

# PERFORMANCE SPEAKS

## CULTURAL COMPETENCE IN MENTAL HEALTH

### *What is Culture?*

Culture may be defined as the behaviors, values, and beliefs shared by a group of people, such as an ethnic, racial, geographical, religious, gender, class, or age group. Everyone belongs to multiple cultural groups, so that each individual is a blend of many influences.

Culture includes or influences dress, language, religion, customs, food, laws, codes of manners, behavioral standards or patterns, or beliefs. It plays an important role in how people of different backgrounds express themselves, seek help, cope with stress, and develop social supports. Culture affects every aspect of an individual's life, including how we experience, understand, express, and address emotional and mental distress.

### *What is Cultural Competence?*

Cultural competence is the ability to relate effectively to individuals from various

groups and backgrounds. Culturally competent services respond to the unique needs of members of minority populations and are also sensitive to the ways in which people with disabilities experience the world. Within the behavioral health system (which addresses both mental illnesses and substance abuse), cultural competence must be a guiding principle, so that services are culturally sensitive and provide culturally appropriate prevention, outreach, assessment, and intervention.

Cultural competence recognizes the broad scope of the dimensions that influence an individual's personal identity. Mental health professionals and service providers should be familiar with how these areas interact within, between, and among individuals. These dimensions include:

- \* race
- \* age
- \* ethnicity
- \* disability

- \* language
- \* class/socioeconomic status
- \* sexual orientation
- \* education
- \* gender
- \* religious/spiritual orientation

### *Diversity in the United States*

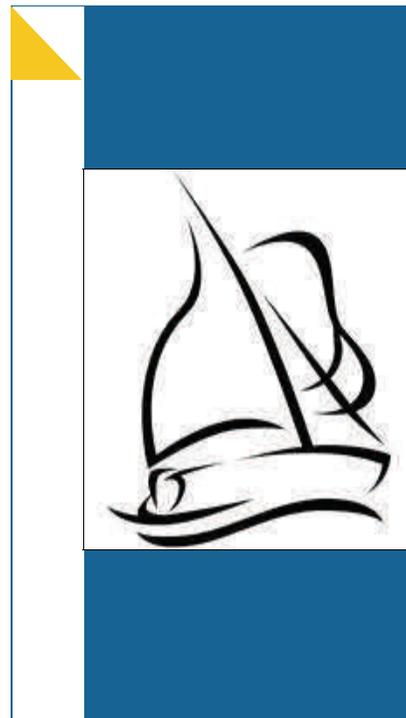
The U.S. population is rapidly diversifying:

\* The decade between 1990 and 2000 saw the largest increase - from 20% to 25% - in population growth of persons of color.

\* According to the 1990 census, the number of persons who speak a language other than English rose 43%, to 28.3 million, compared with 1980 census figures.

\* Nearly 45% of these 28.3 million people indicated having trouble speaking English.

\* One in 10 Americans are now foreign-born.



Inside this issue:	
Cultural Competence in Mental Health	1-4
MMBPIS Dashboard	5
Peer Michigan Conference	6

## PERFORMANCE SPEAKS

\* One in 3 Americans belongs to a group or groups identified as minorities.

The diversity that exists within groups is often overlooked. For example:

\* The term *Asian American* includes people from a variety of nations, such as Afghanistan, China, India, Syria, and Japan.

\* The term *African American* implies that 33.9 million people share certain characteristics because of their ties with some of the 797 million people in Africa, who live in 54 different countries and speak some two thousand different languages.

\* The term *Native American* includes people who may be of unmixed ancestry or whose Native American lineage is only a fraction of their backgrounds, who may trace their roots to any of more than 500 different tribes, and who may or may not identify with tribal culture.

\* According to 2006 Census Bureau estimates, some 44.3 million Americans were identified as Hispanic. Within this "group", 64% were of Mexican background, 9% were of Puerto Rican background, 3.5% Cuban, 3% Salvadoran, and 2.7%

Dominican. The remainder are of some other Central American, South American, or other Hispanic or Latino origin.

With the increasing diversity of the U.S. population, mental health service providers must be aware of the influences that culture has on psychological processes, mental illnesses, and the ways that people seek help. They must also be aware of the variety within groups.

### *Disparities in Mental Health Services*

The Surgeon General's report *Mental Health: Culture, Race, and Ethnicity* discusses disparities in behavioral health services for members of racial and ethnic minority populations. People in these populations:

\* are less likely to have access to available mental health services;

\* are less likely to receive necessary mental health care;

\* often receive a poorer quality of treatment; and

\* are significantly under-represented in mental health research.

Members of racial minority

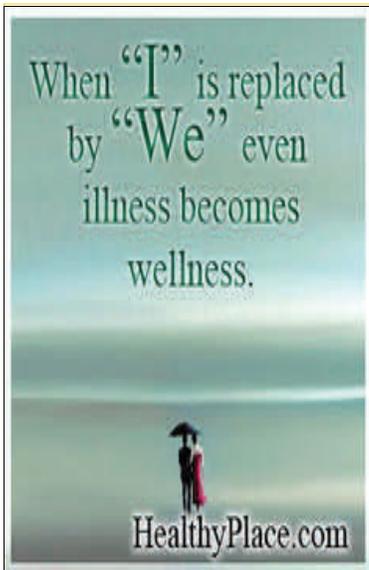
groups, including African Americans and Latinos, underuse mental health services and are more likely to delay seeking treatment. Consequently, in most cases, when such individuals seek mental health services they are at an acute stage of illness. This delay can result in a worsening of untreated illness and an increase in involuntary services.

Generally, rates of mental disorders among people in most ethnic minority groups are similar to rates for Caucasians. However, members of minority populations are more likely to experience factors - such as racism, discrimination, violence, and poverty - that may exacerbate mental illnesses.

Cultural disparities include the following:

\* For decades, studies have shown that African Americans are more likely to be misdiagnosed with schizophrenia than any other ethnic group. Reasons for this remain unclear.

\* A protein that metabolizes several antidepressant medications is less active in East Asians. This increases the risk of higher blood levels of medication and more side effects within



members of this population, indicating that everyone doesn't respond to and metabolize medication in the same way and at the same rate.

\* Research on Native Americans and Alaskan Natives is limited, but existing studies suggest that members of these populations experience a disproportionate percentage of mental health problems and disorders. For example, the suicide rate among Native Americans and Alaskan Natives is 50% higher than the national rate.

### *Cultural Barriers to Mental Health Care*

Cultural barriers that prevent members of minority populations from receiving appropriate care include:

- \* mistrust and fear of treatment;
- \* alternative ideas about what constitutes illness and health;
- \* language barriers and ineffective communication;
- \* access barriers, such as inadequate insurance coverage; and
- \* a lack of diversity in the

mental health workforce.

### *Cultural Biases and Stereotypes*

In general, discrimination refers to the hostile or negative feelings of one group of people toward another. It can cause bias in service provision and can prevent people from seeking help. Cultural competency must address the biases and stereotypes that are associated with an individual's culture and various identities.

Forms of discrimination include:

**Racism:** prejudice or discrimination based on a person's race, or on the belief that one race is superior to another;

**Ageism:** bias toward an individual or group based on age. For example, young people may be stereotyped as immature and irresponsible; older adults may be called slow, weak, dependent, and senile;

**Sexism:** discrimination or prejudice based on gender.

**Heterosexism:** prejudice against people who are gay, lesbian, bisexual, transgender, or intersex. It

is also the assumption that all people are heterosexual and that heterosexuality is correct and normal;

**Homophobia:** the fear and/or dislike of homosexual people or homosexuality;

**Classism:** any form of prejudice or oppression against people who are members of (or who are perceived as being similar to those who are members of) a lower social class; and

**Religious intolerance:** an inability or unwillingness to tolerate another's beliefs or practices.

### *How to Incorporate Cultural Competency Standards Into Practice*

Mental health professionals and service providers can improve their cultural competence by taking the following steps:

- \* Use open-ended questions to identify each person's unique cultural outlook.
- \* Re-evaluate intake and assessment documentation, as well as policies and procedures, to be more inclusive.

**Muskegon County  
Community Mental  
Health of Muskegon  
County**

**376 E. Apple Ave.  
Muskegon, MI  
49442  
(231) 724-1111**

**We're on the Web:**

**customer.services@  
muskegoncmh.org**



## PERFORMANCE SPEAKS

\* Employ qualified mental health workers who are fluent in the languages of the groups being served.

\* Understand the cultural biases of staff and provide training to address educational needs.

\* Understand the cultural biases in program design.

\* Identify resources, such as natural supports, within the community that will help an individual recover.

\* Design and implement culturally sensitive treatment plans.

\* Evaluate procedures and programs for cultural sensitivity and effectiveness.

\* Survey clients and workers to elicit their understanding of cultural competence and culturally competent practice.

### *An Example of Cultural Competence in Practice: A Community-Based Intervention for Elderly Chinese Americans*

Depression and dementia are the most common forms of mental illness in older adults. Depression, often associated with physical illness or disability, increases health care costs

and can lead to suicide.

**“Chinese elders typically don’t seek help for depression and other mental disorders,” said Sandy Chen Stokes, a nurse and geriatric specialist at El Camino Hospital’s Older Adult Transitions (OATS), an outpatient counseling service in Mountain View, California. “...You go along with what your culture tells you: tough it out or let time heal the problem...They don’t know depression can be treated...(Some) end up as an inpatient or in a locked facility.” (Cloutman, 2001)**

Stokes began an outreach program by first disseminating information about depression in Chinese-language newspapers, radio, and television programs. With a gift from an anonymous donor, Stokes purchased translation devices so that Chinese clients could be integrated into an English-speaking counseling group.

### *Conclusion*

The mental health system is slowly improving, but large gaps in services still exist. When you are seeking and/or providing mental health services, it is good to under-

stand that cultural differences influence every individual, both provider and client. With the proper training for mental health workers and educational materials for members of minority populations, culturally sensitive services can be effective in treating and possibly preventing episodes of acute mental illness.

[www.upennrrtc.org](http://www.upennrrtc.org)

**“IF YOU ARE ALWAYS TRYING TO BE NORMAL YOU WILL NEVER KNOW HOW AMAZING YOU CAN BE.”**

*Maya Angelou*

# Lakeshore Behavioral Health Alliance

## MMBPIS Performance Indicator Dashboard

FY12/13

	Meets or exceeds target for goal
	Does not meet target for goal
	Close - Within 5 % of target

MMBPIS Indicator #	Quarterly Measures	Target	Oct-Dec12	Jan-Mar13	Apr-Jun13	July-Sept13
<b>Indicator #1</b>	% of Pre-Admission Screening Dispositions 3 hrs or less - Children	95%	100.0%	98.5%		
	% of Pre-Admission Screening Dispositions 3 hrs or less - Adults	95%	96.7%	97.3%		
<b>Indicator #2</b>	F/F Assessment within 14 days --MIC	95%	98.5%	100.0%		
	F/F Assessment within 14 days --MIA	95%	100.0%	99.2%		
	F/F Assessment within 14 days --DDC	95%	100.0%	100.0%		
	F/F Assessment within 14 days --DDA	95%	100.0%	100.0%		
	F/F Assessment within 14 days -- SA	95%	96.5%	97.3%		
	<b>F/F Assessment within 14 days --Lakeshore PIHP Total</b>	95%	98.1%	98.8%		
<b>Indicator #3</b>	Start of Service Within 14 Days --MIC	95%	97.5%	95.1%		
	Start of Service Within 14 Days --MIA	95%	98.3%	95.0%		
	Start of Service Within 14 Days --DDC	95%	100.0%	100.0%		
	Start of Service Within 14 Days --DDA	95%	100.0%	100.0%		
	Start of Service Within 14 Days --SA	95%	97.9%	97.9%		
	<b>Start of Service Within 14 Days --Lakeshore PIHP Total</b>	95%	98.0%	96.6%		
<b>Indicator #4a</b>	% Seen Within 7 Days of Inpatient Discharge - Children	95%	100.0%	92.3%		
	% Seen Within 7 Days of Inpatient Discharge - Adults	95%	100.0%	100.0%		
<b>Indicator #4b</b>	% Seen Within 7 Days of SA Detox Unit Discharge -SA	95%	100.0%	100.0%		
<b>Indicator #12</b>	Inpatient Recidivism Rate - Children	15% or less	10.3%	13.8%		
	Inpatient Recidivism Rate - Adults	15% or less	14.1%	8.3%		



Mark Your  
Calendar!

Announcing the

## PEER MICHIGAN Conference

September 23, 24, 25, 2013

Best Western Plus Hotel in Lansing, MI

### Conference Goals;

- Promote and advance collaboration among consumers / peers.
- Expand the knowledge base and resources available for peer to peer based services
- Highlight creative and effective peer to peer and self management practices.
- Foster statewide networking around shared advocacy, interests and goals.
- Extend awareness and access to tools that support individuals self-advocacy.

### Educational Tracks:

The Conference will include educational tracks for the following groups:

Consumers / Peers  
Peer Support Specialists  
Recovery Coaches  
Peer Mentors  
Advocates

### Providing Input:

To provide input or workshop recommendations please email the conference planning committee by contacting, Colleen Jasper at [jasperc@michigan.gov](mailto:jasperc@michigan.gov)

Look for registration brochures in July.