CUTLTURAL COMPETENCY PLAN

The Culture of Mental Health

Culture can be defined as the sum of all things passed on from one generation to the next. Culture is always evolving. What makes us unique from each other are our differences. Worldview, beliefs, language, family, traditions, and experience are just a few areas that make us unique and different from each other. In mental health, the culture and diversity of the consumer has an influence in mental health, mental illness, value orientation, mental health utilization and expectations related to how mental health services should be offered. Providers of mental health services also have a culture that is based on treatment of "mental disease", and the diagnosis of symptoms. Culture brings an added challenge to mental health providers. Symptoms of mental health, and disorders are found worldwide thus requiring providers to have an increased awareness of the complexity of perspectives in diagnosing mental illness and how mental health services are offered. If a provider only views symptoms from a single cultural vernacular he or she will miss valuable information to provide an accurate diagnosis, appropriate treatment and the right intervention. Another variable of culture to consider is the "stigma" society places on people with mental illness.

Stigma, Racism, Discrimination and Mental Health Disparities

Stigma is widespread in the United States and Western nations. Stigma is a negative attitude and belief that motivates the general public to fear and discriminate against people with mental illness. Discrimination is a stressful and traumatic occurrence that adversely affects consumers with mental illness and their families. In the United States minorities and diverse groups face a social and economic environment of inequalities. In fact disparities and inequalities in mental health treatment have been well documented in the literature, for example:

- Elderly African American community residents, are less likely to receive antidepressant medications by service providers (Blazer et al. 2000)
- African American Medicaid recipients when compared with whites are less likely to receive newer atypical anti-psychotic medications that result in less and fewer side effects and are more likely to get injectable anti-psychotics. (Kuno et al. 1997)
- Some investigators who have studied Latinos and African Americans visiting primary care clinics with mental health related complaints find that when compared with Whites these two groups are less likely to receive prescriptions for psychotropic medications. (Snowden et al.2002, Sclar et al.1999)
- When prescribed psychotropic medications, minority individuals are likely to sometimes receive suspiciously high doses. (*Segal et al. 1996, Chung et al. 1995*)

- African Americans, Asian and Latinos are less likely to receive guideline-adherent treatment when suffering from anxiety disorders and depression when compared with Whites. (*Wang et al. 2001 , Young et al. 2001*)
- Native Americans and African Americans are over represented in inpatient settings. African Americans are also over represented in inpatient psychiatric emergency rooms. (*Herrera et al. 1999*)
- African Americans and Asians are more likely than whites to be diagnosed with an organic or psychotic disorder (Schizophrenia). (Unequal Treatment, IOM, 2003)
- African Americans are 6 times more likely than whites to be labeled as alcoholic or substance abusers. (Unequal Treatment, IOM, 2003)
- Consumers who do not speak the same language as the emergency room doctor will have about a 70% increased likelihood of being admitted to the hospital. If an interpreter is used during the visit, then the chance of hospitalization decreases. *(Lee E.D., Rosenberg C.R., Sixsmith D.M. ,Pang D., Abularrage J., 1998)*

Communication offered in another language than the primary language of the consumer will lead to misunderstanding. Non- English patients reported only understanding 59% of diagnosis, prescribed medications, additional instructions and plans for follow-up care after contact with providers. *(Crane, J.A., 1997)*

When considering discrimination, racism and the supportive empirical evidence of the existence of disparities in mental health, minorities and diverse groups are at a higher risk for mental disorders. And in cases when linguistic appropriate services are not available those consumers are likely not to receive services at all. If we are going to provide mental health services, we must promote a “culture of recovery” that integrates cultural knowledge, cultural competency and inclusion.

Definition of Cultural Competence

Cultural and linguistic competence is a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations. “Culture” refers to integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups. “Competence” implies having the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities. (Based on Cross, Bazron, Dennis, & Issacs, 1989)

Jackson County Mental Health Fund also understands that to continually work on our level of cultural competence we must intentionally develop processes for our self as well as for our provider network to continue learning the skills necessary to provide services to our diverse communities. These differences

include but are not limited to ethnic, racial, sexual orientation, geographical, age, disability and low socioeconomic status.

At the Jackson County Mental Health Fund we believe our mental health system must intentionally and continuously evolve with our understanding and practice of mental health services. Our primary goal is to meet the needs and expectations of the consumer and families we serve.

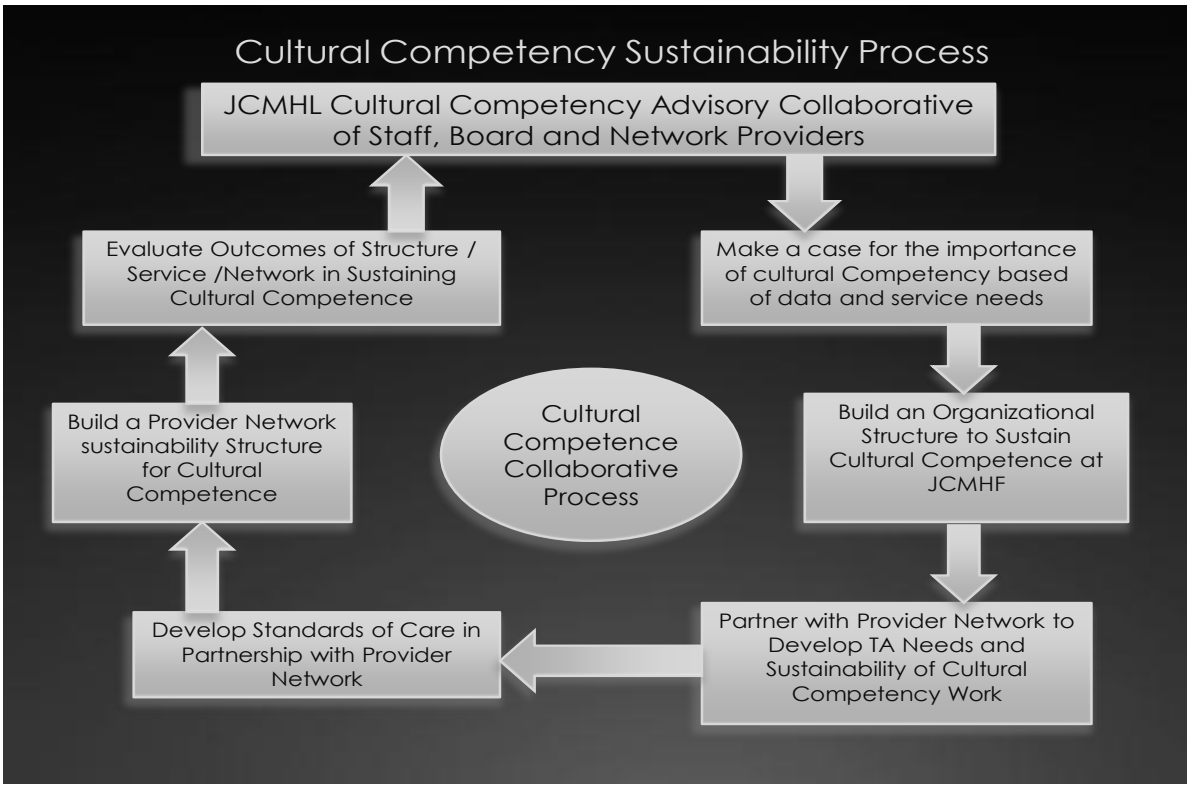
The Jackson County Mental Health Fund and the Board of Directors are committed to continually promote a culture of recovery that fosters and supports culturally competent practices that will meet the needs of all consumers and families served in our provider network. The Jackson County Mental Health Fund is invested to work with our provider network to develop a collaborative and comprehensive approach to cultural competency that is built on a foundation of understanding, acceptance, and inclusion.

The Jackson County Mental Health Fund also recognizes that quality care for all diverse communities in our catchment area depends on inclusion and accessibility of services. We are committed to a service network of providers that have competencies in servicing diverse communities. We are invested in promoting collaboration and partnerships with providers who recognize that in order to be effective in servicing diverse communities, providers must have a level of cultural competency skills in dealing with divergent norms, beliefs, and expectations and how these important factors impact recovery and the empowerment of service recipients.

Development of a Cultural Competency Plan:

The Jackson County Mental Health Fund defines inclusion as the ability to behave in a manner that is sensitive to the needs and varying backgrounds of consumer, families and staff. To this end we have developed a Cultural Competency Plan that will require participation and collaboration with experts in

our service network who also have direct experience with the needs in our service area.



This Cultural Competency Sustainability Plan will guide the Jackson County Mental Health Fund and partners through a process to implement the Jackson County Mental Health Levy Cultural Competency Plan. The overarching goal of the Cultural Competency Sustainability Plan is to ***make cultural competency a sustainable part of our service network***. We recognize that in order for this process to be sustainable we must partner with our provider network, Board of directors and community expertise. The proposed steps to carry out this Plan will involve the following:

1. The Formation of a Jackson County Mental Health Fund Cultural Competency Collaborative:

This Advisory Committee to the Jackson County Mental Health Fund will report directly to the Board of Directors and will be tasked with the implementation of the JCMHF Cultural Competency Plan. This Advisory Committee will be composed of JCMHF staff, Board of Directors and selected experts from our provider network. This Advisory Committee will:

- ✓ Capitalize on provider network strengths to build on cultural competency.
- ✓ Have representation of all levels of stakeholders to include consumers, JCMHL staff and Board of Directors and Provider Network representatives.

- ✓ Emphasize the collaborative relationship between the JCMHF and its provider network for the purpose of sustaining cultural competence.
- ✓ Promote a shared vision and direction with all stakeholders in building cultural competency.

The sustainability Process Plan will be as follows:

MAKE A CASE FOR THE IMPORTANCE OF CULTURAL COMPETENCY BASED DATA AND SERVICE

Make the case for the importance of cultural competence in providing services to diverse communities, and for creating a network that will sustain cultural competence for the purpose of serving the needs of all diverse communities living in Jackson County.

- ✓ Focus efforts on data gathering to continue to make the case for the importance of cultural competence in service delivery.
- ✓ Collect and present data on mental health disparities in Jackson Country.
- ✓ Set guidelines on data collection to account for disparities and service trends in Jackson County.
- ✓ Provide direction to the provider network on data collection to account for the reduction and impact of cultural competence.
- ✓ Report pertinent data to stakeholders.
- ✓ Report continuous improvement to service network and stakeholders.

BUILD AN ORGANIZATIONAL STRUCTURE TO SUSTAIN CULTURAL COMPETENCE AT JCMHF

- ✓ Begin developing indicators of cultural competence for the service network.
- ✓ Develop cultural competency sustainability requirements for funded providers (provider network).
- ✓ Develop sustainability structure for JCMHF.
- ✓ Build an organizational structure to disseminate information, communication and accountability for cultural competency with provider network.
- ✓ Report continuous improvement to service network and stakeholders.

PARTNER WITH PROVIDER NETWORK TO DEVELOP TA NEEDS AND SUSTAINABILITY OF CULTURAL COMPETENCY WORK

- ✓ Assess service network training needs and offer standardized trainings in the area of cultural competence.
- ✓ Develop a plan to promote linguistic competency standards throughout the service network.
- ✓ Promote interpreters certification standards to be used by the service network.
- ✓ Report continuous improvement to service network and stakeholders.

DEVELOP STANDARDS OF CARE IN PARTNERSHIP WITH PROVIDER NETWORK

- ✓ Develop cultural competence indicators of care for the JCMHL network providers.
- ✓ Select indicators for measurement and reporting.
- ✓ Develop a Quality Improvement process to account for progress.
- ✓ Report continuous improvement to service network and stakeholders.

BUILD A PROVIDER NETWORK SUSTAINABILITY STRUCTURE FOR CULTURAL COMPETENCE

- ✓ Build on current strengths of provider network to solidify sustainability structure.
- ✓ Work with network providers to build sustainability plans for cultural competence.
- ✓ Provide training and TA on building sustainability of cultural competence.
- ✓ Formalize a TA component to the JCMHL to work with network providers.
- ✓ Report continuous improvement to service network and stakeholders.

EVALUATE OUTCOMES OF STRUCTURE / SERVICE /NETWORK IN SUSTAINING CULTURAL COMPETENCE

- ✓ Create an evaluation plans for the initiative.
- ✓ Evaluate JCMHL effectiveness in network development.
- ✓ Evaluate provider network and efficacy in sustaining cultural competence.
- ✓ Report continuous improvement to service network and stakeholders.

Attachment 1

JACKSON COUNTY MENTAL HEALTH LEVY

CULTURAL COMPETENCY PLAN GOALS

- PROMOTE A SYSTEM OF MENTAL HEALTH CARE THAT IS CULTURALLY AND LINGUISTICALLY RESPONSIVE TO ALL MEMBERS AND FAMILIES.
- DEVELOP AN ORGANIZATIONAL STRUCTURE THAT WILL SUSTAIN DIVERSITY/CULTURAL COMPETENCY AND INCLUSION PRACTICES AMONG THE BOARD, STAFF AND PROVIDERS.
- INCREASE AND PROMOTE WORKFORCE DIVERSITY.
- PROMOTE AND INTEGRATE CULTURAL COMPETENCE, DIVERSITY AND INCLUSION WITH BOARD OF TRUSTEES.
- SET BENCHMARKS FOR QUALITY IN RESPONSE TO MEMBERS AND FAMILIES NEEDING CULTURALLY AND LINGUISTICALLY APPROPRIATE SERVICES.
- SERVE AS A MENTAL HEALTH SERVICE LEADER IN THE AREA OF CULTURAL AND LINGUISTIC COMPETENCE.

Attachment 2

PROVIDER NETWORK REQUIREMENTS FOR 2011

In its effort to promote the Cultural Competency Initiative the JCMHF Board of Trustees continues to require that all funded network providers show evidence of their continued work in the area of cultural competency. The JCMHF continues to use the Culturally Linguistic and Appropriate Standards (CLAS) standards as a guideline for network quality improvement in the area of cultural competency.

The JCMHL has adopted the following requirement for funded network providers to accomplish for the year 2011 through 2013.

2011 - Develop/implement a Cultural Competency advisory structure

- ✓ Develop a functional cultural competency committee composed of members of the organization represented by consumers, program staff, Board and other stakeholders.
- ✓ Develop a job description for the committee and outline reporting of the committee to the organization. (Incorporate Committee into organizational Chart)
- ✓ Committee task: Develop a cultural competency definition for the organization, Development and adoption of an inclusion policy for the organization, Assess the organizations training needs in cultural competence as indicated by an organization assessment.
- ✓ Show written record of the Committee function by having minutes of all meetings.
- ✓ For the Committee to develop a staff cultural competence training program utilizing staff feedback, service data, program data

2012 – Develop implementation of policies on consumer rights for competent language assistance (For recipients of federal funding such as Medicaid, policy should be concordant with Department of Health and Human Services (DHHS), Office of Minority Health requirements).

2013-Develop strategies to recruit, retain and promote at all levels of the organization, a diverse staff and leadership and Board of Directors that are representative of the demographic characteristics of the service area.

The Board has selected these standards to continue building sustainability and structure to sustain cultural competence with our provider network. Board and Staff at JCMHL will continue work in partnership with the JCMHF Cultural Competence Advisory Committee to evaluate progress.

Attachment 3

NATIONAL STANDARDS ON CULTURALLY AND LINGUISTICALLY APPROPRIATE SERVICES (CLAS)

The CLAS standards are primarily directed at health care organizations; however, individual providers are also encouraged to use the standards to make their practices more culturally and linguistically accessible. The principles and activities of culturally and linguistically appropriate services should be integrated throughout an organization and undertaken in partnership with the communities being served.

The 14 standards are organized by themes: Culturally Competent Care (Standards 1-3), Language Access Services (Standards 4-7), and Organizational Supports for Cultural Competence (Standards 8-14). Within this framework, there are three types of standards of varying stringency: mandates, guidelines, and recommendations as follows:

CLAS **mandates** are current Federal requirements for all recipients of Federal funds (Standards 4, 5, 6, and 7).

CLAS guidelines are activities recommended by OMH for adoption as mandates by Federal, State, and national accrediting agencies (Standards 1, 2, 3, 8, 9, 10, 11, 12, and 13).

CLAS recommendations are suggested by OMH for voluntary adoption by health care organizations (Standard 14).

Standard 1 Health care organizations should ensure that patients/consumers receive from all staff member's effective, understandable, and respectful care that is provided in a manner compatible with their cultural health beliefs and practices and preferred language.

Standard 2 Health care organizations should implement strategies to recruit, retain, and promote at all levels of the organization a diverse staff and leadership that are representative of the demographic characteristics of the service area.

Standard 3 Health care organizations should ensure that staff at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery.

Standard 4 Health care organizations must offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each patient/consumer with limited English proficiency at all points of contact, in a timely manner during all hours of operation.

Standard 5 Health care organizations must provide to patients/consumers in their preferred language both verbal offers and written notices informing them of their right to receive language assistance services.

Standard 6 Health care organizations must assure the competence of language assistance provided to limited English proficient patients/consumers by interpreters and bilingual staff. Family and friends should not be used to provide interpretation services (except on request by the patient/consumer).

Standard 7 Health care organizations must make available easily understood patient-related materials and post signage in the languages of the commonly encountered groups and/or groups represented in the service area.

Standard 8 Health care organizations should develop, implement, and promote a written strategic plan that outlines clear goals, policies, operational plans, and management accountability/oversight mechanisms to provide culturally and linguistically appropriate services.

Standard 9 Health care organizations should conduct initial and ongoing organizational self-assessments of CLAS-related activities and are encouraged to integrate cultural and linguistic competence-related measures into their internal audits, performance improvement programs, patient satisfaction assessments, and outcomes-based evaluations.

Standard 10 Health care organizations should ensure that data on the individual patient's/consumer's race, ethnicity, and spoken and written language are collected in health records, integrated into the organization's management information systems, and periodically updated.

Standard 11 Health care organizations should maintain a current demographic, cultural, and epidemiological profile of the community as well as a needs assessment to accurately plan for and implement services that respond to the cultural and linguistic characteristics of the service area.

Standard 12 Health care organizations should develop participatory, collaborative partnerships with communities and utilize a variety of formal and informal mechanisms to facilitate community and patient/consumer involvement in designing and implementing CLAS-related activities.

Standard 13 Health care organizations should ensure that conflict and grievance resolution processes are culturally and linguistically sensitive and capable of identifying, preventing, and resolving cross-cultural conflicts or complaints by patients/consumers.

Standard 14 Health care organizations are encouraged to regularly make available to the public information about their progress and successful innovations in implementing the CLAS standards and to provide public notice in their communities about the availability of this information.

U.S. Department of Health and Human Services, OPHS – Office of Minority Health