TDMHSAS BEST PRACTICE GUIDELINES

Cultural Competence

Providers of mental health services must acknowledge that culture counts. For the patient, culture will influence how s/he communicates and manifests his/her symptoms. It might also affect whether the patient will even seek out mental health services. For the clinician, culture will play an important role in diagnosis, treatment, and service delivery. It is estimated that population growth for youth of color will far exceed that of Caucasian youth. During the 20-year period between 1995 and 2015, the population growth for Caucasian youth is expected to hover around three percent, compared to 17 percent for Hispanic youth; 19 percent for African American youth; and 74 percent for Asian American youth (Nguyen, Huang, Arganza, & Liao, 2007). Of particular importance are the issues to which clinicians must be attuned in order to provide effective and efficient service to racial and ethnic minorities.

Any discussion of the services that youth receive would be incomplete without highlighting that issues of cultural competence and institutional racism are rife in this field. Youth of color, especially African Americans, are more likely to receive harsher treatment when involved in school discipline proceedings, child welfare cases, or the juvenile justice system. Tunneling, then, is not only a function of a youth's problem, but is also influenced by conscious and unconscious biases on the part of government agencies (Ross & Miller, 2005, p. 5, cited in Podmostko, 2007).

- **African Americans**: Research showed that errors in diagnosis are made more often for African Americans than for Caucasians with certain disorders, like schizophrenia and mood disorders. In addition, it is less likely that African Americans will receive clinical care that adheres to evidence-based practice in accordance with professional treatment guidelines, when compared to Caucasians (DHHS, 2001).

- **American Indians and Alaska Natives**: Limited research exists on these subgroups, though appropriateness and outcome issues are critical for planning treatment and prevention programs. Nevertheless, it should be noted that these subgroups prefer traditional healing methods as treatment options. Besides getting out of the "office" setting, clinicians should be willing to incorporate into treatment traditional healing and spiritual activities and customs that are likely part of the client's belief system and that of his/her family (Barnett & Bivings, 2003; DHHS, 2001).

- **Asian Americans and Pacific Islanders**: Limited research abounds for these subgroups as well. However, patients from these subgroups may benefit from lower dosages of certain drugs than typically prescribed for whites because of differences in their rates of drug metabolism. Whenever possible, try to match these patients with therapists of the same culture. The end result would likely be higher rates of mental health service utilization (Africa & Carrasco, 2011; DHHS, 2001). Efforts should also be made not to "lump" these subgroups together as "one". Their languages and dialects are quite diverse (in excess of 100) and typically resources are not available in sufficient diversity to accommodate this subgroup (Africa & Carrasco, 2011).

- **Latino Americans**: As with many other subgroups, research is limited; yet, the data suggests that this subgroup can experience favorable outcomes, given mental health treatment (DHHS, 2001). Clinicians who present as distant or cold in the therapeutic relationship will experience high attrition

rates from their Latino clients. Self-disclosure is also a requirement for a successful therapeutic relationship (Barnett & Bivings, 2003). Like African Americans, Latinos, too, are less likely to receive evidence-based clinical care in accordance with professional treatment guidelines (DHHS, 2001).

Culture must always weigh into the mental health service delivery equation. Mental health professionals should use one or more of the following strategies in their efforts to provide the highest quality of care to every child and family, regardless of race, ethnicity, cultural background, English proficiency or literacy.

- Provide interpreter services. Recommended practices for working with interpreters can be found at the website of the National Association of School Psychologists (NASP). The practices are designed to be applicable during interviews or assessment sessions. They also assume that the interpreter has a high level of proficiency in English and the second language, as well as adequate training working in the setting. (See Lopez, 2002). A PDF containing the practices can be downloaded from the following link: http://www.nasponline.org/resources/culturalcompetence/recommend.pdf.
- Recruit and retain minority staff.
- Provide training to increase cultural awareness, knowledge, and skills. When is the last time your staff attended cultural competence training? When is the last time you attended training in cultural competence?
- Coordinate with traditional healers. Healing practices figure prominently in the lives of Native Americans and Alaskan natives (DHHS, 2001).
- Use community health workers
- Incorporate culture-specific attitudes and values into health promotion tools
- Include family and community members in health care decision making
- Locate clinics in geographic areas that are easily accessible for certain populations
- Expand hours of operation
- Provide linguistic competency that extends beyond the clinical encounter to the appointment desk, advice lines, medical billing, and other written materials

Fourteen culturally and linguistically appropriate services (CLAS) standards in health care, organized by themes, have been developed and issued by the Department of Health and Human Services, Office of Minority Health. Actual standards can be found http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=15 (DHHS Office of Minority Health, 2007). ***CLAS mandates (Standards 4, 5, 6, and 7) are current Federal requirements for all recipients of Federal funds***. The CLAS mandates focus on: 1) offering and providing language assistance services without cost and in a timely manner; 2) providing verbal and written notices of rights to receive language assistance services in the service recipient's preferred language; 3) assuring the competence of language assistance services; and 4) making available easily understood materials including visuals in languages of the commonly encountered/represented groups in the service area. In addition, the American Psychological Association (APA) publishes *Guidelines for Providers of Psychological Services to Ethnic, Linguistic, and Culturally Diverse Populations*. These guidelines provide a sociocultural framework to better aid the mental health professional in considering culture in his/her interactions with diverse populations and, additionally, offer suggestions on how to interface with various groups (APA, 1990). They can be obtained from http://www.apa.org/pi/oema/resources/policy/provider-guidelines.aspx. Georgetown University's

Center for Child and Human Development (n.d.) maintains a National Center for Cultural Competence website that houses a plethora of resources and tools, including publications and promising practices. The material is available in both English and Spanish, and can be accessed from the following link: http://www11.georgetown.edu/research/gucchd/nccc/.

Cultural competence is more than ethnicity, race, or language issues and the specialized training required of providers of mental health services in Tennessee encompasses the broadness of the topic. Network providers that render behavioral health services for Managed Care Organizations (MCOs) must provide specialized training in cultural competence and diversity to all staff, licensed as well as staff for whom a license is not required. Cultural competence training may emphasize eye contact, health values, help-seeking behaviors, work ethics, spiritual values, attitudes regarding treatment of mental illness and substance abuse, language, dress, traditions, notions of modesty, concepts of status, and/or issues of personal boundaries and privacy. Staff training should occur within the first 90 days of employment initially, a requirement that can be met either through training or assessment of competency. Thereafter, this specialized training should be documented annually (TDMHSAS and Bureau of TennCare, 2010).

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