Cultural Competence

Gains Made Challenges Ahead

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Overview

- Disparities in Behavioral Health: Why we are here today
- Cultural Competence: Gains Made and Moving Forward
- Ongoing Challenges and Emerging Solutions

Individual Cultural Competence

"The state of being capable of functioning effectively in the context of cultural differences"

Elements of Cultural Competence

1. Awareness and acceptance of difference
2. Awareness of own cultural values
3. Understanding the "dynamics of difference"
4. Development of cultural knowledge
5. Ability to adapt practice to fit the cultural context of the family (Cross, 1989)

Organizational Cultural Competence

"A set of congruent practice skills, attitudes, policies, and structures, which come together in a system, agency or among professionals and enable that system, agency or those professionals to work effectively in the context of cultural differences. "

Organizational Elements of Cultural Competence

- Valuing diversity
- Cultural self assessment of organization
- Managing for the dynamics of difference
- Institutionalization of cultural knowledge
- Adaptation to diversity
  - Policies
  - Values
  - Structure
  - Services

Organizational Components

Advisory Committees
Review Procedure
Cultural Consultants
Cultural Competence Plans
Cultural Coordinator
Facility/Décor
Job Descriptions

STRUCTURE
PRACTICE
POLICY
ATTITUDE

Organization Cultural Competence

Extended Family Support
Identity Enhancement
Values Clarification
Ethnographic Interviewing
Cultural Assessment
Clinical/Cultural Plans
Context Stretching
Cross-cultural Supervision

Agency Standards
Mission Statement
Job Qualifications
Cultural Competence
    Policy Statement

Self-Assessment
Training
Increased Contact
Staffing
Collaboration

Cultural Competence Continuum
(Cross, 1989)

- Culturally Destructive
- Cultural Incapacity
- Cultural Blindness
- Pre-Competence
- Basic Cultural Competence
- Cultural Proficiency

"Somewhere between cultural incapacity and basic cultural competence lie the roots of disparity."
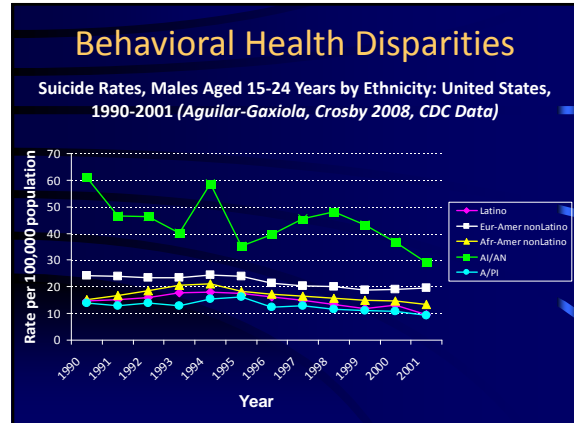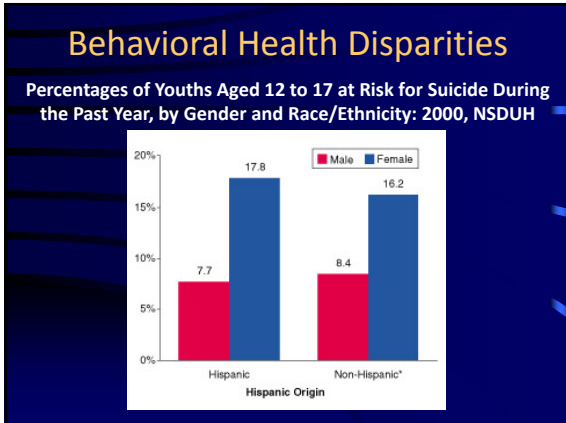
Child Well-Being
(Sample Items)

KIDS COUNT DATA	Total	White	African American	Asian and Pacific Islander*	American Indian*	Latino
Child death rate (deaths per 100,000 children ages 1 - 14)	22	20	31	15	29	19
Rate of teen deaths by accident, homicide and suicide (deaths per 100,000 teens ages 15 - 19)	50	48	63	28	92	47
Percent of teens who are high school dropouts (ages 16 - 19)	8	6	10	5	10	17
Percent of children in poverty	17	9	32	12	35	29

Temporary Assistance To Needy Families (CDF, 2001)

- 30% of recipients were White;
- 39% were Black;
- 26% were Hispanic;
- 2.1% were Asian, and
- 1.3% were Native American (under represented)

Behavioral Health
(CMHS, 2003)

- African Americans
  - More likely to experience a mental disorder than their white counterparts
  - Less likely to seek treatment but more likely than whites to receive inpatient care
- Hispanics
  - Rate of mental illness tends to be similar to that among non-Hispanic whites
  - Hispanic women tend to suffer from depression more often than Hispanic men

Behavioral Health
(CMHS, 2003)

- Asian American/Pacific Islanders
  - Only 25 percent as likely as whites to seek outpatient care
  - When they do seek care, they are more likely to be misdiagnosed as "problem-free"
- American Indians/Alaska Natives
  - Alcohol-related deaths among Native Americans ages 15-24 are 17 times higher than the national averages
  - The suicide rate for Native American youth is three times the national average (10X for some*)
  - Only one trained mental health provider for every 17,000 Indian Children (Georgetown, 1996)

Behavioral Health Disparities

Percentages of Youths Aged 12 to 17 at Risk for Suicide During the Past Year, by Gender and Race/Ethnicity: 2000, NSDUH

Behavioral Health Disparities

Suicide Rates, Males Aged 15-24 Years by Ethnicity: United States, 1990-2001 *(Aguilar-Gaxiola, Crosby 2008, CDC Data)*

Juvenile Justice

- African American youth are 15% of the population but 26% of those arrested and 44% of those detained (CWLA, 2003)

- American Indian youth are represented at 2.4 times the rate of Whites in state and federal juvenile justice systems and in secure confinement (DOJ, 1999)
  - Incarcerated Indian youth are much more likely to be subjected to the harshest treatment in the most restrictive environments (Pepper spray, restraint, isolation and death while in confinement appear to be grossly and disproportionately applied to Indian youth) (YLC, 2003)

Theories Of Disproportionate Representation

- View I: "Disproportionate Need"
  - Poverty
    - American Indian/Alaska Native: 35% in poverty (rural 45%)
    - African American: 30% (rural 46%)
    - Hispanic: 28% (rural 41%)
    - Asian-Pacific Islander: 12% (unknown)
    - White: 10% (rural 12%)

Theories Of Disproportionate Representation

- Link Between Poverty and Maltreatment
  - Families with incomes under $15,000 are 26.5 times more likely to have a substantiated incidence of maltreatment
  - Neglect incidents are three times that of abuse (NIS-3)
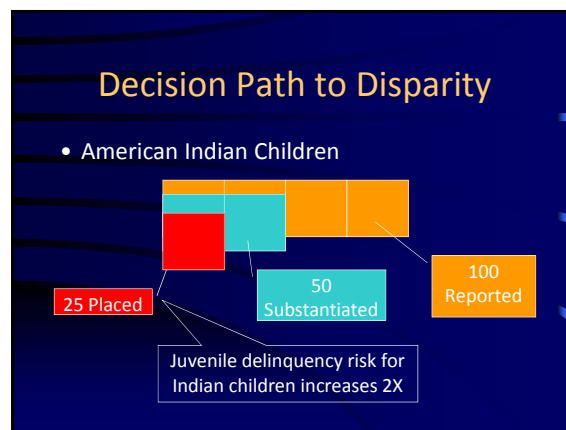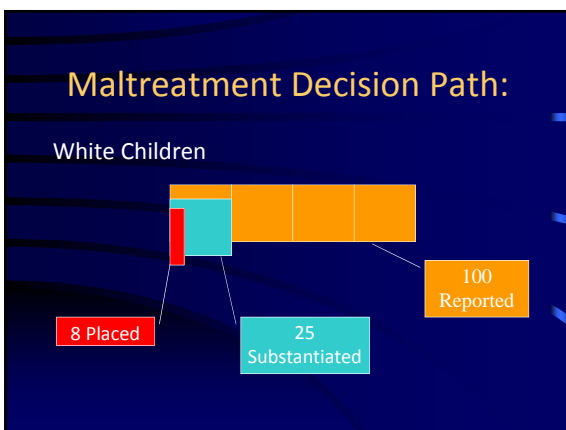
Theories Of Disproportionate Representation

- View II: "Bias in Decision Making"
  - Differential treatment: Reporting
    - African American and White women are equally likely to test positive for drugs during pregnancy
    - African American women are ten times more likely to be reported to CPS as a result of a positive test (USGAO, 1994)

Theories Of Disproportionate Representation

– Different treatment: Investigation and Substantiation

- Indian children are victims of maltreatment at about the same rate as other children nationally, however, they:
  - Are substantiated as maltreated twice as often as white children
  - Experience placement 3 times as often (CWLA, 2003)

Theories Of Disproportionate Minority Representation

- View II: Bias and Child Welfare Decision Making
  - Differential treatment: Service Choices
    - All children of color are less likely to receive family preservation
    - Families of color are less likely to receive mental health, substance abuse or supportive services
    - Families of color are less likely to receive reunification services
    - Resource families of color are less likely to receive help to adopt

Maltreatment Decision Path:

White Children

100 Reported

8 Placed

25 Substantiated

Decision Path to Disparity

- American Indian Children

100 Reported

25 Placed

50 Substantiated

Juvenile delinquency risk for Indian children increases 2X

Child Welfare Services

- Families received very few poverty reduction services
- Families receive few housing related services.
- Families receive few mental health services
- Families receive few substance abuse treatment services

Linking Maltreatment, Placement, Delinquency and Mental Health

- Victims of maltreatment have delinquency rates an average of 47% higher than non-victims
- 16% of children placed in substitute care experience at least one delinquency petition compared to 7% of victims not removed from their families
- Placement instability further increases risk for delinquency
- One in five juvenile offenders have an untreated SED (CWLA,2003)

Potential Answers

- Research to better understand the dynamics
- Reduction of poverty, housing as a right, access to treatment
- Community based services that are child centered and family driven.
- Cultural competence among professionals, organizations and systems

Let's remember why we are really here today...

The Cultural Competence Action Team of the TA Partnership

- Formed in 2005 to address the cultural and linguistic competence technical assistance needs of the Children's Mental Health Initiative
- Composed of seven members
- Provide technical assistance, training, consultation, product development and facilitation

CCAT

- Formed a Community of Practice
  - Five Learning Communities
    - Latino
    - African Heritage
    - Asian American, Native Hawaiian and other Pacific Islander
    - LGBTQI2-S
    - Fatherhood Initiative

CCAT – COP Resources

- Monthly community calls/webinars
- Webpage
- CLC Implementation Guide
- Products
  - CLC Plan Template
  - CLC Committee Description
  - CLC Sample Budget and spreadsheet
  - CLC Coordinator sample job description
  - CLC Tip Sheet

Special Analysis for Surgeon General's Report on Culture, Race and Ethnicity

- The 2001 Surgeon General's Supplement Report on Mental Health: Culture, Race and Ethnicity found very little empirical evidence regarding outcomes of mental health care for ethnic/racial groups (Miranda, et al., 2003)
- Between 1983 and 1999, nearly 10,000 participants were included in randomized control trials evaluating the efficacy of interventions for four mental health conditions (bipolar disorder, schizophrenia, depression and ADHD)
  - 561 African Americans
  - 99 Latinos
  - 11 Asian Americans and Pacific Islanders
  - 0 American Indians and Alaska Natives were available for analysis. Furthermore, not a single study analyzed the efficacy of the treatment by ethnicity or race (Miranda et al., 2003)

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Cautions

- Ethnic/racial groups "are largely missing from the efficacy studies that make up the evidence base for treatments…well-controlled efficacy studies examining outcomes of mental health care for minorities are rarely available… There is *some,* albeit limited research, that *some* ESTs are appropriate for *some* ethnic groups   (Miranda et .al., 2005)
- Most ESTs and EBTs are conducted with White, educated, verbal and middle class individuals and may not generalize to ethnic/racial groups and third world communities   (Bernal & Scharron-del-Rio, 2001)
- We should be concerned about the "dogmatism of an exclusive ideology." Imposition of EBTs on another cultural group can be considered a new form of "cultural imperialism"
  (Bernal & Scharron-del-Rio, 2001)

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Who Defines Evidence?: We Need Other "Measuring Sticks"

- What if "evidence" was defined broadly and not from one world view or epistemology?
- What if policy makers, researchers, funders, administrators, key decision makers added other definitions of "evidence" (from other world views) to their repertoire of accepted research, practice and policy and funding criteria?
- What if "evidence" was also defined from the "bottom up" instead of only from the "top down?"

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Practice Based Evidence

- "A range of treatment approaches and supports that are derived from, and supportive of, the positive cultural attributes of the local society and traditions. Practice Based Evidence services are accepted as effective by the local community, through community consensus, and address the therapeutic and healing needs of individuals and families from a culturally-specific framework. Practitioners of practice based evidence models draw upon cultural knowledge and traditions for treatments and are respectfully responsive to the local definitions of wellness and dysfunction......"
  (Isaacs, Huang, Hernandez, Echo-Hawk, 2006)

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An Alternative: Community Defined Evidence (CDE)

- Working Definition: A set of practices that communities have used and determined to yield positive results as determined by community consensus over time and which may or may not have been measured empirically but have reached a level of acceptance by the community
  (Martinez, 2008)

- A supplemental approach to Empirically Supported Treatments (ESTs) and Evidence Based Treatments (EBTs)

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Community Defined Evidence Project (CDEP)

- The CDEP is a partnership of:
  - The National Latino Behavioral Health Association (NLBHA) and the
  - The National Network to Eliminate Disparities (NNED) in Behavioral Health
  - Working in collaboration with the Department of Child and Family Studies at the University of South Florida's Florida Mental Health Institute.
- The central goal of the CDEP is to discover and develop a model for establishing an evidence base using cultural and/or community indices that identify community-defined and based practices that work

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Continuing Challenges, Evolving Solutions

- Framing Disparities as Disability Burden
- The Essential Role of Data
- Quality Access and Care
- Financing
- The NNED: National Network to Eliminate Disparities in Behavioral Health

Disease Burden:
The Impact of Disparities: QALYs

- QALY (Quality Adjusted Life Years): a measure of disease burden, including both the quality and the quantity of life lived

- Cost effectiveness of problem drinking screening and brief counseling: $14,000-$35,000/QALY

- Cost effectiveness is measured by the average cost of each QALY that is saved by the provision of a particular health intervention
  - QALYs are a measure of survival adjusted for its value: 1 year in perfect health is equal to 1.0 QALY, while a year in poor health would be something less than 1.0.
  - A lower cost per QALY saved indicates a greater degree of cost effectiveness.

From AHRQ's National Healthcare Disparities Report, 2008

The Impact of Disparities: DALYs

DALY (Disability Adjusted Life Years): sum of years of potential life lost due to premature mortality and the years of productive life lost due to disability

Among the top 20 leading causes of DALYs for men in the US:
- Alcohol use (ranked 5)
- Self-inflicted injuries (ranked 9)
- Unipolar major depression (ranked 10)
- Drug use (ranked 13)
- Cirrhosis of the liver (ranked 17)

Among the top 20 leading causes of DALYs for women in the US:
- Unipolar major depression (ranked 2)
- Alcohol use (ranked 11)
- Post-traumatic stress disorder (17)
- Panic disorder (19)
- Anxiety disorder (20)

(McKenna, et al, 2005, "Assessing the Burden of Disease in the United States Using Disability-Adjusted Life Years")

The Impact of Disparities: DALYs

DALY: sum of years of potential life lost due to premature mortality and the years of productive life lost due to disability

Among the top 10 leading causes of DALYs for men in the US (ranked for race/ethnicity):
- Alcohol use (blacks-4; NA-1; whites-5)
- Self-inflicted injuries (NA-4; whites-7)
- Unipolar major depression (API-2; NA-8; whites-9)
- Drug use (API-9)
- Cirrhosis of the liver (NA-6)

Among the top 10 leading causes of DALYs for women in the US (ranked for race/ethnicity):
- Unipolar major depression (blacks-4; whites-2; API-1)
- Alcohol use (Hispanic-5; blacks-6; NA-1)

(McKenna, et al, 2005, "Assessing the Burden of Disease in the United States Using Disability-Adjusted Life Years")

Factors Contributing to Disparities

Institute of Medicine: identifies 3 categories of factors:

Patient-level:
- Socioeconomic status
- Language barriers
- Poor health literacy

Health case systems-level:
- Organizational complexity of a health care system
- Financial complexity of the system
- Geographic location of the health care facility

Care process-level:
- Characteristics of an individual provider that contribute to disparities (including racial and ethnic biases)

Smedley BD. Unequal treatment: Confronting racial and ethnic disparities in health care, 2003.

Factors Contributing to Disparities

Social Determinants of Health: conditions in which people are born, grow, live, work and age, including the health system; these circumstances are shaped by the distribution of money, power and resources at global, national and local levels, which are themselves influenced by policy choices

- Income and social status
- Social support networks
- Education and (health) literacy
- Employment/Working conditions
- Social environments
- Physical environments
- Culture
- Life skills
- Personal health practices and coping skills
- Healthy child development
- Biology and genetic endowment
- Health services
- Gender

http://www.who.int/social_determinants/en/

Evolving Steps/Solutions: Data

Need for Better and Useful Data: repeated call by national and community groups, government agencies, stakeholder groups.
"What you don't measure, doesn't get addressed"

Current Status:
- A lack of valid and reliable data (to help develop a collective understanding of racial and ethnic disparities)
- A lack of coordination and standardization policies and regulations regarding data collection
- A lack of widespread knowledge and understanding of OMB standards
- Data on social determinants of health (housing, employment, etc.)
- Insufficient racial and ethnic categories reflected in the standards (particularly given the wide variations of subgroups that exist within ethnicities)

Mathematica, 2009, Measuring Racial and Ethnic Disparities in Health Care: Efforts to Improve Data Collection

Data Essential For:

- Inform program development, planning, and priority setting
- Target quality improvement efforts
- Understand differences in performance within a plan
- Understand the health needs of specific populations and develop appropriate interventions
- Identify the need for and deploy resources for the provision of culturally and linguistically appropriate services
- Evaluate and monitor the effectiveness of interventions
- Make cross-institutional comparisons to detect variations in quality of care between entities

IOM, 2009, Race, Ethnicity, and Language Data: Standardization for Health Care Quality Improvement

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IOM Report: Race, Ethnicity and Language Data: Standardization for Health Care Quality Improvement

The IOM recommends:
» Collection of the existing OMB categories
»Collection of more fine-grained categories of "granular" ethnicity and language need (*granular ethnicity distinctions reveal differences in utilization of health care services and outcomes that can be hidden by only using the OMB categories*)
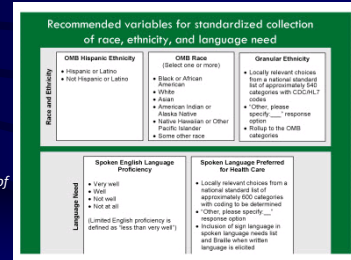
IOM, 2009, Race, Ethnicity, and Language Data: Standardization for Health Care Quality Improvement

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Quality Improvement: Using Data

Medicaid Managed Care Initiative:

- Use data on race ethnicity to:
  - Identify differences in health status,
  - Service use
  - Create Disparity Index
  - Develop, implement monitor targeted interventions aimed at these gaps/disparities
- General Uses
  - Priority setting
  - Determining translation and interpretation needs

Resource: *Reducing Racial and Ethnic Disparities: A Quality Improvement Initiative in Medicaid Managed Care Toolkit: www.chcs.org, 2007.*

Health Care Quality and Access to Care

Disparities in health care quality are staying the same or increasing
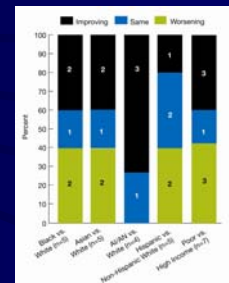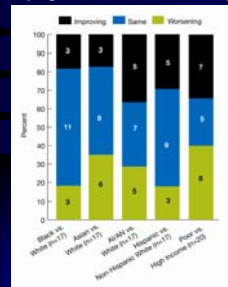
Disparities in access to care are staying the same or increasing

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Core Measures That are Getting Worse for More Than One Racial and Ethnic Group

Topic	Measure	Blacks	Asians	AI/AN	Hispanics
Cancer	Adults age 50 and over who received a colonoscopy, sigmoidoscopy, proctoscopy, or fecal occult blood test	*	*	*	*
Mental health and substance abuse	Adults with a major depressive episode in the last 12 months who received treatment for depression in the last 12 months	*			*
Respiratory diseases	Adults age 65 and over who ever received pneumococcal vaccination	*	*		
Patient centeredness	Adults with poor provider-patient communication	*	*		

Note: AHRQ Disparities Report 2008 A complete table of the disparities that worsened for specific populations can be found in Chapter 4, Priority Populations.

Quality Access

- Integrated Care: behavioral health care in primary care settings
- Linking Faith-based and behavioral health organizations
- Engagement and Outreach: community health workers, peer specialists, promotoras, patient navigators

A Health Example: Tuberculosis Community-based, Cultural Case Manager Model
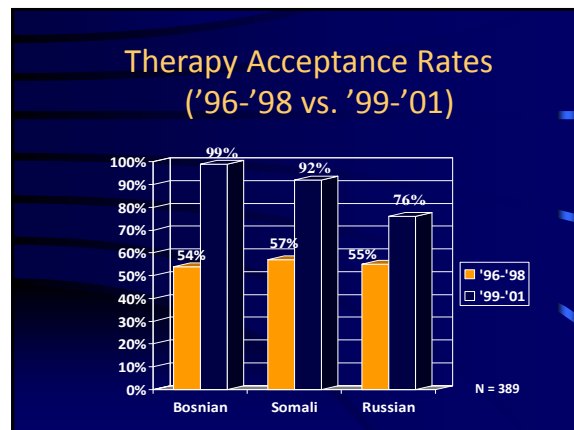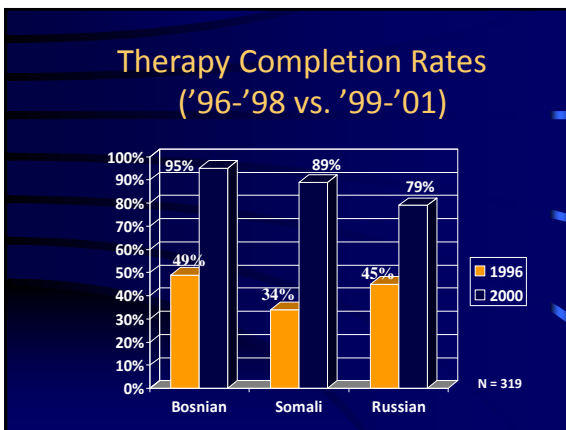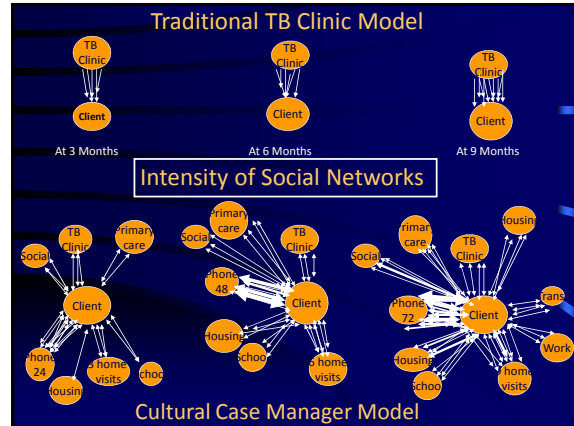*(Chaulk, 2004)*

Builds on the "local knowledge" of the target neighborhood.

Views cultural competence as not just skin color or language fluency

- Interpreters as mediators most effective.

Relies on "Neighborhood Health Messengers"—trusted, credible people from the community—who can translate information into and out of the neighborhood ("two-way flow of information") and help bridge the worlds of vulnerable families and public systems

Incorporates team orientation with communities and community residents--not just doctors and nurses seen as experts.

Traditional TB Clinic Model / Intensity of Social Networks / Cultural Case Manager Model

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Therapy Completion Rates ('96-'98 vs. '99-'01)

Bosnian: 49% (1996), 95% (2000); Somali: 34% (1996), 89% (2000); Russian: 45% (1996), 79% (2000). N = 319

Therapy Acceptance Rates ('96-'98 vs. '99-'01)

Bosnian: 54% ('96-'98), 99% ('99-'01); Somali: 57% ('96-'98), 92% ('99-'01); Russian: 55% ('96-'98), 76% ('99-'01). N = 389

A Focus on Trauma as Access and Quality Issues

- Understanding the trauma underlying behavioral health issues (mental health, substance abuse and related problems)
- Historical trauma
- Trauma-informed Care
- Reducing stigma of mental health through outreach regarding trauma
- Trauma Screening
- Association of trauma with other health problems

Financing Strategies

- Reimbursement of integrated culturally-traditional and alternative services
- Payment plans for faith-based healers, community health workers, cultural brokers, peer specialists
- Holistic health care services in reimbursement practices for public and private insurance
- Payment for interpreter services
- Sustain health coverage for offenders reentering community from incarceration

NNED Website
www.nned.net

National Network to Eliminate Disparities in Behavioral Health

- Vision
  - *Striving for behavioral health equity for all individuals, families, and communities.*
- Mission
  - *To build a national network of diverse racial, ethnic, cultural and sexual minority communities and organizations to promote policies, practices, standards and research to eliminate behavioral health disparities.*

NNED Desired Outcomes

- Link community providers, organizations and networks in diverse communities and research/training centers
- Identify and link pockets of excellence
- Develop an infrastructure for collecting, analyzing and disseminating information, best practices, research and policy
- Build capacity through learning collaboratives, internet training strategies, and community action
- Impact disparities via targeted actions through community partnerships
- Eliminate disparities by ensuring access to and availability of culturally appropriate, high quality, results-oriented care

Key Operations of the NNED

- Provide a network structure for the sharing, dissemination, and uptake of effective practices, policies, innovations and resources
- Provide a structure for peer training and technical assistance
- Foster researcher-provider collaborations
- Implement communication strategies
- Develop and support Learning Clusters
- Convene Webinar+ Plus Community of Practice

Learning Clusters

- Community-Defined Evidence Models to Measure Practice Effectiveness
- Culturally-Driven Public Education Campaigns on Mental Health Recovery and Prevention of Underage Drinking
- Parental Depression in Low-Income Culturally Diverse Communities
- Best Practices for Pacific Island and Native American Indigenous Communities
- Screening, Brief Intervention and Referral to Services (SBIRT) in Community Health Centers
- Developing Collaborations Between Faith-based and Healthcare organizations
- Integration of Behavioral Health and Primary Care
- Advocacy and Community Engagement

NNED Learning Cluster Workspace
http://nned.sharepointsite.net

Invitation to Join the NNED:
www.nned.net