NASMHPD

National Association of State Mental Health Program Directors
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Assessment #9

CULTURAL AND LINGUISTIC COMPETENCE AS A STRATEGY TO ADDRESS HEALTH DISPARITIES IN INPATIENT TREATMENT

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Eighth in a Series of Ten Briefs Addressing: *What Is the Inpatient Bed Need if You Have a Best Practice Continuum of Care?*

Cultural and Linguistic Competence as a Strategy to Address Health Disparities in Inpatient Treatment

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Executive Summary

Individuals receiving mental health services, and the children of those individuals, have greater cultural and linguistic disparities than individuals receiving any other health-related services, especially in inpatient treatment where there is a disproportionate number of cultural and ethnic minority populations. Research has found increased rates of anxiety, depression, post-traumatic stress disorder, suicide, and substance abuse in that is due in part to toxic stress linked to oppression and discrimination, poverty, inter-generational trauma, immigration or refugee status, assimilation or forced acculturation, and individual struggles with cultural identity development. Left untreated, this can lead to serious emotional disabilities in youth, severe mental illness in adults, and higher rates of inpatient treatment across age groups.

Cultural and linguistic competence (CLC) is a recognition of the unique cultural differences shaping the patient's access to treatment and his or her response and adherence to treatment regimens, and adapting screening and treatment interventions to that individual's cultural background and influences. A provider's CLC is an important element in ensuring that minority individuals in psychiatric inpatient treatment settings or at risk of being admitted to psychiatric inpatient treatment facilities achieve positive outcomes that avoid or hasten the duration of treatment in an inpatient setting.

This paper suggests a number of actions that State Mental Health Authorities (SMHAs) can take in advancing CLC before, during, and after inpatient treatment, in the areas of policy development, administration and infrastructure development, workforce development, systems coordination, and community and stakeholder engagement.

Introduction

> *People are only the symptom bearers of larger problems embedded within their community and society. It is our responsibility to know and understand who we serve.[1]*

Individuals receiving mental health services have greater cultural and linguistic disparities than individuals receiving any other health-related services, especially in inpatient treatment where there is a disproportionate number of cultural and ethnic minority populations.[2] In order to address these disparities and disproportionalities, we must break down barriers that prevent diverse groups[3] from pursuing mental health services earlier in the continuum of care, eliminate the social conditions that result in mental health problems for diverse

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[1] Reese L.E. & Vera E.M., Culturally Relevant Prevention: The Scientific and Practical Considerations of Community-Based Programs, *The Counseling Psychologist*, Vol. 35 No. 6, p. 770 (2007).

[2] Satcher D. & Druss B. Bridging mental health and public health. *Preventing Chronic Disease,* 7(1), A03. (2010), http://www.cdc.gov/pcd/issues/2010/jan/09_0133.htm.

[3] While we consider diversity in the broadest sense to include race, ethnicity, language, sexual and gender minorities, creed, economic status, ability, geography, for the purposes of this paper, we focus on racial/ethnic, language, and sexual/gender minority groups in comparison to Caucasians.

populations, and alter our methods of service delivery so that they might be more accessible to and appropriate for underserved populations,[4] and result in better outcomes.

Cultural and linguist competencies in mental health services will become an even more urgent need in the near future. Current trends show that the demographic profile of the United States is changing dramatically. The nation's population will rise from 296 million (2005) to 438 million by 2050, with 82 percent of this growth attributable to immigrants arriving between 2005 and 2050 and their descendants. By the mid-21st Century, nearly one in five Americans (19 percent) will be foreign-born. Minorities who have been disadvantaged in their access to mental health services will soon outnumber non-minorities.

Common Challenges that Lead to Inpatient Treatment of Minorities

Diverse minorities have many of the same mental health challenges as the majority population, but experience some mental health issues at higher rates. Research has found increased rates of anxiety, depression, post-traumatic stress disorder, suicide, and substance abuse in that is due in part to toxic stress linked to oppression and discrimination, poverty, inter-generational trauma, immigration or refugee status, assimilation or forced acculturation, and individual struggles with cultural identity development.[5, 6, 7] Left untreated, this can lead to serious emotional disabilities in youth, severe mental illness in adults, and higher rates of inpatient treatment across age groups.

Challenges are often compounded when one experiences an intersectionality (or overlap) of multiple cultural factors.[8, 9, 10] An intersection such as race and sexual orientation can be even more complicated when a person experiences discrimination from both within and outside of their racial community. While cultural involvement normally serves as a protective factor,[11] when that is not the case, the impact of discrimination can make accessing mental health services in the community even more difficult.[12]

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[4] Culturally Relevant Prevention: The Scientific and Practical Considerations of Community-Based Programs, pp. 763-778.

[5] Sue D. W., Sue D. & Sue, D. W., *Counseling the Culturally Diverse: Theory and Practice*, J. Wiley (New York 2016)..

[6] Bostwick W. B, *Mental Health Risk Factors among GLBT Youth,* National Alliance on Mental Illness: NAMI Multicultural Action Center (2007).

[7] *Cultural Competence Standards for Managed Care Mental Health for Four Racial/Ethnic Underserved/ Underrepresented Populations,* Four Racial/Ethnic Panels, Center for Mental Health Services, Substance Abuse and Mental Health Administration, U.S. Department of Health and Human Services, (Rockville, MD, 1999).

[8] *Ibid.*

[9] Bostwick, W. B..

[10] Sue D.W., Sue D., & Sue D. W.

[11] McIvor O., Napoleon A., & Dickie K.M., Language and Culture as Protective Factors for At-Risk Communities, *Journal of Aboriginal Health*, November 2009 issue, pp. 6-25 (2009).

[12] Glick D.A., Krishnan M.C., Fisher S.K., Lieberman R.E. & Sisson, K., Redefining Residential: Ensuring Competent Residential Interventions for Youth with Diverse Gender and Sexual Identities and Expressions, *Residential Treatment for Children & Youth,* Vol. 33, No. 2, pp. 107-117 (2016).

Disparities in Mental Health Care Exist Across Minority Populations

It is well documented that diverse racial, ethnic, language, and sexual and gender minorities have less access to the full continuum of mental health care, often delay seeking help, have lower levels of outpatient usage, have higher levels of usage of more expensive crisis services, and complete treatment at a lower rate than non-minorities.[13]

• African Americans utilize inpatient hospitalization at more than twice the rate of non-minorities, incur a high percentage of inaccurate diagnoses, and report the least satisfaction with mental health services.[14]

• Native Americans have the highest risk for mental health challenges of all ethnic groups.[15]

• Asian Americans often experience language barriers when trying to access mental health services. Stigma related to mental health issues and a lack of awareness of available resources and services also limit help-seeking behavior among this population.[16]

• Latinos in states with more restrictive immigration policies have poorer mental health.[17]

• Sexual and gender minorities experience unique health disparities, have less access to health care, experience major barriers to health and well-being, and have higher burdens of certain diseases. Youth who are LGBTQ receive inpatient mental health services at higher rates than non-minority youth who are heterosexual and have longer stays in treatment.[18]

• Individuals who have limited English proficiency are even less likely to receive the right services.[19] With more than 350 languages currently spoken in the U.S., and about one in five people speaking English as a second language,[20] it is vital that states prioritize language access and linguistic competence in their service delivery systems.

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[13] *Cultural Competence Standards for Managed Care Mental Health for Four Racial/Ethnic Underserved/ Underrepresented Populations.*

[14] Smith J.R., Mental Health Care Services for African Americans: Parity or Disparity*? The Journal of Pan African Studies*, Vol. 7, No. 9, pp. 55-63 (2015).

[15] *Mental Health Disparities: American Indians and Alaska Natives,* American Psychiatric Association (2010),

[16] Nishi K., MA, *Mental Health Among Asian-Americans*, American Psychological Association website (2016), http://www.apa.org/pi/oema/resources/ethnicity-health/asian-american/article-mental-health.aspx.

[17] Katzenbuehler M.L., Prins S.J., Flake, M., Phibin M., Frazer M.S., Hagen D. & Hirsch J. Immigration Policies and Mental Health Morbidity among Latinos: A State-Level Analysis, *Social Science & Medicine* Vol. 174, pp. 169-178 (2016).

[18] *Cultural Competence Standards for Managed Care Mental Health for Four Racial/Ethnic Underserved/ Underrepresented Populations.*

[19] Acevado-Polakovich I.D., Hernandez M. & Nesman T., Cultural Competence: a Literature Review and Conceptual Model for Mental Health Services, *Psychiatric Services* Vol. 60, No. 8, pp. 1046-1050 (2009).

[20] Passel J. S. & Cohn D., *U.S. Population Projections: 2005-2050*, Pew Research Center (February 11, 2008), http://www.pewhispanic.org/2008/02/11/us-population-projections-2005-2050/.

These inconsistencies may be attributable in part to providers who are not of similar cultures and thus lack familiarity with how mental illness manifests and presents in diverse cultural groups.[21]

Mental Health Care Disparities Are Even Greater for Minority Children

While the disparities and disproportionalities described above are evident across the lifespan, children and youth experience additional cultural barriers to mental health services that relate to cultural identity and potential cultural intersectionality, given their stages of physical and mental development. When cultural differences are not recognized and addressed appropriately, early mental health concerns can be left untreated, which can lead to children and youth being referred to inpatient treatment at entry into care. In particular, young people from cultural and ethnic minority groups are often referred directly to inpatient treatment rather than to community-based prevention or treatment options.[22]

Suicide Risk Higher for Minority Youth

Risk factors for suicide vary across cultures. Symptomology and the ability to talk about suicide openly manifest differently across cultures. Disparities and disproportionality associated with suicide must be considered in inpatient treatment settings.

In 2015, the highest U.S. suicide rate (20 per 100,000) was among American Indians and Alaska Natives and the second highest rate (17 per 100,000) was among Caucasians. Much lower and roughly similar rates were found among Hispanics (5.8 per 100,000), Asians and Pacific Islanders (6.4 per 100,000), and African Americans (5.6 per 100,000).[23]

However, the suicide rate for African American children has been rising over time (from 2.35 per 100,000 in the period 2003 to 2007 to 2.54 per 100,000 in the period 2008 to 2012).[24] And it is the second leading cause of death for Native American youth between 15- and 24-years of age, who have nearly twice the national suicide rate. Similarly, while the suicide rate for Asian Americans is about half the national rate, it is the second leading cause of death for Asian-Americans aged 15-34.[25]

LGBTQ youth whose families do not accept their sexual identification are six times more likely to have high levels of depression and more than eight times as likely to have attempted suicide.[26] Latina adolescents have the highest rate of suicide attempts among all adolescent groups in the US.[27]

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[21] *Ibid.*

[22] McMillen J. C., Scott L. D., Zima B. T., Ollie M. T., Munson M. R., & Spitznagle E., Use of Mental Health Services among Older Youth in Foster Care, *Psychiatric Services*, pp. 811-817 (2004).

[23] *Centers for Disease Control and Prevention Data & Statistics Fatal Injury Report* (2015).

[24] Bridge J., Asti L., & Horowitz L., Suicide Trends Among Elementary School-Aged Children in the United States from 1993 to 2012, *Journal of the American Medical Association,* Vol. 169 (7), pp. 673-677 (July 2015).

[25] Heron M., Deaths: Leading Causes for 2007, *National Vital Statistics Reports,* Vol. 59, pp. 8 (2011).

[26] Glick D.A, *et al.*

[27] 2015 *Centers for Disease Control and Prevention Data & Statistics Fatal Injury Report.*

Cultural and Linguistic Barriers Require Culturally Adapted Screening and Treatment Interventions

With an increased risk for suicide should come an increased screening and intervention within the inpatient setting.[28] Cultural and linguistic barriers exist that inhibit individuals from ethnic and cultural minority groups from accessing services and supports that promote mental health as well as those that prevent or intervene early with mental illness, including suicidality. While there is little research on suicide-specific interventions by culture, the approaches that work well for suicide prevention in diverse populations align with what has been previously discussed. When suicidal ideation is identified as a risk factor, treatment modalities that are culturally and linguistically effective should be selected.

Cultural and Linguistic Competence: A Strategy for Reducing Disparities Before, During, and After Inpatient Treatment

Delivering what individuals need, at the right time and in the right way, should reduce the use of inpatient treatment. Likewise, when inpatient treatment is required, improving the quality of care and outcomes achieved by this level of care will aid in minimizing client return. Mental health treatment that does not consider and respond effectively to the culture of the individuals and families served contributes to lower access and utilization of services, inappropriate and/or lower quality of service, treatment noncompliance and early terminations, patterns of disparities, and a cycle of reliance on costlier crisis and/or inpatient care.[29]

There are many benefits to individuals, families, organizations, and communities when organizations seek to use culturally and linguistically-appropriate outreach, engagement, and service strategies. CLC across the continuum of care leads to outcomes that are comparable to the outcomes achieved by the non-minority population.[30] Studies show that when services are culturally responsive, clients experience more effective communication, more accurate diagnoses, a positive therapeutic alliance, and greater satisfaction, all of which strongly correlate with increased treatment adherence.[31] In a meta-analysis of 76 studies, mental health care that was culturally adapted for the local service population was found to be four times more effective than services broadly adapted for individuals from a variety of cultural backgrounds.[32] The ability of a substance abuse treatment program to respond to cultural and linguistic needs/norms has been found to be associated with greater

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[28] Goldston D.B., Molock S.D., Whitbeck L.B., Murakami J.L., Zayas L.H., & Hall G.C., *Cultural Considerations in Adolescent Suicide Prevention and Psychosocial Treatment, American Psychologist* Vol. 63, pp. 14-31 (2008).

[29] Mancoske R.J. Cultural Competency, Children's Mental Health, and School Performance, *Race, Gender & Class 2012 Conference*, Vol. 20, No. ½, pp. 307-325 (2013).

[30] *Cultural Competence Standards for Managed Care Mental Health for Four Racial/Ethnic Underserved/ Underrepresented Populations.*

[31] Guerrero E.J, Enhancing Access and Retention and Substance Abuse Treatment: The Role of Medicaid Payment Acceptance and Cultural Competence, *Drug and Alcohol Dependence* Vol. 132, No. 3, pp. 555-561 (2013).

[32] Griner D. & Smith T.B., Culturally Adapted Mental Health Interventions: A Meta-Analytic Review, *Psychotherapy: Theory, Research, Practice, Training,* Vol. 43, pp. 531-548 (2006).

service utilization among Latinos and African Americans, potentially reducing the need for future more-intensive levels of care.

A culturally and linguistically competent organization has a defined set of values and principles related to the importance of culture, and administrators demonstrate behaviors and practices, and implement policies and structures, that enable providers to work at ease across cultures.[33] Such an organization values diversity, conducts self-assessments, manages differences, institutionalizes cultural knowledge, and adapts to meeting the needs of the local cultural communities. A culturally and linguistically proficient organization uses culture as a central guide and foundation to all of its efforts, shares its efforts and findings with the field, mentors other agencies in CLC, and advocates with and for diverse groups. And culturally competent organizations realize additional benefits, as outlined in Figure 1.

Figure 1. Benefits of Becoming a Culturally Competent Health Care Organization [34]

Social Benefits	Health Benefits	Business Benefits
• Increases mutual respect and understanding between patient and organization • Increases trust • Promotes inclusion of all community members • Increases community participation and involvement in health issues • Assists individuals and families in their care • Promotes individual and family responsibilities for health	• Improves data collection • Increases preventive care by patients • Reduces care disparities in the population • Increases cost savings from a reduction in medical errors, number of treatments and legal costs • Reduces the number of missed medical visits	• Incorporates different perspectives, ideas and strategies into the decision-making process • Decreases barriers that slow progress • Moves toward meeting legal and regulatory guidelines • Improves efficiency of care services • Increases the market share of the organization

[33] *A Guide to Infusing Cultural & Linguistic Competence in Health Promotion Training,* National Center for Cultural Competence Georgetown University Center for Child & Human Development.

[34] Adapted from *Becoming a Culturally Competent Health Care Organization,* Institute for Diversity in Health Management and the Health Research & Educational Trust (2013), http://www.hpoe.org/Reports-HPOE/becoming_culturally_competent_health_care_organization.PDF.

A review of over 1000 articles found that cultural and linguistic competence occurs when there is compatibility among community cultural context, organizational infrastructure, and direct service support. The challenge of becoming a culturally and linguistically competent organization can be overwhelming, but it is important to note that CLC is an ongoing process. Small, well-intended changes can be impactful for all service recipients. As illustrated in Table 1, research has found strategies that are effective in creating a culturally- and linguistically-responsive agency within specific groups.

Table 1: Support for Cultural and Linguistic Competence in Specific Groups

Asian	Flexible hours, community-based facilities, bi-cultural and bilingual staff, and implementation of culturally congruent treatment plans increased utilization, longer treatment durations and completions, consumer satisfaction, and positive therapeutic outcomes.[35]
Latino	Community-based clinics that offer language assistance improved mental health access/usage for those of limited English proficiency by 25 percent.[36] In California, providing Spanish language translation of materials was associated with increased rates of treatment adherence.[37]
African American	Mental health care that includes cultural preference for community engagement/support increases therapeutic alliances.[38] When clients are engaged in culturally competent treatment, prescription medication use decreases.[39]
Youth	Culturally diverse youth, who perceived culturally competent care that is family driven, community based, and with comprehensive wraparound services, reported greater levels of access, active participation, satisfaction, academic outcomes, and clinical outcomes.[40] Intervening early with youth can lead to decreased use of more intensive levels of care, and prevent entry into the juvenile justice system.

A Statewide Approach to CLC in Inpatient Treatment

State Mental Health Authorities (SMHAs) are tasked with ensuring timely and efficient delivery of mental health services, either through contracts with community-based organizations or, in some instances, by directly providing services. Additionally, since

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[35] *Cultural Competence Standards for Managed Care Mental Health for Four Racial/Ethnic Underserved/ Underrepresented Populations.*

[36] Snowden L.R. & McClellan S.R., Spanish-Language Community-Based Mental Health Treatment Programs, Policy-Required Language-Assistance Programming, and Mental Health Treatment Access Among Spanish-Speaking Clients, *American Journal of Public Health*, , Vol. 103, No. 9, pp. 1628-1633(2013).

[37] Guerrero E.J.

[38] Briggs H.E. & McBeath Bowen, Infusing Culture into Practice: Developing and Implementing Evidence-Based Mental Health Services for African American Foster Youth, *Child Welfare,* Vol. 89, No. 1, pp. 31-60 (2010).

[39] Kruzich J.M. & Friesen B.J., Voices of African American Families: Perspectives on Residential Treatment, *Social Work*, Vol. 47, No. 4, pp. 461-470 (2002).

[40] Mancoske R.J., Lewis M.L., Bowers-Stephens C. & Ford A., Cultural Competence and Children's Mental Health Service Outcomes, *Journal of Ethnic & Cultural Diversity in Social Work*, Vol. 21, No. 3, pp. 195-211 (2012).

mental health services within states are provided through both private and public entities, the SMHA and its leadership are also responsible for providing governance, leadership, and accountability for mental health services across the care continuum. This includes: supporting the promotion of mental health and the prevention of serious emotional disability and severe mental illness; supporting a full continuum of community-based services; assuring access to inpatient treatment for those who need it, and ensuring that the services in inpatient treatment centers are culturally and linguistically competent and promote healthy outcomes for all individuals who receive inpatient treatment.

The responsibilities of SMHAs can be categorized into the following broad areas: Policy Development, Administration & Infrastructure Development, Workforce Development, Systems Coordination, Community & Stakeholder Engagement, and Continuous Quality Improvement. Each area is important in moving toward CLC.

Policy Development

Health care organization leadership often believes that if its staff is appropriately trained, services will be culturally competent. A well-informed leader recognizes that providing culturally competent services requires a shift in values, beliefs, practices, and behaviors of personnel at all levels of the organization. This transformation should be led by the SMHA and institutionalized through organizational policies.

The following are some strategies that support policy development.

✓ Create the context for the policy change

- Create a sense of urgency within the organizational leadership about the integration of CLC.
- Ensure that CLC is integrated in the way the organization perceives all services and support and not as a stand-alone component.

✓ Lay the groundwork to justify policy change

- Collect and analyze state demographic data periodically so that information related to service use is current in terms of cultural and ethnic factors.
- Review organizational policies to ensure that embedded structural bias or discrimination is addressed, e.g., in hours of visitation, relationship of visitors to the individual requiring inpatient treatment.
- Assess the need for new policies related to the integration of CLC and include diverse staff and stakeholders in the development of new policies.
- Create a shared vision for ensuring the provision of culturally competent services and ensure that vision is shared with all staff via orientation, onboarding, and ongoing professional development activities.

✓ Enact new policy

- Embed requirements for assessment of culturally competent interventions that are aligned with best cultural practices along with measures to ensure ongoing culturally competent practices in contracts and regulations.
- Require that demographic and disparities data be included as criteria to approve new or ongoing funding.
- Require that state employees acquire cultural and linguistic competencies.

Administration & Infrastructure Development

To lead the integration of CLC, SMHAs require that all components for effective administration of services and supports are in place and managed effectively within the agency's infrastructure. Standard operating procedures (SOPs) of the organization should support a seamless integration of CLC within existing services and supports. All intake, treatment, and outtake forms must be culturally appropriate; services and supports operations must be accessible and appropriate; and communication strategies must be inclusive and comprehensive.

Some strategies for ensuring effective administration are listed below.

✓ Create a guiding team comprised of personnel from all levels and service types that can provide leadership in the review of existing SOPs, current services and operations, intake and communication materials, etc. through a CLC lens.

✓ Review existing administrative protocols to ensure that they support personnel in implementing culturally competent services.

✓ Identify and remove common systemic barriers to implementation and fidelity in order to support the provision of culturally competent services.

✓ Integrate data related to demographics and other social determinants in systems to ensure decision-making around services and supports is well-informed.

✓ Review the need for added infrastructure based on the needs of current and potential recipients of mental health services and their families (*e.g.,* need for materials in other languages, interpretive services).

✓ Review the accessibility of services and supports. For instance: Intake processes should be sensitively handled based on the cultural needs of potential residents, and hours of operation should include visiting hours that meet the needs of residents and recognize a broader definition of family membership where culturally appropriate.

Workforce Development

Workforce development includes recruitment, onboarding, orientation, ongoing professional development, and retention activities. One reason provided for not hiring diverse staff has been the notion that there are an insufficient number of people from diverse cultural backgrounds who have the academic or professional qualifications to be considered for new hires. However, insufficient attention is paid to integrating new hires into the organization. In addition, implementation of CLC provides opportunities for professional development and promotions into positions of management and leadership.

Effective workforce development strategies include the following:

- Including academic and professional requirements in job descriptions that are commensurate with the roles and responsibilities of the position and include experience with diversity/cultural issues.

- Posting job descriptions in a variety of locations and modalities to ensure that they are accessible to diverse populations.

- Ensuring that onboarding processes support the needs of new hires.

- Ensuring that all new hires undergo an orientation process that includes CLC training and, if feasible, connecting them with a staff mentor to support them in the early organizational acculturation process.

- Providing ongoing professional development opportunities that have integrated CLC and that support future promotions and leadership opportunities.

> ## FROM THOUGHT TO ACTION
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> The Integrated Healthcare System of NYC offers regular CLC workshops that include a "sharing based" approach where cultural knowledge can be learned directly from employees as opposed to an expert teacher. It is an opportunity to share and experience first-hand, which increases engagement and passion around the topic.
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> "JBFCS analyzed their staff by having their Human Resources Department create a profile of the types of candidates hired by the agency, along with justification on why certain candidates are hired and others are not. This information was used to develop a training tool and hiring process that is more inclusive of candidates that reflect the diversity of the residents served across the organization." (From *Cultural and Linguistic Competence Guidelines for Residential Programs,* a guide developed by the National Building Bridges Initiative Cultural and Linguistic Competence Workgroup, http://www.buildingbridges4youth.org/sites/default/files/BBI_CLC_Guidelines_FINAL.pdf.)
>
> "The Children's Village established a Junior Executive Development track for administrators (directors, supervisors, and managers) to increase the number of executive leaders of color."

Systems Coordination

Inpatient services and supports are available through a variety of provider types and reimbursed by multiple payers. Providers may include state-run facilities through behavioral health, adult and child welfare, corrections, or private entities such as hospitals or other behavioral health agencies. Medicaid, Medicare, and private insurers pay for a variety of services, but may not cover all inpatient services. Given this variation in providers and payers, it is essential that SMHAs take a lead in assuring system coordination through the following strategies:

- Creating and supporting a network of diverse behavioral health services provider organizations that is competent in serving members of diverse cultural and ethnic groups. The purpose of the network should be to provide the latest information from Federal and State sources that impact behavioral health services within the state.

- Ensuring ongoing communication between payers and service providers to address the impact of culture on funding, reimbursements, array of services, caseload requirements, and other system elements.

- Creating opportunities to inform population groups about funding, services, and other system elements.

- Framing discussions through the lens of the SMHA's vision and mission of integrating CLC.

Community & Stakeholder Engagement

SMHA leaders can reach out to a variety of cultural leaders and organizations to address the challenges of diminishing resources and expanding needs. While the discussion of resources often includes only fiscal resources, SMHA leaders should also consider personnel, talent,

and partners as resources. When thinking about the promotion of mental health and the prevention of serious emotional disabilities and severe mental health illnesses that might require inpatient treatment, a variety of community partners should be engaged. Peer services, extra-curricular activities, educational opportunities, and other community and natural supports can be availed through partnership with businesses, private foundations, ethnic community organizations, and private individuals who may donate time and other non-financial amenities. Some strategies that leadership might consider are:

- Developing clear and well-articulated health educational materials in a variety of reading levels and languages to share with stakeholders.

- Encouraging stakeholders to educate their communities, so that people are aware of, and understand the behavioral health issues in their communities.

- Addressing the barrier of stigma regarding mental health challenges, and encouraging early access to services to reduce the severity of the illness and the need for inpatient treatment.

- Engaging stakeholders in creating a community where people with mental health challenges can be offered supports that can enable them to live full and meaningful lives.

> ## FROM THOUGHT TO ACTION
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> The KTS Statewide Work Group asked their Chinese members to contribute 10 to 15 hours and offered a $300 stipend for their time. The workgroup's focus was CLC suicide prevention, which included Chinese perceptions of suicide, help seeking preferences, insight into how to reach the community effectively. Since members were geographically distant, most activities took place through a private facilitated online discussion forum. There were initial and final webinars to kick off the project and to provide closure, with conference calls in between.
>
> Lawrence Hall Youth Services developed a Youth Advisory Committee to gather recommendations and feedback on the types of services and programming needed for LGBTQ youth and children and youth of color.

Continuous Quality Improvement

Meaningful transformation cannot occur without ongoing monitoring and evaluation of client-, program-, and system-level outcomes. Strategies to integrate CLC should include ways to measure the transformation and its impact, including the following:

- ✓ Engaging diverse stakeholders in the evaluation design, outcomes planning, and implementation;

- ✓ Developing process and outcome measures that are culturally responsive;

- ✓ Creating a process for, and providing training and coaching on, using data for decision-making;

- ✓ Developing training and resources for ongoing measurement of change processes and outcomes; and

✓ Developing fidelity measures to ensure services and supports contracts are also culturally competent.

Additional Considerations

Medicaid Requirements

Through the Affordable Care Act and Mental Health Parity and Addiction Equity laws, public programs such as Medicaid have expanded to meet the needs of those living below poverty by providing access to mental health services, including inpatient treatment.[41] Medicaid is the fastest growing payer of mental health services and provides about 29 percent of state spending on mental health. It is important to look at Medicaid because of the volume of Medicaid dollars spent, and because the population it serves is primarily low-income, many of whom are from culturally diverse backgrounds and are two to three times more likely to have a mental health disorder.

While Medicaid is shown to greatly improve access to culturally and linguistically competent treatment,[42] disparities still exist. The Centers for Medicare and Medicaid Services (CMS) is engaged in a multi-partner health disparities collaboration with the following objectives:[43]

• Disseminate information about promising practices in health disparities in Medicaid and CHIP to the forum and external organizations;

• Identify vulnerabilities and areas of opportunity in Medicaid and CHIP for quality improvement and the reduction of health disparities in Medicaid enrollees; and

• Identify and collaborate with states and external organizations to develop partnerships to reduce health disparities in Medicaid and CHIP.

While the federal government requires Medicaid to provide CLC services, state implementation is not consistent. A study of five states found varying and vague CLC definitions and expectations included in provider contracts and monitoring tools, a lack of standardized performance indicators related to CLC, no active CLC assessment of providers, and very little data collection or outcome monitoring by culture.[44]

States primarily relied on language requiring access to measure efforts towards CLC and passively monitored CLC through complaint tracking. These findings suggest a significant disconnect between the Federal intent and state operationalization of culturally and linguistically competent mental health care. It appears that states perceive CLC implementation as optional and ideal rather than critically necessary.

Technological Innovations

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[41] Smith J.R., Mental Health Care Services for African Americans: Parity or Disparity? *The Journal of Pan African Studies,* Vol. 7, No. 9, pp. 55-63 (2015).

[42] Guerrero E.J.

[43] *Quality of Care Health Disparities*, https://www.medicaid.gov/medicaid/quality-of-care/improvement-initiatives/health-disparities/index.html.

[44] Stork E. & Scholle S., Monitoring and Enforcing Cultural Competence in Medicaid Managed Behavioral Health Care. *Mental Health Services Research*, Vol. 3, No. 3, pp. 169–177 (2001).

Technology has an important place in contributing towards CLC across the continuum of care, perhaps most apparently in data collection and language assistance. Electronic health records (EHR) help monitor service use, satisfaction, and outcomes for all clients, including those with diverse backgrounds. Client experience, from intake to completion of inpatient treatment, can be included in the EHR and analyzed and interpreted against a variety of cultural variables. Interpreting services can be provided remotely via video, which is now the next best option to having the translation services available in person, removing transportation barriers often faced by cultural and ethnic minorities.

Technology is also being used in innovative ways to facilitate CLC training, where experiential emotion-triggering videos and simulations are taking the forefront. In one study, seeing CLC applied in a medical-specific context was helpful to students' learning. It created an overall appreciation of and interest in cultural awareness and improved CLC skills.[45] The use of similar technology in a nursing study resulted in improved CLC in both assessment scores and participant self-report.[46]

Specific to the fields of mental health and social work, one study used avatars in a virtual community to facilitate CLC education.[47] Results showed that participants had a better learning experience about concepts relating to diversity, increased self-awareness about their own perceptions, and a higher average confidence score in working with diverse populations. The trigger of emotion in this style of learning also increased empathy and cultural humility for participants.

Transitioning from Inpatient Treatment

Transitioning back to the community following inpatient treatment can be difficult for the individual served, the family, agencies that support the individual and family, and the community as a whole. Therapeutic gains do not always continue in new settings, and often families and other supports are anxious about the individual's return. Done well however, the transition into a community setting provides an opportunity to make meaningful connections to continuing traditional and community services and natural supports. When these supports are culturally and linguistically relevant and selected by the individual and family, progress made in treatment is more likely to be sustained in the community.[48]

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Conclusion

State Mental Health Authorities are charged with ensuring that services provided by their contracted agencies are accessible and appropriate to all populations. While the focus of the current paper is on CLC in inpatient treatment settings, in order to truly affect positive change, CLC must be considered across the system of care.

The Substance Abuse and Mental Health Services Administration (SAMHSA), the primary Federal funder of state mental health services after Medicaid, includes cultural and linguistic competence as a core value across its promotion, prevention, treatment, and recovery programs. To that end, SAMHSA requires a Disparity Impact Statement (DIS) for all grant awards. A DIS is intended to guide and assist behavioral health administrators in creating and sustaining policies at the program, policy, and system levels that eliminate mental health disparities and disproportionalities across cultures.[49]

To improve consistency among programs, SMHAs should review their program-specific DIS and consider creating a DIS summary for their state system of care. The development of a DIS can serve an impetus and framework for developing a Cultural and Linguistic Competence Action Plan. A number of resources exist to aid in plan development.[50] These include organizational self-assessments, checklists, and sample plans that are available in the public domain.

In order to improve mental health at a population level, it is critical that SMHAs view the provision of culturally and linguistically competent services and supports as non-negotiable across the continuum of care. In return, states will see improved and sustained outcomes for individuals served, better workforce recruitment and retention, and healthier communities.

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