Diversity Is Often Discounted*, Washington Post, quoting Michael W. Smith, M.D., assistant professor of psychiatry at UCLA and a principal investigator of the Research Center on the Psychobiology of Ethnicity .



An abundance of research over the past two decades has shown that unless mental health practitioners *actively* pursue cultural competency they have a much higher likelihood of inadequately, and at times, inappropriately serving their minority clients resulting often in poor outcomes and a widening of the barriers to treatment for ethnic/racial minorities.

Cultural Competency

Dimensions Include:

- ✓ **Awareness**
- ✓ **Knowledge**
- ✓ **Empathy**
- ✓ **Skills**
- ✓ **Flexibility**
- ✓ **Resource Adaptation**
- ✓ **Workforce Diversity**


Professional Organizations

All recognized National Professional organizations involved in Behavioral Health treatment include Cultural Competency as part of their Ethics.

Some behavioral health professional organizations provide an extra layer of support in this area. A few examples of this support include:

*American Psychiatric Association's
Cultural Formulation Interview (CFI)*

*National Association for Social Work's
20 page 'Standards of Cultural
Competency'*

A decorative graphic at the bottom of the slide consists of several colorful, semi-transparent geometric shapes, including triangles and polygons in shades of yellow, blue, red, green, and purple, scattered across the bottom right area.

American Psychiatric Association

Free and available online as well as in the DSM-5 is the APA's Cultural Formulation Interview (CFI).

<http://www.psychiatry.org/psychiatrists/practice/dsm/dsm-5/online-assessment-measures#Disorder>

Available at the same link are Supplementary Modules. Some of these expand areas already in the CFI and some address specific age groups. These modules expand the list of possible questions greatly, with suggestions for phrasing questions.

Additionally there is a module for immigrants and refugees, and one for care givers.

The Cultural Formulation Interview has four General areas of query:

- ✓ Cultural Definition of the Problem
- ✓ Cultural Perceptions of Cause, Context, and Support
- ✓ Cultural Factors Affecting Self-Coping and Past Help Seeking
- ✓ Cultural Factors Affecting Current Help Seeking


National Association for Social Work

NASW provides a 20 page document titled 'Standards of Cultural Competency. NASW defines Cultural Competency as 'the process by which individuals and systems respond respectfully and effectively to people of all cultures, languages, classes, races, ethnic backgrounds, religions, and other diversity factors in a manner that recognizes, affirms, and values the worth of individuals, families, and communities and protects and preserves the dignity of each.'

<https://www.socialworkers.org/practice/standards/naswculturalstandards.pdf>

NASW standards for Cultural Competency include guidance in 10 areas:

1. Ethics and Values
2. Self-Awareness
3. Cross-Cultural Knowledge
4. Cross-Cultural Skills
5. Service Delivery
6. Empowerment and Advocacy
7. Diverse Workforce
8. Professional Education
9. Language Diversity
10. Cross-Cultural Leadership



The Migrant Clinician Network article on Cultural Competency elegantly and succinctly captures the spirit of this diverse age:

“Cultural competency in practice requires that one be a continual learner. Cultural humility and a desire to better understand your patients are essential. Models for improvement suggest that we often make the greatest progress by taking a series of small steps and pausing frequently to assess if that step is a step in the right direction.”

Only a beginning...

The information in this presentation is meant to highlight some of the cultural characteristics and identified needs of persons belonging to some of the major ethnic groups in Louisiana. This information is simply an overview and not meant to be comprehensive.

It should also be remembered that each person is an individual, may embrace and display varying characteristics common to their ethnic background, and should always be approached and treated based on their individual situation and needs.

Magellan Assists with Cultural Competency

From the Magellan Provider Handbook:

Magellan's responsibility is to:

- Provide ongoing education to deliver competent services to people of all cultures, races, ethnic backgrounds, religions, and those with disabilities;
- Provide access to language assistance, including Braille for the visually impaired, and bilingual staff and interpreter services to those with limited English proficiency, during all hours of operation at no cost to the consumer;
- Provide easily understood member materials, available in the languages of the commonly encountered groups and/or groups represented in the service area;
- Provide access to TDD / TTY services for the hearing impaired;
- Monitor gaps in services and other culture-specific provider service needs. When gaps are identified, Magellan will develop a provider recruitment plan and monitor its effectiveness.

Need language assistance?

Contact Magellan at 800-424-4489

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Thanks

