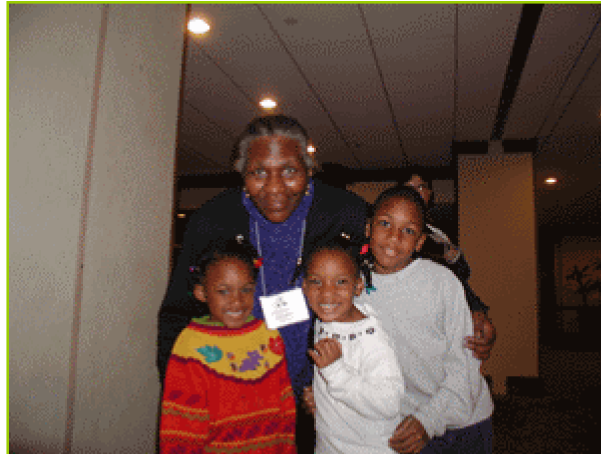
REFLECTING ON CULTURAL COMPETENCE: A NEED FOR RENEWED URGENCY



In the document, *Towards a Culturally Competent System of Care*, Cross, Bazron, Dennis and Isaacs (1989) first presented a model of cultural competence that in the past thirteen years has gained widespread recognition, provoked changes in thinking about serving diverse communities, provided the framework for numerous training efforts, stimulated attempts to measure and assess this construct, and infused cultural competence into the lexicon of mental health and human services. At the time, this was a landmark monograph. Thirteen years after, where are we?

While the concept of cultural competence has permeated children's services and bold efforts have been made to improve the system of care for culturally diverse children and their families, significant barriers to access, quality, and positive outcomes of care still remain. The Surgeon General's recent supplemental report, *Mental Health: Culture, Race, and Ethnicity* (U.S. Department of Health and Human Services, 2001) detailed striking disparities in mental health services for racial and ethnic minorities compared to Whites. Minority populations had less access to and availability of mental health services, were less likely to receive needed mental health care, often received poorer quality care when in treatment, and were underrepresented in mental health research.

Many of the barriers that deter communities of color from accessing and engaging in treatment pertain to all populations: fragmentation of services, lack of availability, cost of services, and societal stigma about mental illness. However, additional barriers deter people of color from seeking services, including mistrust and fear of treatment, different cultural conceptualizations of illness/ health and help seeking, differences in language and communication patterns, and racism and discrimination at the personal and institutional levels. As a result, racial and ethnic minorities experience collectively a greater disability burden from emotional and behavioral disorders than do Whites. This higher burden arises from receiving less care and poorer quality of care as opposed to the disorders being inherently more severe or prevalent in these populations (U.S. DHHS, 2001).

A key message in the Surgeon General's supplemental report was the pivotal role of culture in mental health, mental disorders, and mental health services. Culture is critical in determining what people bring to the clinical setting, how they express and report their concerns, how they seek help, what they develop in terms of coping styles and social supports, and the degree to which they attach stigma to mental health problems. This concept, however, is not just limited to the child and family; it is also relevant to the providers. Each group of providers and each system of service delivery embodies a "culture" with shared beliefs, norms, values and patterns of communication. Each of these provider groups may tend to perceive strengths, weaknesses, helpseeking behavior, symptoms, diagnosis, assessment and intervention in ways that diverge from each other and from that of the child and family.

There is a renewed sense of urgency for children of color in our current systems of care. This is fueled by several factors. First, there is a demographic imperative documented by census data clearly showing that racial and ethnic minority populations are growing as a proportion of the total US population. There is no doubt

that, as we progress into the 21st century, more youth of color will be involved in childserving systems.

Second, numerous studies indicate that children of color are faring poorly in our current systems of care. While the prevalence of mental health issues appears to be similar to that of the mainstream population, the unmet need for culturally diverse groups is significant. For youth of color, who often do not access a specialty mental health system, other systems such as juvenile justice, child welfare, and special education become the de facto mental health service. In these systems, they often tend to be unserved, underserved or inappropriately served (Hernandez, Isaacs, Nesman & Burns, 1998). In juvenile justice or child welfare systems, treatment may be based more on social control and removal from the family than on support for positive growth and development (U.S. DHHS, 2001). The need for mental health services among youth involved in juvenile justice is increasingly well documented. Yet studies indicate that youth of color fare even worse than their White counterparts. For example, studies suggest a dual pathway for White and minority youth who commit delinquent offenses with the former more likely to be diverted from the juvenile justice system into the mental health system for "treatment" while minority youth are more likely to be processed in the juvenile justice system for "punishment" (Dembo, 1988; Hutchinson, 1990). *[Ed. Also see the article by Breda on page 10 in this issue for an examination of this topi*c.] An examination of the child welfare system reveals several significant findings with implications for children of color. First, these children and their families are disproportionately represented in childwelfare, and experience poorer outcomes and receive fewer services than their White counterparts (Courtney, et al., 1996); second, mental health disorders are prevalent and an estimated 30% to 80% of children in foster care have severe emotional problems (Blatt, Saletsky, Meguid, Church, & Critzet, 1997). Children of color have the least chance for mental health service recommendations, are least likely to have plans for family contact and are most likely to be in out-of-home placements.

In terms of mental health services, numerous studies find disparities between the types of services received by minority children and those received by their White counterparts. African American children receive less treatment in schools and in psychiatric inpatient care and receive more services from publicly funded residential treatment centers. American Indian children rarely receive services in specialty mental health and more likely through juvenile justice, schools and residential settings. Latino youth are underrepresented in outpatient mental health facilities and limited service utilization data exist for Asian American youth.

The third factor underscoring the urgency for culturally competent care is highlighted in isolated yet recurring stories of tragic outcomes for children of color. In August 2002, the *Fresno Bee* reported a string of youth suicides in the Fresno, California Hmong (Asian refugees from Laos) community. Emerging from their intergenerational and intercultural confusion and distress, parent leaders in the Hmong community appealed to public systems to help prevent further suicides. Different plans were proposed and discarded due to various bureaucratic obstacles and lack of appropriate providers. While the local district was assembling its plan, four more children killed themselves.

In spite of a rather dismal national picture, there are pockets of innovation and culturally responsive services that are contributing to positive outcomes for these youth. However, we need a broader cross system action agenda that consistently produces good outcomes. This effort must translate the principles and practices put forth in the 1989 cultural competence model to build a policy agenda, programs, and a workforce to reduce racial and ethnic disparities.

A national policy agenda would address several critical areas.

(1) Building a primary mental health care system to integrate mental health services into education and primary health care represents a fundamental shift in service delivery, drawing upon a public health approach to reach the children where they live and function. Frontline providers for children are the schools and primary health care providers; these systems are more readily accessible to children of color, who rarely utilize the specialty mental health system. Furthermore, this approach would converge well with patterns of helpseeking in diverse communities, reduce barriers to mental health care, and further the building of appropriate systems of care. For ethnic minority clients who receive referrals from primary care to mental health, there is usually poor follow through on these referrals. Thus, policies that integrate culturally appropriate mental health services into schools and primary health and policies that build partnerships between these providers to provide early identification, prevention and intervention may be more effective in reaching children of color.

(2) Restructuring financing of mental health services is necessary to promote equity in mental health care for children of color. Families of color are grossly uninsured, with rates ranging from 21% for Asian Americans and Pacific Islanders to 37% for Latinos. Black children are

20% more likely and Latino children twice as likely to be uninsured than White children (U.S. DHHS, 2001; Kaiser Foundation, 2000). Current state prioritization for mental health funding is ranked as a high priority in only seven states and state appropriations for mental health have increased at a much lower rate than total state spending and spending for corrections (Lutterman, Hirad and Poindexter, 1999). While Medicaid is an invaluable funding source for public mental health services, it is founded on a medical model of treatment that is not designed for community based services and supports or the complex array of nonmedical services needed by children of color with mental health needs.

(3) Assessing quality and increasing accountability of services for minority youth and their families is consistent with the widespread emphasis on results, outcome data, performance requirements, and standards of care that have become an integral part of the operations of human service agencies on both the state and federal levels. In 2000, the federal Center for Mental Health Services published Cultural Competence Standards in Managed Mental Health Care Services: Four Underserved/Underrepresented Racial/ Ethnic Groups (CMHS, 2000). Standards such as these should provide the benchmarks for providers serving children of color. Minority populations are vulnerable to discriminatory practices and systemic racism. Policies and procedures must be developed to systematically document the service access, treatment plans, and outcomes for these children.

(4) Including racially and ethnically diverse populations in mental health research is imperative to gaining a better understanding of the epidemiology of mental health problems, building the evidence base for these groups, and understanding the impact of mental health services. Without basic epidemiological data, we lack understanding of the breadth of problems and the data necessary to advocate on behalf of these populations. Without their inclusion in studies of evidence-based practices, we don't really know what works for these groups and therefore what constitutes "quality" services. Youth of color are rarely included in efficacy or effectiveness studies. Community based and ethnicspecific agencies have been providing services to diverse populations for several decades but have not developed an evidence base to support their practice. Because payers and purchasers of services will increasingly be guided by the "evidencebase," these agencies need to be involved in a services research endeavor. Additionally, proven evidencebased practices need to be disseminated to those community programs that have an established infrastructure for delivery of care that is accessible, acceptable, and affordable to communities of color.

(5) Developing strategic plans for cultural competence at the state and local level may provide policies and incentives that potentially change the delivery of mental health interventions and supports at multiple levels. Several states have statewide operational cultural competence plans. For example, Pennsylvania's plan, adopted by the Department of Public Welfare's Office of Mental Health and Substance Abuse Services, aims to improve cultural and clinical competence at administrative and provider levels throughout the state's behavioral health system. The plan calls for regular training in cultural competence; articulating policy and program objectives, and providing monthly reporting on these objectives; and for incorporating cultural competence standards into policies, training, programs, and initiatives of each state mental health facility. Other states' plans also address human resource issues, a critical piece in developing culturally competent systems of care. Dr. David Satcher, the recent U.S. Surgeon General, states, "To the extent that we meet the health needs of the most vulnerable among us, we actually do the most to promote and protect the health of the nation. Whether we're talking about children or ethnic minorities, the extent to which we respond to the needs of our most vulnerable citizens and the degree to which we make changes to alleviate the unique needs of our least protected says a great deal about how well we are promoting and protecting the health of the nation" (Carter Center, 2000, p. 13).

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Larke Nahme Huang, Ph.D., *is a Senior Policy Associate at the National Technical Assistance Center for Children's Mental Health at Georgetown University.*