Position 18: Cultural and Linguistic Competency in Mental Health Systems

Policy

Mental Health America (MHA) believes that it is essential that all aspects of wellness promotion and mental health and substance use disorder prevention and treatment be reflective of the diversity of the communities being served and that mental health and substance abuse agencies strive to become and remain culturally and linguistically competent. A culturally and linguistically competent system incorporates skills, attitudes, and policies to ensure it is effectively addressing the cultural and communication needs of consumers and families with diverse economic and social resources and capacities and diverse values, beliefs, and sexual orientations, in addition to backgrounds that vary by race, ethnicity, religion, and language. This requires (1) a thorough understanding of the culture of the many segments of American society, (2) adequate language skills to serve the language needs of substantial limited-English-speaking communities[(1)] and also of the deaf and blind communities and (3) an understanding of the full range of sexual orientations, currently summarized as LGBTQQIAP (lesbian, gay, bisexual, transgender, queer, questioning, intersex, ally and pansexual). Mental Health America urges that planning and advisory councils and governing boards, staff and peer service workers of mental health and substance abuse treatment agencies all be chosen and trained to reflect and respect cultural and linguistic diversity as a basic civil right.[(2)]

Background

Identification and treatment of mental health and substance use conditions requires a full understanding of the culture and language of the person and an ability to relate successfully to the person through culture and language. Thus, culture and language are indispensible means of communication, and when barriers exist, they must be addressed for prevention and treatment to be effective. This requires recruitment, resources, integrity, and sustained effort. Most importantly, cultural competence requires training and self-criticism to combat stereotypes, such as the legacy of racism and ethnic prejudice in America(3), the condemnation of diverse sexual orientations in prior mental health diagnostic systems(4), and other cultural biases and prejudices that still haunt us.

There can be no doubt that poverty, race and ethnicity affect the treatment of people with mental health and substance use conditions and that active programs are necessary to promote cultural and linguistic competency throughout the mental health and substance use disorder treatment systems.(5) Disproportionate criminal justice system involvement often is used to justify this systemic discrimination and requires separating the person from the record. This is hard to do, but essential to assure cultural competency.

The main message of *Mental Health: Culture, Race, and Ethnicity-A Supplement to Mental Health: A Report of the Surgeon General* (2001) is that "Culture counts:"

"The cultures of racial and ethnic minorities influence many aspects of mental illness, including how [people] from a given culture communicate and manifest their symptoms, their style of coping, their family and community supports, and their willingness to seek treatment. Likewise, the cultures of the clinician and the service system influence diagnosis, treatment, and service delivery. Cultural and social influences are not the only determinants of mental illness and patterns of service use, but they do play important roles.

- Cultural and social factors contribute to the causation of mental illness, yet that contribution varies by disorder. Mental illness is considered the product of a complex interaction among biological, psychological, social, and cultural factors. The role of any of these major factors can be stronger or weaker depending on the specific disorder.
- Ethnic and racial minorities in the United States face a social and economic environment of inequality that includes greater exposure to racism, discrimination, violence, and poverty. Living in poverty has the most measurable effect on the rates of mental illness. People in the lowest strata of income, education, and occupation (known as socioeconomic status) are about two to three times more likely than those in the highest strata to have a mental disorder.
- Racism and discrimination are stressful events that adversely affect health and mental health. They place minorities at risk for mental disorders such as depression and anxiety. Whether racism and discrimination can by themselves cause these disorders is less clear, yet deserves research attention.
- Mistrust of mental health services is an important reason deterring minorities from seeking treatment. Their concerns are reinforced by evidence, both direct and indirect, of clinician bias and stereotyping.
- The cultures of racial and ethnic minorities alter the types of mental health services they need. Clinical environments that do not respect, or are incompatible with, the cultures of the people they serve may deter minorities from using services and receiving appropriate care."

"Cultural differences must be *accounted for* to ensure that minorities, like all Americans, receive mental health care tailored to their needs."(6)

The Surgeon General expressly declined to deal with sexual orientation, stating that: "Clearly, the four racial and ethnic minority groups that are the focus of this supplement are by no means the only populations that encounter disparities in mental health services. However, assessing disparities for groups such as people who are gay, lesbian, bisexual, and transgender or people with co-occurring physical and mental illnesses is beyond the scope of this Supplement. Nevertheless, many of the conclusions of this Supplement could apply to these and other groups currently experiencing mental health disparities."(7)

In its 2011 report, *The Health of Lesbian, Gay, Bisexual and Transgender People*,(8) The Institute of Medicine concluded that little is known to science about LGBTQQIAP culture, and that: "While LGBT populations are [often] combined as a single entity for research and advocacy

purposes, each is a distinct population group with its own specific health needs. Furthermore, the experiences of LGBT individuals are not uniform and are shaped by factors of race, ethnicity, socioeconomic status, geographical location, and age, any of which can have an effect on health-related concerns and needs."

Thus, according to the IOM, data on "sexual and gender minorities" should be included in the battery of demographic information that is collected in federally funded surveys, in the same way that race and ethnicity data are collected. In addition, data on sexual orientation and gender identity should be collected in electronic health records, like race and ethnicity. While all data collected in electronic health records are subjected to high levels of privacy and security protections, information on sexual orientation and gender identity could be perceived by some as more sensitive than other information, but its collection is important for the development of effective treatment protocols.

Asking study participants about their sexual orientation and gender identity also presents a challenge for researchers. While questions designed to elicit this information have been developed and used, HHS and all of its operating divisions should support research to evaluate the questions and develop additional measures. Similarly, questions about sexual orientation and gender identity on federally funded surveys should be standardized to allow for the comparison and combination of data across large studies. (9)

For LGBTQQIAP teens and young people and families of color, the challenges of growing up are especially difficult. Stresses and confusion are pronounced in young people who are coming to terms with a stigmatized sexual orientation and considering coming out, as they are for racial and ethnic minorities seeking a positive role in American society. Studies show a strong correlation between gay, lesbian or bisexual sexual identity and the risk of suicide,(10) and the criminal justice system disproportionally affects (and sometimes targets) racial and ethnic minorities.(11)

In order for people disadvantaged by any cause to participate in treatment, promotion of health literacy is essential. MHA Position Statement 12, Evidence-based Healthcare, stresses this issue and MHA's role in promoting health literacy. (12)

Health literacy was defined by the IOM in 2004 and 2011 as, "the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions."(13) Capacity to make decisions is the core issue in assuring consumer autonomy and self-directed care and treatment. Promotion of such capacity can be complicated by individual learning skills and preferences and issues such as literacy/language skills, cultural differences, age-related physical, emotional and cognitive changes and disabilities, and individual challenges that affect listening, learning and remembering. Cultural competency requires crossing all of these barriers.

Call to Action

Unfortunately, many mental health systems and agencies, including those that serve highly diverse populations, pay only lip service to these concepts, despite the significant impact that cultural and linguistic competence has on both positive outcomes and costs. In order to improve the cultural sensitivity and responsiveness of mental health delivery systems, the Mental Health America urges all organizations that provide mental health services to:

- Assess the diversity and needs of the people and community that it serves and develop and implement plans and practices that work best for them.
- Develop a formalized, written cultural and linguistic competency plan. The cultural composition of communities tends to shift over time, and organizations must periodically update these plans to reflect changes in the populations they serve and work with.
- Form planning and advisory councils and governing boards with diverse and culturally and linguistically competent membership, reflective and respectful of the communities being served.
- Provide enrollment and educational materials in different languages and in Braille, consistent with the linguistic diversity of the population being served.
- Pre-test the reader-friendliness of enrollment and education materials with focus groups comprised of persons who are reflective of the cultural and linguistic diversity of the population.
- Measure the reader-friendliness of such materials as an indicator in consumer satisfaction surveys.
- Ensure availability of providers with language skills that complement the languages spoken by the population being served and provide needed linguistic support and translation services, including signing professionals as well as sign language services, to consumers and families (at no cost to them), beginning at the point of entry into the system and throughout the course of care.
- Develop and implement standards for recruitment and hiring of culturally and linguistically competent leadership and staff (including a range of genders and sexual orientations as well as linguistic and cultural understanding).
- Develop care plans that are compatible with consumers' community environments.
- Direct consumers and their families to treatment modalities that are culturally acceptable to them to ensure the likelihood of acceptance of and compliance with the treatment plan (including sensitivity to religious beliefs and sexual orientation).
- Have a regular quality-monitoring program with indicators that separately evaluate both the quality of services and outcomes with respect to culturally diverse populations.
- Provide regular cultural and linguistic competency training for leadership and providers.
- Ensure that providers have an understanding of the cultural attitudes about healing systems held by the consumers whom they serve.
- Ensure that providers have an understanding of the family dynamics and sexual orientations of the consumers whom they serve.
- Ensure that providers are skilled in specialized assessment and treatment techniques to serve consumers with diverse ethnicities and sexual orientations.

Effective Period

The Mental Health America Board of Directors approved this Policy on September 17, 2011. It is reviewed as required by the Mental Health America Public Policy Committee.

Expiration: December 31, 2016

1. Communities that have adopted a legal standard have often used a threshold of five percent of the population served.
2. Section 601 of Title VI of the Civil Rights Act of 1964, 42 U.S.C. 2000d, provides that no person shall, "on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance." See also United States Department of Health and Human Services, "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (2004). http://www.hhs.gov/ocr/civilrights/resources/specialtopics/lep/policyguidancedocument.html
3. Citations can only skim the surface, but a good starting point is Alva and Gunner Myrdal's classic *An American Dilemma: The Negro Problem and Modern Democracy* (Harper & Bros., 1944) and the words of the Rev. Martin Luther King, Jr.
4. In 1973, the weight of empirical data, coupled with changing social norms and the development of a politically active gay community in the United States, finally led the Board of Directors of the American Psychiatric Association to remove homosexuality from the *Diagnostic and Statistical Manual of Mental Disorders* (DSM). Some psychiatrists who fiercely opposed their action subsequently circulated a petition calling for a vote on the issue by the Association's membership. That vote was held in 1974, and the Board's decision was ratified.
5. Institute of Medicine, *Unequal Treatment: What Healthcare Providers Need to Know about Racial and Ethnic Disparities in Healthcare* (2002), http://www.google.com/search?sourceid=chrome&ie=UTF-8&q=Unequal+Treatment%3A+What+Healthcare+Providers+need+to+Know+About+Racial+and+Ethnic+Disparities+in+Healthcare (pdf).
6. Satcher, David, Department of Health and Human Services, Mental Health: Culture, Race, and Ethnicity-A Supplement to Mental Health: A Report of the Surgeon General. U.S. Department of Health and Human Services, Washington, D.C. (2001). http://www.surgeongeneral.gov/library/mentalhealth/cre/execsummary-3.html http://www.surgeongeneral.gov/library/mentalhealth/cre/execsummary-6.html (emphasis in original).
7. http://www.surgeongeneral.gov/library/mentalhealth/cre/execsummary-1.html
8. http://www.iom.edu/~/media/Files/Report%20Files/2011/The-Health-of-Lesbian-Gay-Bisexual-and-Transgender-People/LGBT%20Health%202011%20Report%20Brief.pdf
9. http://www.iom.edu/Reports/2011/The-Health-of-Lesbian-Gay-Bisexual-and-Transgender-People/Report-Brief.aspx
10. See, e.g., Fergusson, D.M., Horwood, L.J., & Beautrais, A.L., "Is Sexual Orientation Related to Mental Health Problems and Suicidality in Young People?" *Arch Gen Psychiatry* 1999 Oct.; 56(10):876-80 (1999), http://archpsyc.ama-assn.org/cgi/content/full/56/10/876 . Gay, lesbian, and bisexual young people were at increased risks of major depression (odds ratio [OR], 4.0; 95% confidence interval [CI], 1.8-9.3), generalized anxiety disorder (OR, 2.8; 95% CI, 1.2-6.5), conduct disorder (OR, 3.8; 95% CI, 1.7-8.7), nicotine dependence (OR, 5.0; 95% CI, 2.3-10.9), other substance abuse and/or dependence (OR, 1.9; 95% CI, 0.9-4.2), multiple disorders (OR, 5.9; 95% CI, 2.4-14.8), suicidal ideation (OR, 5.4; 95% CI, 2.4-12.2), and suicide attempts (OR, 6.2; 95% CI, 2.7-14.3).
11. In Position Statement 56, MHA acknowledged this shameful fact: "MHA recognizes the nation must acknowledge and address the forces that contribute to the disproportionately high involvement of persons from ethnic and racial minority communities in the criminal justice system. A system that continues to incarcerate so many people of color with inconsistent lengths of incarceration when compared to others is inherently unjust."
12. MHA Position Statement 12, Evidence-based Healthcare
13. http://www.iom.edu/Activities/PublicHealth/RtblHealthLiteracy.aspx